Adult Obesity Provider Toolkit

2013

CMA FOUNDATION

California Association of Health Plans

California Medical Association Foundation
3840 Rosin Court, Suite 200
Sacramento, CA 95834
Phone: 916.779.6631
Fax: 916.779.6658
Website: http://www.thecmafoundation.org

California Association of Health Plans
1415 L Street, Suite 850
Sacramento, CA 95814
Phone: 916.552.2910
Fax: 916.443.1037
Website: http://www.calhealthplans.org

Allergan, Inc
P.O. Box 19534
Irvine, CA 92623
Phone: 714.246.4500
Fax: 714.246.4971
Website: http://www.allergan.com

Ethicon Endo-Surgery, Inc.
4545 Creek Road
Cincinnati, OH 45242
Phone: 513.337.7000
Fax: 513.337.7912
Website: http://www.ethicon.com

In order to continue to improve the information we make available to you, we ask that you provide us with feedback once you have read and use this resource. Your feedback will be essential in helping us continuously improve this toolkit and provide ongoing support and information that focuses on key messages and issues that are important to California health care providers.

The online survey is available at: https://s.zoomerang.com/s/2013AdultObesityProviderToolkitEvaluation

This provider toolkit is also available in an electronic format. If you would like to download a free copy, please visit the Obesity Prevention Project website at http://www.thecmafoundation.org/projects/obesityProject.aspx

Adult Obesity Provider Toolkit

2013

Preface

Dear colleagues,

More than two-thirds (68 percent) of American adults are either overweight or obese with 35.5% considered obese. In California, 60% of adults are overweight and 24% are obese. Higher rates of obesity are found in our state's ethnic minority and underserved communities. A combination of poor diet and lack of physical activity has caused adults to be at greater risk for major chronic diseases such as type 2 diabetes, heart disease and cancer.

We know the challenge you encounter with your patients and obesity. Many physicians feel overwhelmed and frustrated by the daunting task of addressing weight issues with their patients given the physical, emotional, social, and environmental factors associated with obesity and weight management. The wide variety of messages about the prevention, treatment and management of obesity makes it increasingly difficult to determine the best plan of action to pursue with patients. We offer this toolkit as a resource in your practice to help overcome some of these challenges.

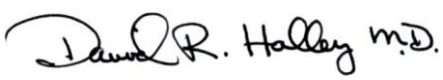
The California Medical Association (CMA) Foundation and California Association of Health Plans (CAHP) convened an expert panel of physicians and other health care providers to update our Adult Obesity Provider Toolkit with the support and partnership of Ethicon-Endo Surgery and Allergan, Inc.
The expert panel:

- Broadened the Toolkit's resources for organizing your office.
- Updated the Toolkit's resources to include the most up-to-date clinical preventive and weight management guidelines.
- Reviewed and updated the Toolkit to include the 2011 USDA Dietary Guidelines.
- Strengthened the Toolkit's section on patient/provider communications adding new resources on multicultural communications.
- Ensured that a stronger component of multicultural and multilingual patient education materials and resources was included.
- Expanded the Toolkit's section on patient goal setting & behavior management.
- Updated the Pharmacotherapy overview.
- Reinforced the Bariatric Surgery overview.
- Addressed the link between clinical prevention and community advocacy, offering health care providers the opportunity to become a physician walk leader of the CMA Foundation's Walk with a Doc Program.
- Updated the Toolkit section on billing and procedure codes.

The Toolkit provides clinical preventative resources and advocacy interventions to address adult obesity at the community level.

The CMA Foundation and CAHP Foundation support the efforts of physicians to reverse obesity trends by providing you with this resource developed by health care providers for health care providers. The toolkit and additional resources are available on the CMA Foundation website. For more information visit: http://www.thecmafoundation.org/projects/obesityProject.aspx.

Sincerely,



David Holley, MD
Chair, Board of Directors
California Medical Association Foundation

Patrick Johnston
President & CEO
California Association of Health Plans

Toolkit Purpose

In 2006, the California Medical Association (CMA) Foundation and the California Association of Health Plans (CAHP) collaborated with commercial and Medi-Cal managed care health plans, practicing physicians and other health provider organizations to complete a Pre/Post Bariatric Surgery Provider Toolkit addressing the prevention, early identification, weight management education of overweight and obesity.

In 2013, CMA Foundation and an Expert Panel again convened to update the clinical components and guidelines in this toolkit and added new resources addressing culturally competent care, multicultural communications and stronger patient and provider resources. This work brought together academic thought leaders from academic medical centers, physicians, physician assistants and nurse practioners working daily with our patients and their families as well as dietitians, nutritionists, health educators, experts in multicultural communications and health plan leadership. Expert panel members shared their daily experiences of working to address the growing obesity epidemic in their practice and community and communication expertise to strengthen this toolkit.

Through these collaborative efforts, the Adult Obesity Provider Toolkit has been updated to address overweight and obesity prevention and management in adults.

The objective of the Adult Obesity Provider Toolkit is to equip health care providers with strategies and tools to assess, prevent and effectively manage adult patients who are overweight and obese, and to offer pertinent information for providers to consider when discussing healthy lifestyles and weight management with their patients, including those from diverse and underserved communities.

Disclaimer

This toolkit is intended for physicians and healthcare professionals to consider in managing the care of their patients before and after bariatric surgery. While the toolkit describes recommended courses of intervention, it is not intended as a substitute for the advice of a physician or other knowledgeable healthcare professional. This toolkit represents best clinical practice at the time of publication, but practice standards may change as more knowledge is gained. Funding for this toolkit was provided by Ethicon-Endo Surgery and Allergan, Inc.

Ethicon Endo-Surgery
PART OF THE Johnson & Johnson FAMILY OF COMPANIES

ALLERGAN

Acknowledgements

The California Medical Association Foundation and California Association of Health Plans would like to thank the following individuals for their dedication to this project. Their support, time, and expertise were critical to the development of this document.

Expert Panel

Sylvia Gates Carlisle, MD, MBA
Anthem Blue Cross

Dennis Carrillo
Health Promotion Specialist
Health Net of California
State Health Programs

David Chen MD, MBA
Central Health Medicare
Plan of California

Scott Gee, MD
Medical Director, Prevention & Health Information
Regional Health Information
Kaiser Permanente Northern California

Sue Wong Gengler, DrPH, MCHES
Health Education Manager
Inland Empire Health Plan

John J. Granato Jr., MD
Medical Director
CIGNA Healthcare

Lawrence Hammer, MD
Professor of Pediatrics
Stanford University School of Medicine

William Henning, DO
Chief Medical Officer
Inland Empire Health Plan

Donald Hufford, MD
Chief Medical Director
Western Health Advantage

Nai Kasick, MPH, CHES
Director, Cultural & Linguistic Services
Health Education
LA Care Health Plan

NJ Mitchell
Vice President of Operations & Content
Management Marketing
Human Communication Institute, LLC

John Morton, MD, MPH, FACS, FASMBS
Chief, Minimally Invasive Surgery
Director, Bariatric Surgery
Stanford University School of Medicine

Pamela Perkins
Management Marketing
Human Communication Institute, LLC

Donald Waldrep, MD, FACS, FASMBS
Bariatric Surgeon
Sutter Roseville Medical Center

Seleda Williams, MD, MPH, PHMOIII
Public Health Medical Officer
CA Department of Health Care Services
Systems of Care Division
Children's Medical Services

Sophia Yen, MD, MPH
Clinical Instructor, Division of Adolescent Medicine
Lucille Packard Children's Hospital
Stanford University Medical Center

Acknowledgements

California Medical Association Foundation Staff

Sandra Robinson
Vice President of Programs

Vanessa Saetern
Obesity Prevention Program
Project Coordinator

California Association of Health Plans

Nicole Kasabian Evans
Vice President, Communications

Sunshine Moore
Policy Analyst and Writer

Table of Contents

Table of Contents

1 Understanding Adult Overweight & Obesity

- Trends in Overweight & Obesity
- Costs Associated with Obesity
- Definition of Overweight & Obesity
- Risk Factors
- Health Consequences of Overweight & Obesity

Chapter 1 Understanding Adult Overweight & Obesity

Trends in Overweight & Obesity

Obesity is a complex chronic disease affected by environmental (physical, social and cultural), genetic, physiologic, metabolic, behavioral and psychological factors. More than two-thirds (68 percent) of American adults are either overweight or obese with 35.5% considered obese.[1,2] The prevalence of obesity poses a significant public health challenge because it is a major contributor to preventable deaths in the United States.[3] Overweight and obesity in adults has been associated with an increased risk of early mortality and co-morbid health conditions such as diabetes and cardiovascular disease in both adult males and females. There are also significant health disparities, with African American and Latino populations showing significantly higher rates of overweight and obesity.[4]

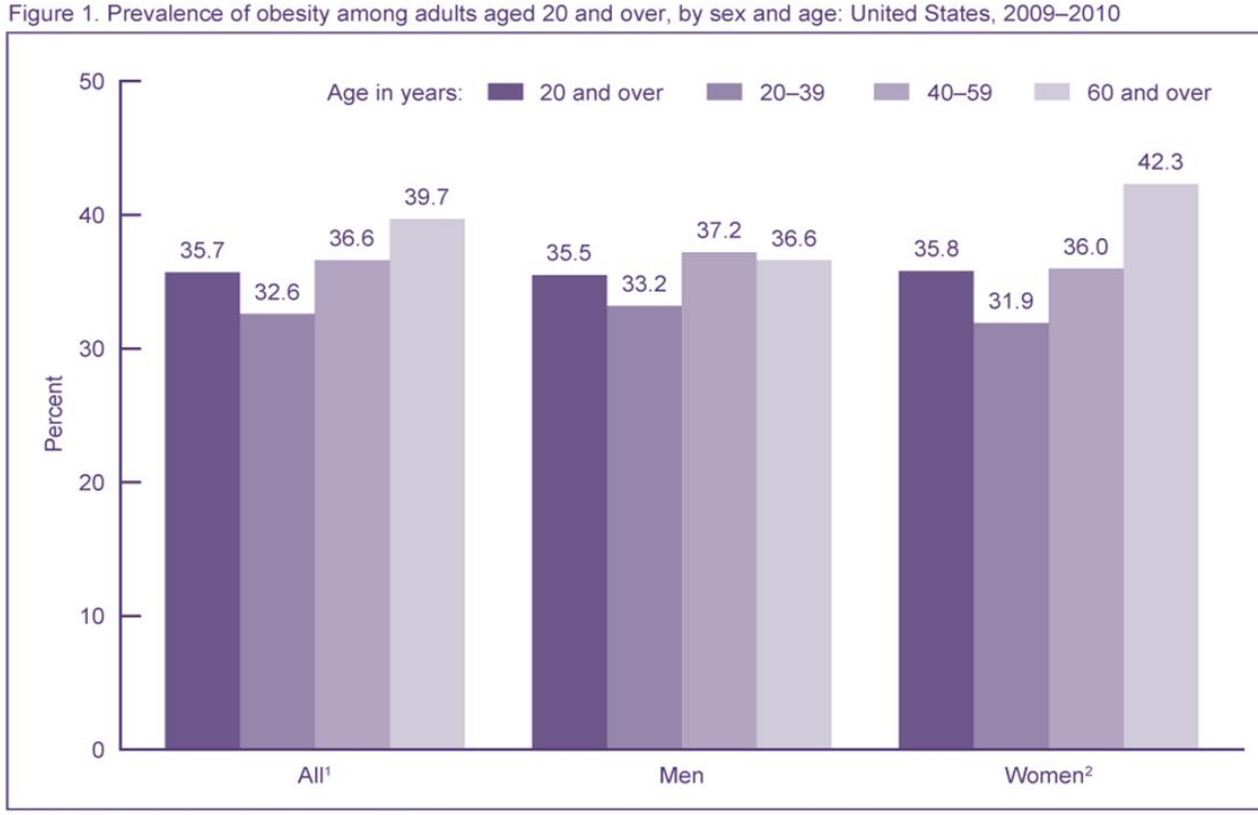
Costs Associated with Obesity

Overweight and obesity and their associated health problems have a significant economic impact on the U.S. health care system.[5] Medical costs associated with overweight and obesity may involve direct and indirect costs.[6,7] Direct medical costs may include preventive, diagnostic, and treatment services related to obesity. Indirect costs relate to morbidity and mortality costs. Morbidity costs are defined as the value of income lost from decreased productivity, restricted activity, absenteeism, and bed days. Mortality costs are the value of future income lost by premature death.

National Estimated Cost of Obesity

The medical care costs of obesity in the United States are staggering. In 2008 dollars, these costs totaled about $147 billion. Nine percent of annual medical spending was due to obesity. The increased cost associated with treating obesity led obese patients to have 42% greater healthcare costs and 80% greater prescription costs when compared to normal weight individuals.[8] Overall, the United States spends about $1.8 trillion a year in medical costs associated with chronic diseases such as diabetes, heart disease and cancer, and all three are linked to smoking and obesity, the nation's two largest risk factors, according to the America's Health Rankings report.

Figure 1. Prevalence of obesity among adults aged 20 and over, by sex and age: United States, 2009–2010



¹Significant increasing linear trend by age ($p < 0.01$).
²Significant increasing linear trend by age ($p < 0.001$).
NOTE: Estimates were age adjusted by the direct method to the 2000 U.S. Census population using the age groups 20–39, 40–59, and 60 and over.
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey, 2009–2010.

The total annual estimated cost to California for overweight, obesity and physical inactivity was $41.2 billion – $21.0 billion for overweight and obesity, and $20.2 billion for physical inactivity.[9] Health care costs totaled $20.7 billion and lost productivity costs reached $20.4 billion. Health care costs associated with overweight and obesity were $12.8 billion while health care costs associated with physical inactivity totaled $7.9 billion.

Definition of Overweight and Obesity

Obesity is defined as an excessively high amount of body fat or adipose tissue in relation to lean body mass. Overweight refers to increased body weight in relation to height, which is then compared with a standard of acceptable weight. Body Mass Index (BMI)–an individual's ratio of weight to height–is the widely accepted measurement of overweight and obesity. The National Institutes of Health define an adult individual overweight when their BMI is greater than or equal to 25kg/m^2. An individual is obese when BMI is greater than or equal to 30kg/m^2. Overweight and obesity occur when an individual's calorie absorption exceeds the amount of energy burned by the body. Evidence suggests that a number of risk factors contribute to obesity.

OBESITY: an excessively high amount of body fat or adipose tissue in relation to lean body mass.

Risk Factors[10]

Genetic Influences	• **Family history of chronic diseases and genetic diseases.**
Lifestyle	• **Limited physical activity** • **Poor eating habits and/or timing of eating that leads to excessive calorie consumption** • **Smoking, alcohol and narcotic use** • **Lack of sleep**
Family Environment	• **Regular fast food consumption** • **More than 2hours per day of TV or computer use** • **Sedentary lifestyle**

Community & Social Influences	• **Lack of access to healthy foods**
	  - **Many low income neighborhoods are without full service grocery stores or farmers markets**
	• **Unsafe Neighborhoods**
	  - **No sidewalks for safe walking or biking**
	  - **Limited access to safe parks**
	  - **Crime rates**

Psychological	• **Clinical Depression** • **Disordered eating** • **Adverse childhood events**

Health Consequences of Overweight & Obesity
Obesity increases the risk for common related health consequences and chronic disease, which can result in poor health and premature death. Even a modest weight loss (5-10% of bodyweight) is associated with health benefits that include improvement of co-morbid health conditions.[11]

Common obesity-related health conditions:[12, 13]

Psychological
- Negative Self-Image
- Depression
- Eating Disorders

Endocrine
- Diabetes Mellitus Type 2
- Metabolic Syndrome
- Thyroid Disorders

Pulmonary
- Obstructive Sleep Apnea
- Asthma

Orthopedic
- Osteoarthritis
- Gout

Oncology
- Gall bladder
- Esophagus
- Kidney
- Pancreas
- Colon
- Breast (post-menopausal)
- Endometrial
- Ovaries

Gastrointestinal
- Gastro Esophageal Reflux Disease (GERD)
- Gall Bladder Disease
- Non-Alcoholic Steatohepatitis

Cardiovascular
- Heart Disease
- Hypertension
- Atherosclerosis
- Stroke
- Dyslipidemia
- Stasis Edema Lymphedema

Reproductive
- Infertility
- Menstrual Irregularities
- Polycystic Ovarian Syndrome

Dermatologic
- Cellulitis

Cardiopulmonary Co-morbidities
Obese subjects are more prone to suffer from cardiopulmonary co-morbidities such as hypertension and coronary heart disease. Compared to lean men and women, obese adults are six times more likely to have hypertension. Each 10kg increase in weight is associated with a 3mm Hg higher systolic and a 2.3mm Hg higher diastolic blood pressure translating to a 12% higher risk of coronary heart disease in the obese individual.[14]

Diabetes and Prediabetes[14,15,16]
There is a clear link between being overweight and developing type 2 diabetes, with statistics showing that more than 80% of people with type 2 diabetes are overweight. Not surprisingly, as obesity rates have increased, so too have the number of newly diagnosed cases of diabetes in the U.S.

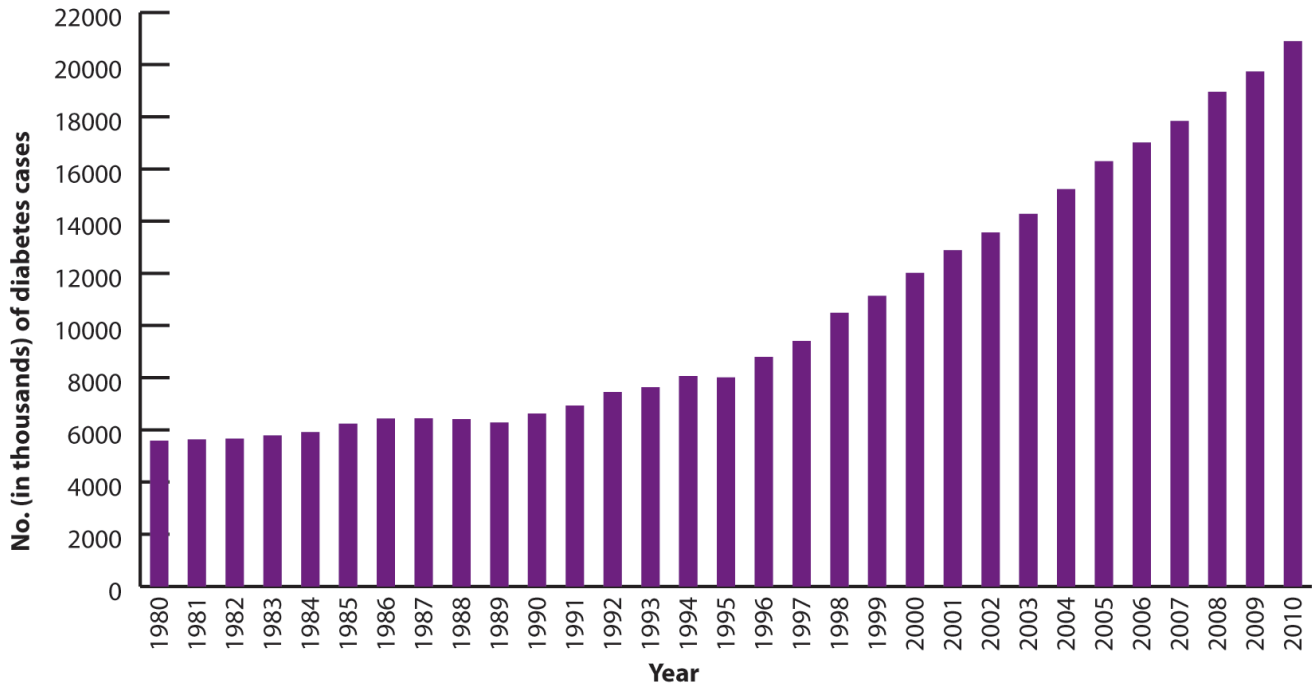
Approximately 26 million American adults have diabetes. Diabetes is one of the fastest growing diseases in the country, according to the American Diabetes Association. Additionally, experts predict that one out of three children born in the year 2000 will develop diabetes in their lifetimes, which will raise their risks for heart and kidney disease nerve damage, blindness and limb amputation.

Figure 2 illustrates the total number of diagnosed diabetes cases since 1980. While the prevalence remained fairly constant during the first 10 years, it has steadily increased since 1990. Twenty years later, the prevalence has increased by approximately 200%. If current trends continue, as many as 1 in 3 adults could have diabetes by the year 2050.

Diabetes mellitus (MEL-ih-tus), or simply, diabetes**,** is a group of diseases characterized by high blood glucose levels that result from defects in the body's ability to produce and/or use insulin.

Prediabetes is a condition whereby individuals have blood glucose levels that are higher than normal, but not high enough to be classified as diabetes. Over time, the condition often leads to the onset of diabetes.

Figure 2. Annual Number of U.S. Adults Aged 18–79 Years with Diagnosed Diabetes, 1980–2010



Source: National Diabetes Surveillance System, National Health Interview Survey data.

An additional 67 million Americans (approximately 33% of American adults) are estimated to have prediabetes, a warning sign of type 2 diabetes. In prediabetes, there are often no symptoms. The vast majority—more than 90 percent—of people with prediabetes, and about a quarter of people with diabetes, are unaware of their condition.

By 2020, an estimated 52 percent of the adult population will have diabetes or prediabetes.

Gaining just 11 to 16 pounds doubles the risk of type 2 diabetes, while an increase of 17 to 24 pounds nearly triples this risk. Obesity, particularly abdominal obesity, is associated with the insulin resistance that is characteristic of type 2 diabetes.

While there is no cure for diabetes, progression to type 2 diabetes can be prevented or delayed. Studies show that by losing 5-7% of body weight, coupled with 150 minutes of moderate physical significantly lower their risk. In some cases, some can return their blood glucose level to normal.

Researchers have found that high-intensity counseling for diet and exercise, combined with behavioral support, can produce sustained weight loss in obese adults, resulting in improved glucose metabolism, lipid levels, and blood pressure.

Total prevalence of diabetes

Total: 25.8 million children and adults in the United States—8.3% of the population—have diabetes.

Diagnosed: 18.8 million people

Undiagnosed: 7.0 million people

Prediabetes: 79 million people*

** In contrast to the 2007 National Diabetes Fact Sheet, which used fasting glucose data to estimate undiagnosed diabetes and prediabetes, the 2011 National Diabetes Fact Sheet uses both fasting glucose and A1C levels to derive estimates for undiagnosed diabetes and prediabetes. These tests were chosen because they are most frequently used in clinical practice.*

Metabolic Syndrome[17, 18]

Overweight and obese individuals are at greater risk of having metabolic syndrome. According to the American Heart Association, the syndrome is defined by a combination of conditions that result in a higher risk for coronary artery disease. Other organizations use a slightly different classification system. Conditions include type 2 diabetes, obesity, high blood pressure, and a poor lipid profile with elevated LDL ("bad") cholesterol, low HDL ("good") cholesterol, and elevated triglycerides due to the association with higher blood insulin levels. The fundamental metabolic syndrome defect is increased insulin resistance in both adipose tissue and muscle. While patients with excess body fat who are physically inactive are at greater risk for developing insulin resistance, some individuals have a genetic predisposition to developing the syndrome.

Drugs used to decrease insulin resistance usually have the added benefit of lowered blood pressure and improved lipid profile. Patients with three or more of the following clinical indications are diagnosed with metabolic syndrome:

Risk Factor	Determinant Level
Abdominal Obesity • Men • Women	Waist Circumference • 102cm(>40in) • > 88cm(> 35in)
Triglycerides	≥ 150mg/dL
HDL Cholesterol • Men • Women	 • < 40mg/dL • <50md/dL
Blood Pressure	≥130/85mmHg
Fasting Glucose	≥100mg/dL

Sleep Apnea

Obesity is considered a major risk factor for the development and progression of Obstructive Sleep Apnea (OSA). The prevalence of OSA in obese or severely obese adults is nearly twice that of normal weight adults, and it is estimated that overweight and obese patients represent over 70% of subjects with OSA.[19] Even modest weight loss improves OSA, and positively affects both metabolic and cardiovascular risk profiles.[20]

Non-alcoholic Steathepatitis (NASH)[21]

NASH affects 2 to 5 percent of Americans. An additional 10 to 20 percent of Americans have fat in their liver, but no inflammation or liver damage, a condition called “fatty liver.” NASH is becoming more common, possibly because of the greater number of Americans with obesity. A major attempt should be made to lower body weight into the healthy range. Weight loss can improve liver tests in patients with NASH and may reverse the disease to some extent. Research at present is focusing on how much weight loss improves the liver in patients with NASH and whether this improvement lasts over a period of time.

2 Organizing the Office

- The Waiting Area
- The Nurses' Station
- Exam Rooms
- Electronic Health Records
- Leading by Example
- Involving Staff
- Making Quality Assurance on Office Priority
- Organizing the Office for Limited English Proficiency - (LEP) Patients
- Culturally Competent Care

Chapter 2 Organizing the Office

Primary care providers are on the front lines addressing the obesity epidemic facing patients in their offices. The office environment and visit provide opportunities to communicate key messages to patients focusing on healthy weight, how to achieve it, and why it is important for the overall health of families, including working with families who are limited English proficient (LEP).

What follows are a number of suggested actions health care providers and their staff can take to organize the office most effectively to communicate these messages.

The Waiting Area[22]

Time that patients spend in the waiting area can be used to support key messages about the importance of healthy eating and physical activity for the patient and his or her family. The waiting area can be used to display messages and resources for patients to read and take with them to support these key health messages.

Posters

Posters are most effective when placed in areas where visitors are not otherwise engaged in communication with their health care provider, such as in the waiting room. They also reinforce the verbal advice given by a health care provider during the visit. If permitted, hang physical activity and healthy eating posters in the waiting room.

- Posters can reinforce the verbal advice given by a health care provider during the visit.

Patient Handouts

Consider setting up sections or tables that address different health topics. For example, there can be a nutrition section with recipes for healthy foods, handouts and a resource list of programs for overweight patients (these should also be available in exam rooms).

Brochure Racks

Brochure racks in the waiting area allow patients to take materials with them to reinforce these positive health messages. These can be organized by topic. Areas relating to healthy weight management include healthy eating at home, tips for dining out, making healthy choices and physical activity.

Bulletin Board

Create a bulletin board. Monthly or quarterly updates can feature:

- A list of community sports and physical activity programs that patients can sign up for
- Resources and news articles for patients
- Seasonal activities
- Fruit or vegetable of the month

Video

If your waiting area is equipped with a television, play videos supporting nutrition and physical activity. These will help introduce topics that are reinforced during teachable moments with the provider. Topics may include the MyPlate food groups, Rethink Your Drink and basics of exercise.

Furniture & Misc.

Consider having some sturdy, open-arm chairs that can support a larger weight patient. Have at least 6-8 inches of space between them. Sensitivity is still a key issue. Remove waiting room artwork or magazines that glamorize being thin as the ideal image.

The Nurses' Station

Have a good scale for weighing people who are over 300lbs. Many providers prefer using digital scales for overweight and obese patients.

Exam Rooms

Exam rooms present the opportunity to reinforce health messages for patients. If permitted, posters can be placed in the room in locations that are in the patient's line of sight. A brochure or pamphlet rack can be placed in each room as well. Rooms might also have themes where one room has more information on healthy eating and another on physical activity.

Have handouts ready to provide to patients on the key topics associated with their preventive visit. These can aid in teachable moments specific to healthy eating or physical activity, during or at the end of the visit. Make sure they are written in plain English without technical terms.

Obese and super-obese patients may require special exam accommodations as part of the routine office encounter. To help these patients

feel more welcomed in the medical setting, consider providing appropriately sized gowns, accommodating furniture in the exam and waiting room (ex. sturdy step stool for exam tables), large adult blood pressure cuffs, longer measuring tape and scales with a wide base that can handle weights over 300 pounds.

Electronic Health Records[23]

When discussing digitizing your practice, you will likely hear two different terms-- Electronic Medical Record (EMR) and Electronic Health Record (EHR). EMR only refers to the digital version of the traditional, paper-based patient record. EHR is a more comprehensive term that refers to a complete system. An EHR will usually contain a patient "portal," along with clinical decision support tools.

What is an Electronic Health Record (EHR)?

At the most basic level, an Electronic Health Record (EHR) is a computer database used for storing clinical information about the care and treatment of your patients. Storing patient information in digital format makes it efficient and easy to find informational and to track patient care across time and different treatment locations.

EHRs also generally contain additional tools that promote quality improvement and efficiency at your practice. They may contain or can be connected to a practice management system that contains scheduling software and a billing system, or other computer based practice tools. They may also contain clinical decision support tools, such as alerts to notify you if a drug you are about to prescribe has a known interaction with another drug the patient is already taking. When fully implemented, EHRs will eliminate much of the paper in your practice and potentially allow you to reallocate staff time to administrative tasks for more productive pursuits.

For more information, you can access the California Medical Association & California Medical Association Foundation's Electronic Health Records Desk Reference at: http://www.rcmanet.org/Portals/17/Assets/pdf/EHR_desk_reference_PracticeTools.pdf.

Leading by Example

Be sure that the habits of the staff reflect a healthy environment. Educate staff on the local resources that help make the healthy choice the easy choice. Model healthy eating in the office. You and your staff will be role models for your patients.

- Keep food in the staff lunchroom and not at the reception desk.
- If the office or clinic operates vending machines, stock them with water, 100% fruit juices and other healthy snacks, instead of candy, chips or sodas.
- Develop a healthy food/snack policy for staff meetings and events.
- Discourage sugar-sweetened beverage consumption.
- Do not offer sugared or unhealthy treats or beverages to patients (i.e. lollipops).
- Show a personal commitment to physical activity.
- "Walk With Your Doc" program or a walking club for staff and patients.
- Use the stairs instead of the elevator whenever possible.
- Fitness breaks or walks during the workday.
- Encourage staff to use pedometers on a daily basis. Wear them somewhere that's visible to patients.

Work with staff to become aware of locations in the community where affordable fresh fruits and vegetables are readily available, including farmers' markets and food banks.

- Farmers' Markets across California can be found at: www.farmersmarketonline.com/fm/California.htm
- Food banks in California can be found at: www.cafoodbanks.org/Find_A_Food_Bank.html

Understand national food programs and identify local resources to better serve your patients who are food insecure, including CalFresh (formerly the Food Stamp Program) and the Women, Infants and Children (WIC) program.

Another important way to involve staff is to provide support and training for them to strengthen their communication with patients.[24] For example, to build a stronger rapport with patients, staff can:

- Make sure to address patients by their last name. If the patient isn't clear about how he or she would like to be addressed, ask, "How would you like to be addressed?"
- When speaking with patients, focus your attention on them.
- Make sure to find out if the patient needs an interpreter.
- Document the patient's preferred language in the chart.
- Organize how interpreter services will be provided.
- Make sure patient materials are accessible to the patient and easy to understand.

Involving Staff

A team approach can be used in the office to maximize the impact of each patient encounter by training staff to obtain patient measurements, calculate BMI, and ask questions about the patient's lifestyle including diet, physical activity, and sedentary habits. When available, a registered dietitian can be used for conducting patient dietary assessments and providing lifestyle counseling. When appropriate, staff can be trained to assist with providing healthy lifestyle and weight management counseling to patients. Patient information and measurements should be documented in the patient's medical record. Front office staff typically has good rapport with patients – use them to reinforce messages and goals. Work with your staff to make healthy eating and active living a part of patient lives.

Making Quality Assurance an Office Priority

Involving staff in the collection and recording of the BMI will be essential to increase its collection and accuracy in the practice. There are at least three ways staff can be involved with the BMI:

1. **Step One - Hold a Daily Huddle**: Each morning in preparation for the day's visits, hold what's called a "Daily Huddle" between the healthcare provider and office manager to briefly review the schedule. This should take about five to seven minutes.
    - *During this time, those patients coming in for Well Care Visits and patients above a healthy weight can be identified. If a paper chart is being used, the Chart Prompt for the BMI can be placed on the outside of the chart to make sure the BMI is measured and recorded.*
2. **Step Two - Office Staff Meetings**: Staff meetings will provide the opportunity for staff and the healthcare provider to discuss ways to strengthen efforts to both accurately record and discuss the BMI with patients. Time can also be spent determining ways to most effectively reach out and stay in touch with those patients whose BMIs are increasing or have not decreased.

BMI as a Quality Measure

The BMI is considered a HEDIS (the Healthcare Effectiveness Data and Information Set) measure used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. For adults, the HEDIS measure focuses on –

- Adult BMI assessment

The measure determines the percentage of members 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.

As part of current healthcare reform efforts, for those healthcare providers who are taking steps to implement an electronic healthcare record (EHR) in their office, calculation of the BMI can play a role. These providers will need to reach Meaningful Use in the implementation of their EHR. Measures will need to be identified as Meaningful Use Objectives. For those offices seeing adults, conducting BMI can serve as one of these objectives.

CMS STAR Rating

The Medicare Stars program is the pay-for-performance (P4P) program for Medicare Advantage (MA) plans. It has been developed by the Center for Medicare and Medicaid Services (CMS) starting in 2007 for MA plans that participate in Medicare Part C and Part D. These MA plans are awarded 1-5 Stars at the contract level for their results on 37 Part C and 18 Part D measures, which

Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria. For details about the incentive programs, visit the CMS Website

are rated individually and rolled up to a plan star rating on an annual basis. The ratings are posted on Medicare's website (www.medicare.gov). Beneficiaries and CMS can assess plan performance.[25]

The Medicare Stars program is particularly important to solo and small group practices because:

- CMS star criteria are all good medicine. On the technical side, they are universally accepted as effective preventive and screening efforts. The patient engagement measures are what we all strive to do, too. We need to do better as a group.
- Your practice has already evolved from a "cottage industry" to a wired, responsive, information-rich advanced approach. You are already using staff members in more resourceful ways. This is just another step in a process you have already started.
- Good patient recall means a better chance of compliance with good medical advice. Reinforcement and consistency are important for seniors.
- Patient satisfaction may seem "soft," but it has a great deal to do with your own practice and the group's success. It's not accidental, and plans need your help. In addition, patient experience measures are weighted 1.5 when plan's ratings are calculated.
- The financial rewards will not be achieved unless the group as a whole performs well to contribute to the MA plan ratings. We will recognize and reward the leaders.
- Financial rewards for Stars could be equal or greater than P4P, if we do well on the measures. It's not trivial dollars. Often times plans will utilize member incentives to complement provider incentives to maximize improvement.
- Medicare Advantage (MA) contracts are generally the ones which keep groups afloat. Our financial security could be threatened if our Star scores do not surge upwards. It's a fact of life that both the individual doctor and the group would be hard pressed to replace the revenue that comes directly from Medicare Advantage.

The Bottom Line for solo and small group practices:

- ***It's good medicine,***
- ***It's good business for you and your group,***
- ***It meshes with your current work flow,***
- ***4+ Stars is what you would want for your parents.***

The Medicare Stars program is also important to plans because CMS is eliminating the 14% of the additional revenues plans have had over Fee-for-Service (FFS) in the coming years. Plans can earn through performance what they are losing in prospective cap rates. Starting in 2012, plans with 4 or more Stars receive a bonus and higher rebates. Plans with 3 or less Stars for 3 years will be flagged as consistently low performers by CMS on the Plan Finder at medicare.gov. After three years in a row, potential enrollees are given a caution to look closely at this plan before enrolling. Plan performance financially affects all groups contracted with a plan because often group contracts are a percentage of the plan's MA premium.[26]

Plans with four Stars or more will receive a sizable bonus, some of which may be shared with their practices:

- In 2012 the plans received an additional 1.5%,
- In 2013 the plans will receive an additional 3%,
- And in 2014 the plans will receive an additional 5%.[27]

Effect on Plan Enrollment

A recent study answered the question about the effect of the STAR ratings on plan enrollment; it found an association between a plan's Star rating and beneficiaries' enrollment decisions among almost 1 million new enrollees and 322,000 enrollees switching plans. For new enrollees, a 1-star higher rating was associated with a 9.5% increased likelihood to enroll. For enrollees switching plans, a 1-star higher rating was associated with a 4.4 % increased likelihood to switch and enroll in the higher rated plan. This finding supports the notion that a plan's Star rating is important to enrollees and at least in part affects decisions to enroll in a plan or to switch from one plan to another.[28]

Diabetes measures are a significant portion of the Medicare Star measures, and improvement will help a plan achieve 4 or 5 Star rating. In addition,

the processes a site uses to implement diabetes improvements will help with other measures/focused areas. Focusing on Stars will also help groups and practices perform better for commercial and Medi-Cal members.

Measures

There are currently 37 Part C 3 and 5 Part D Stars metrics that are measured on an annual basis. Six of the measures are devoted to diabetes care.[29]

Clinical Measures – HEDIS or CMS Methodology

- Breast Cancer Screening,
- Colorectal Screening,
- CV Cholesterol Screening,
- Diabetes - Cholesterol Screening,
- Diabetes - Kidney Monitoring,
- Diabetes - Blood Sugar Control,
- Diabetes - Cholesterol Control,
- Diabetes - Eye Care,
- Glaucoma Testing,
- Access to Primary Care Doctor Visits,
- Osteoporosis Management for Women with a Fracture,
- Controlling Blood Pressure,
- Rheumatoid Arthritis Management,
- All Cause Readmissions,
- Adult BMI Assessment,
- Care for Older Adults – Medication Review (SNP plans only)
- Care for Older Adults - Functional Status Assessment (SNP plans only),
- Care for Older Adults - Pain Screening (SNP plans only).

Part D Measures

- High Risk Medication,
- Diabetes Treatment (diabetics with hypertension who were dispensed and ACEI or ARB),
- Medication Adherence – Oral Diabetes Meds,
- Medication Adherence – ACEI/ARB for Hypertension,
- Medication Adherence – Statin for High Cholesterol.

Health Outcomes Survey®[30]

- Improving Bladder Control,
- Reducing the Risk of Falling,
- Monitoring Physical Activity,
- Improving or Maintaining Physical Health,
- Improving or Maintaining Mental Health.

CAHPS®[31]

- Annual Flu Vaccine,
- Pneumonia Vaccine (not included in plan ratings as of 2013 but is a display-only measure),
- Ease of Getting Needed Care from Specialists,
- Getting Appointments and Care Quickly,
- Overall Rating of Quality,
- Overall Rating of Plan,
- Customer Service,
- Care Coordination.

CMS Data[32]

- Complaint about the Plan
- Plan Makes Timely Decisions
- Fairness of Plan's Denials
- Members Leaving the Plan
- Availability of TTY/TDD and Interpretation
- Access and Performance Problems.

Getting Started

For health care organizations, including solo and small group practices, that would like to improve on the Medicare Stars Program results, here are some evidenced based tips for getting started:

- Utilize a data warehouse or a registry. If you currently have a registry work with your staff to align information so that your practice can identify patients with gaps in care and conduct outreach to those patients to receive needed services. If your Electronic Record does not have a registry or you do not currently use a registry, consider contacting your Medicare Advantage (MA) Plan. Ask the plan to provide you with data available to the plan that can function as a population based tool. The plan may also be able to provide technical assistance and expertise to help you in this area.
- Make sure you include your Medicare patients in your registry. Often plans will include only your commercial or Medicaid members in their database. Work with the plan to design a database that can include data for all of your patients.
- Produce exception reports for MA Stars metrics. Once you have a functioning data warehouse or registry design exception reports to identify patients needing services such as diabetic labs or imaging studies.
- Create an action plan to address gaps in care (outreach to members, etc.). Working with your office staff, develop a team based approach to

care with each staff person having assigned tasks to ensure effective interventions to address patients needing services.
- Conduct planned/prepared visits. As part of your team based approach, design or redesign your daily work flow so that each patient visit maximizes outcomes for members with the chronic conditions pertinent to the Stars Program.
- Work across your entire organization to meet targets. Set realistic, achievable goals and monitor and track your progress toward those goals. Schedule frequent, short huddles or team meetings with your entire office staff to keep your identification, outreach, and interventions on target. Make sure you regularly celebrate your successes.
- Collaborate with health plans.[33] Most plans are anxious to partner with their contracted providers to improve. These plans may offer financial incentives for improvement or results as well as being willing to provide technical assistance to your practice on how to improve.
- Apply proven changes that other groups/practices have implemented to improve performance. The California Quality Collaborative's Clinical Quality Improvement Toolkit includes changes at the group/IPA level, the clinical office practice level, and methods to engage patients. The toolkit is available at http://www.calquality.org/documents/ClinicalQualityImprovement_Toolkit_FA.pdf.

Organizing the Office for Limited English Proficiency (LEP) Patients[34]

According to data, California has one of the largest non-English speaking populations in the United States. Of the 38 million residents in California, an estimated 43% speak a language other than English at home. [35] The top five languages other than English most widely spoken by Californians in their homes are Spanish, Chinese, Tagalog, Vietnamese, and Korean. Together, these languages are spoken by approximately 83 percent of all Californians who speak a language other than English in their homes.

- Over 200 languages are spoken in California.*
- One in five Californians, between 6 and 7 million residents, are Limited English Proficient, meaning they speak English less than very well.**

**CHIA Standards & Certification Committee, California Standards for Health care Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Interventions. 2002. Los Angeles, CA: California Health care Interpreters Association, p 18, citing US Census 2000.*
***US Census 2000.*

To most effectively serve LEP patients in your practice, some practical steps can be taken. These include first understanding the languages spoken in your practice, identifying existing resources and then, identifying additional resources that can help you and your staff to most effectively address issues of overweight and obesity work with your LEP patients.

Three areas to focus on include:
- Signage
- Patient Education Resources
- Interpreter Services

The first step in this process is to identify the most common languages, other than English, spoken by patients in your practice. Can you estimate the percent of patients who speak these languages? If you can estimate this frequency, it will help you to prioritize the language access needs in your practice. If you do not already do so, develop a process to record this in the patient's chart. In this way, you and your staff will be better prepared to address the language needs of your patient prior to them being seen. Staff can help identify LEP patients. Add a color or letter code to the patient's chart to identify those who need an interpreter and to note which preferred language.

Consider hiring staff proficient in another language. If staff members will be used as interpreters, they should be able to pass a formal proficiency assessment or receive training in medical interpretation.

- Identify the patient's preferred language.
- Be equipped to provide language assistance services such as translations and interpreters. Check with your patient's health plan for assistance.
- Have language-appropriate health education materials readily available.
- Offer staff training periodically on cultural awareness and how to access language assistance services.

Signage

Signage and forms should also be made available in non-English languages (for example, "please be seated" signs or registration paperwork). Having signs placed in key locations and providing forms in the most common language of your practice is a simple way to make this a more welcoming place to your LEP patients.

- At the patient check-in desk, there should be a 'greeting' sign in at least the three to five major languages spoken in your practice.
- Consider places where safety directions and other information are typically displayed, such as fire and emergency exits, directions to restrooms and drinking fountains, and other applicable common areas.
- If you use an over-the-phone interpreter service, a wall poster or desktop poster announcing that an interpreter is available could also be posted at check-in.
- Consider non-verbal signs that include universally understood illustrations in areas where multiple-language signage is needed, such as for patient bathrooms.

Patient Education Resources

Posters and patient handouts should be available in the multiple languages reflective of your patient population. Consider featuring a "fruit- or vegetable-of-the-month" bulletin board. Select foods from different cultures. Health education handouts are available in multiple languages at the following sites:

Tufts/SPIRAL: Selected Patient Information in Asian Languages – http://spiral.tufts.edu
SPIRAL is maintained by Tufts University Hirsh Health Sciences Library to increase access to Asian-language health information for consumers and health care providers. The SPIRAL web site is a collection of links to Asian-language patient care documents that have been created by authoritative sources and are freely available online. Links are organized by topic and language.

Resources found on the site include:

Nutrition	Heart Health	Exercise
Weight Control	High Blood Pressure	Diabetes

MedlinePlus Health Information in Multiple Languages -
http://www.nlm.nih.gov/medlineplus/languages/languages.html
Information in over 40 languages from the National Library of Medicine's premier consumer health website.

Resources found include:

Exercise and Physical Fitness	Obesity	Weight Control
Healthy Living		Weight Management

Resources are found in Arabic, Spanish, Vietnamese, Chinese, French, Hindi, Hmong, Japanese, Korean, Russian, Somali, Ukrainian, Bosnian, Portuguese, Tagalog and Vietnamese.

Healthy Roads Media -
www.healthyroadsmedia.org
Health education materials on a variety of topics tailored to low literacy and limited English proficiency populations. Materials are available in audio, multimedia and written formats. Topics include food/nutrition, diabetes, and more. Languages include Arabic, Bosnian, English, Russian, Somali, Spanish and Vietnamese. This Web site also includes a page of useful links.

EthnoMed - www.ethnomed.org
EthnoMed offers patient education materials, including videos, brochures and handouts, in at least 12 languages. It is also a reference for education meetings on cultural proficiency, language access and health disparities. The site also contains background information on cultural groups, as well as identifying cross-cultural health issues, with links to a number of additional multicultural health websites.

Multicultural Health Communication Service -
www.mhcs.health.nsw.gov.au/
Multicultural Health Communication Service offers more than 450 multilingual health information publications in a wide range of languages, with new publications posted monthly.

Please see Chapter 6 for additional Patient Education Resources.

Foundation for Healthy Communities - http://www.healthynh.com
Access to documents created and translated by New Hampshire health agencies and organizations; languages include Albanian, Arabic, Bosnian, Chinese, English, French, Indonesian, Portuguese, Russian, Somali, Spanish, Swahili and Vietnamese.

Refugee Health Information Network (RHIN) - http://rhin.org
RHIN offers resources for those providing care to resettled refugees and asylees including: Health education materials in various languages and formats (brochures, fact sheets, videos), Provider tools (including information on refugee populations and cultures) and links to related Web sites. Resources are available covering physical activity and exercise, healthy eating, eating disorders, overweight, obesity, obesity prevention and walking. Resources are available in up to 95 languages.

Interpreter Services
When a patient who speaks little or no English comes to your office, how does your staff know whether he or she will need an interpreter? How do you and/or your staff communicate with the patient? If an interpreter is needed, does your practice have access to trained interpreters or use family members or staff to interpret? These are key questions that will need to be answered to help you most effectively organize your practice to work with your LEP patients.[36]

Note: Patients have the right to a professional interpreter at no cost if they choose to not use a family member or friend. It should be noted in their medical record if they refuse professional interpretation.

Once you know this, record the information in the patient's record for future reference. If you use a paper chart, record the language needed in the chart. If an EHR is available, add a question on your registration form.[37]

Given the language and cultural diversity of California's population, it is critical to provide resources and support to strengthen a patient's language access. One concrete way to begin this process is to provide a language identification tool, such as "I speak" cards for your patients to complete. These cards will enable patients to let the office staff and healthcare provider know the language with which they will be most comfortable with during their visit. "I Speak" cards are available at http://www.calcomui.org/sb853translationservices.html.

The language cards state:
"I speak (language stated.)"

"I need an (language stated) interpreter for my healthcare appointment. Please write my spoken language and my interpretation need in the patient chart."

The statement is written in the individual's preferred language and then in English. The cards are available in the following 24 languages:

Arabic	Hindi	Mandarin	Tagalog
Bengali	Hmong	Nepali	Tamil
Bosnian	Igbo	Romanian	Thai
Cantonese	Indonesian	Russian	Turkish
Farsi	Japanese	Samoan	Ukrainian
Fijian	Korean	Spanish	Vietnamese

These cards can be used to help your patients share with you their preferred language so that the necessary resources are available to assist you and the patient with their visit.

Interpreter Options
It is important to assess how your office typically communicates with patients who do not speak English well. Do you speak another language well enough to conduct an effective clinical interview with a patient? If yes, then no interpreter will be needed and you will be able to speak directly to the patient with no intermediary.

Office Based Process
Many offices rely on bilingual staff to provide translation within one or two primary languages. Staff plays a key role to speak through you so that the patient engages in a dialog addressing your questions. With some training, bilingual staff can serve as your interpreter during the visit as long as they pass a formal proficiency test.

When hiring new staff, think about the language needs in your practice. Consider including bilingual

speaking ability as either a desired or required position responsibility and place your job announcement in ethnic newspapers in your area. During the interview, ask about their language skills and how these language skills have been used in previous positions. If you think that your bilingual staff member(s) will be spending significant amounts of time interpreting during patient visits, consider sending them to a medical interpretation training.[38]

Health Plan Interpreter Services

When an interpreter is needed for a patient visit, both commercial and Medi-Cal managed care health plans in California are required to provide interpreter services and in-language resources to their members. SB 853 passed in 2009, requires managed care organizations and insurance plans to provide language services for certain languages.

Each health plan in California is required to provide a series of services to its members at no cost to the member or the healthcare provider. These services are provided in the threshold languages designated by each health plan. A threshold language is one spoken by at least 5% of the health plan's enrollees. Medi-Cal health plans have specific guidelines regarding threshold languages. The types of services that may be available by the health plans include:

- Access to telephone advice nurse
- Access to telephone interpreter
- Access to a face-to-face interpreter during business hours
- Training healthcare providers and office staff in how to get an interpreter for a member's medical visit

The first step in accessing the health plan interpreter service is to determine the patient's health plan coverage and then reach out to that health plan. You can also visit the website of the California Office of Patient Advocate which provides information on these health plan services. This can be found at: http://opa.ca.gov/report_card/languageservices.aspx. A list of health plan contacts for interpreter services is found in Chapter 7 Provider Resources.

Typically, if a request is to be made for a face-to-face interpreter, patients or offices need to contact the health plan five days in advance of the appointment. When the call is made the following information will be need to be given:

- Patient's Name
- Patient's Health Plan Member Number
- Doctor's Name and Phone Number
- Date, Time and Address for the Appointment
- Male or Female Interpreter Requested
- Name of Interpreter if One Has Been Used in the Past
- Language Spoken

If an in-person interpreter cannot be arranged to meet the patient at your office, the health plan will arrange for an interpreter by telephone. If there is no accessible speaker phone in the room, the patient should be informed that they may need to make an appointment. If the patient fails to attend his or her appointment, no charge will be made to the patient or the healthcare provider for the interpreter's services. This cost will be borne by the health plan.

Note: Although there is no penalty for missing an appointment, it is still detrimental because health plans must still pay for interpreter services.

If a telephone interpreter will be used for the patient's visit, this can be arranged for when the patient arrives at the doctor's office.

Family & Friends as Interpreters

There may be times when your only option is to use an untrained interpreter, likely a family member or friend. If a patient chooses this option, it should be noted in their medical records. Do not use children as interpreters. This distorts power relationships within families and diminishes parents in the eyes of their children. It often provides poor quality interpretation because children may have limited native language skills.

Untrained interpreters will need more guidance. It will be important to try to determine the interpreter's level of English skills. Remind the interpreter to avoid paraphrasing or answering for the patient and to let you know if you need to repeat yourself, explain something you've said or to slow down.[39]

Be sure to position the interpreter next to and a bit behind the patient. By getting the interpreter out

of sight, there is a better chance that you and the patient will communicate instead of having the patient talk to the interpreter. Particularly in working with an untrained interpreter, check in frequently with the patient, asking them to repeat back to you what you have told them. Remember to speak simply, pausing between sentences. This is very important for an untrained interpreter who will not understand medical terminology. And, be prepared to interrupt the interpreter if you believe he or she is getting off point and not being complete in their translation.

Maximizing the Interpreter's Effectiveness

If you choose to work with an interpreter during office visits, some tips to maximize their effectiveness include:

Briefly check in with the interpreter prior to seeing the patient and inform them of the goal of visit.

- Explain the reason for the visit and the type of information you will be discussing with the patient.
- Determine if there are any time constraints on the interpreter.
- Ask the interpreter if they have any concerns that they want to share with you before the visit.

If the interpreter is in the room, tell the interpreter where you want him or her to sit.

- In back of the patient is best because the patient looks at you and not the interpreter.

Assure the patient that ALL communications are bound by confidentiality.

- Let the patient know that once the visit begins, all communication will be interpreted.

If the interpreter is in the room, be sure to direct your questions to the patient, not to the interpreter unless they are meant for the interpreter.

- If you are going to pause and ask the interpreter a question in English, tell the patient that this is what you will be doing.
- Ask one question at a time, avoiding the use of jargon, slang or metaphor(s).

Briefly check-in with the interpreter after the visit.

Gender and age of the interpreter may be very important.

- In many ethnic groups, women and girls prefer a female interpreter and some men and boys prefer a male. Older patients may want a more mature interpreter.

Write down the interpreter's name and the interview language on the progress note.

Culturally Competent Care

A culturally competent professional has been defined as one who is able to facilitate mutually rewarding interactions and meaningful relationships in the delivery of effective services for families whose cultural heritage differs from his or her own.[40] Cultural competence extends beyond addressing language barriers and translation services and hiring an ethnically diverse group of staff. It requires healthcare providers to demonstrate a high degree of self-awareness in regard to their own cultural beliefs and values. It also requires that healthcare providers develop the communication skills necessary to elicit information about their patient's cultural beliefs and understand how these might impact their patient's health and how they understand the healthcare provider's message.[41] When this happens, patients are more likely to take the right action to improve their health.

There are a number of reasons it is important to focus attention on a practice's cultural competence in providing patient care. Central to this is –

- For the patient and healthcare provider to understand one another's perspectives about how their weight affects their health status, enabling them to plan together the steps to improve their health.
- For the patient to have a positive feeling and satisfaction with their visit because feeling like they are part of the team will increase their willingness participate in the plan to achieve a healthy or healthier weight.
- Ultimately, for improved clinical outcomes.

"Developing cultural competence is a lifelong journey rather than a destination – a verb rather than a noun."

- Robert Like, MD, MS
Director, Center for Healthy Families and Cultural Diversity
UMDNJ – Robert Wood Johnson Medical School

This commitment to developing culturally competent care is an investment in the health and well being of patients that can pay off in terms of greater follow through and time savings for the practice.

The healthcare system can be difficult and confusing for many patients to navigate, regardless of their preferred language and race or ethnicity. Imagine though, how this difficulty can increase due to language barriers, poor health literacy or different cultural norms and beliefs. Incorrect diagnoses or treatment instructions that arise because of cultural barriers can turn misunderstandings into mistakes. Patients who have an unpleasant experience as a result of cultural insensitivity will not look forward to returning to their doctor and may not take the steps discussed to address the issues resulting in an unhealthy weight for themselves.

Culturally competent care can have a positive impact in addressing these issues and strengthens the trust between the patient and his or her healthcare provider. It requires a commitment from healthcare providers and their staff to understand and be responsive to different attitudes, values, and body language. Cultural competency does create a compelling case for understanding the different ways patients act in a clinical setting and for communicating with patients to ensure the best possible clinical outcome.[42]

Our increasing diversity also requires us to identify opportunities within clinical practices to find ways to strengthen the cultural competency of the care provided. A first step in this process is for practices to complete an assessment of their cultural competency. A number of assessment tools have been developed by the National Center for Cultural Competence housed at Georgetown University. The assessment tools provide healthcare providers and their staff the opportunity to identify current strengths and opportunities to strengthen the cultural competency of their patient care. The assessment tools address:

- Physical environment, materials and resources in the office
- Communication styles
- Values and attitudes

3 Patient-Provider Communication

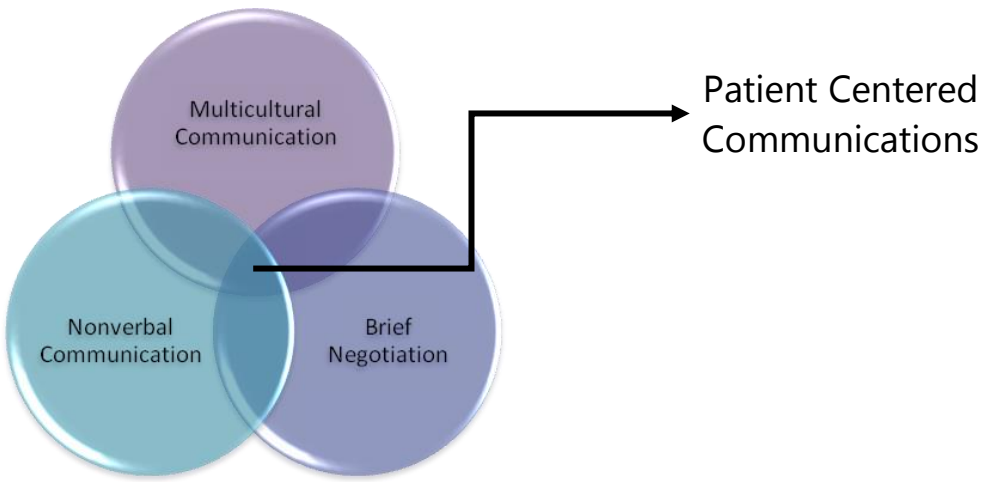
- Overview – Patient Centered Communication
- Multicultural Communications
- Nonverbal Communications
- Brief Negotiation
- Motivational Interviewing
- Sample Patient-Provider Dialogue
- The 3 Point Contract for the Healthy Living

Chapter 3 Patient-Provider Communication

Overview - Patient Centered Communication
Communication between the patient and healthcare provider is a central function of each patient visit and an essential factor for a positive outcome. Many healthcare providers worry about the time it often takes to engage a patient in a dialog about a health issue. Now factor into this equation a difference in language and culture. Effective patient/provider communications will require focus and attention. There is no question. Patient centered communication can enable the practice to save time and be more productive and effective:

- If the patient and healthcare provider understand one another, the visit can take less time.
- If the patient feels respected when in the office and with staff and the healthcare provider, they will feel more inclined to listen and communicate.
- If the healthcare provider and patient find agreement about the steps needed to maintain a healthy weight there is greater likelihood the patient will take action.
- If the patient understands what needs to be done to achieve a healthy weight, why this is important for their health, and has been part of the decision making process, there is a greater likelihood they will attempt to make changes. This can result in the practice spending less time on referrals and patient follow up. The patient will also achieve a greater health status.

There are three key elements that support effective patient/provider communications:



In this chapter, we will outline the key elements of these three patient centered communication components and provide tips and tools to maximize the chances for an effective dialog and positive health outcome.

Defining Communication:
"Communication happens whenever meaning is assigned to behavior or the residue of behavior."

Multicultural Communications

Being aware of and sensitive to a patient's cultural background can strengthen patient/provider communications and improve a patient's health. To improve patient communication and patient care, healthcare providers need to close the gap between the culture of medicine and the beliefs and practices underlying patients' value systems, which include ethnicity, race and family origin.[43]

Why is effective multicultural communications important and necessary? As seen in Chapter One, when we look at adult obesity, greater prevalence for overweight and obesity is seen among several groups. Important among these factors are a patient's race, ethnicity and socioeconomic status.

Multicultural communications is a key component of culturally competent health care to achieve health equity in the health status in individuals of diverse racial, ethnic and cultural backgrounds. It is essential in strengthening the quality of services provided and patient outcomes. It is also an important factor for healthcare providers to gain a competitive edge in the market place and decrease the likelihood of liability and malpractice claims.[44]

How Healthcare Providers Can Engage in Effective Multicultural Communications

The first step is to realize that a patient's culture has a significant influence on how health and illness are viewed. Their culture, including their beliefs, values and behaviors, socioeconomic status, race, ethnicity, the number of generations from their country of origin, level of acculturation to Western culture, and English proficiency will impact how, when and where a patient seeks care, and what they believe to be appropriate care received.[45] Also critical is for healthcare providers to understand the ways their own personal and professional experiences influence how they provide care and shape their views of their patient's cultural practices.

"The ability to communicate and connect with patients of different backgrounds and provide quality care that respects their personal values and beliefs is a critical skill for ob-gyns. Healthcare should not be one-size fits all. When we acknowledge and attempt to understand the cultural identities of our patients, we're better able to deliver beneficial and individualized care."

- Maureen G. Phipps, MD
Chair of ACOG Committee on Health Care for Underserved Women

As we focus on overweight and obesity in adults, it is important to acknowledge that food and diet play an important part in ethnic identity, cultural practices and family traditions, including not only the foods prepared but the sharing of meals. Partnering with a family to achieve a healthy weight for the patient may therefore be more involved than simply changing one food item for another. Socioeconomic status can also limit availability of and access to quality food sources and healthy alternatives.

What follows are "Snap Shots" of diets and discussion that can provide some background and a starting point to initiate conversation with patients to increase healthy eating in the family. Using a patient centered approach, the healthcare provider will learn about the individual practices in the family and build on these. This allows the healthcare provider to not stereotype the patient.

African-American Culture

Families may include immediate, extended, or matriarchal members. The father or eldest male will speak for the family. Grandparents, especially grandmothers, play a crucial role.

- Women prepare meals. The female head of the household does the meal planning.
- Food preparation may include frying, barbecuing, and heavy use of gravy and sauces.
- Known to have reduced intake of fresh fruit and vegetables.
- The family may not put a significant focus on preventive health.
- Emphasize the importance of the family role models in achieving a healthy weight for the child or adolescent.

Suggest:

- Reduce intake of fried foods and avoid late, heavy dinners
- Encourage consumption of fresh fruits and vegetables
- Switch to canola, safflower, or olive oil
- Avoid reusing oil to fry foods because reused oil is higher in fat
- If foods are fried, fry foods at hotter temperatures to soak up less oil
- Prepare gravy with low-fat ingredients, such as low-sodium broth, low-fat milk and whole grain flours
- Use artificial sweeteners and limit all sodas, including diet and caffeine-free
- Include fresh vegetables and fruits with each meal

Cambodian Culture

Cambodian culture is patriarchal but in the family, husband and wife often share authority. Extended families are common, headed by an older parent or grandparent.

- Patients may avoid eye contact. Avoiding eye contact is a sign of the healthcare provider's respect for the patient.
- The head is considered sacred. Begin physical exams at the top of the body and move down.
- Address meal planning to the female head of the household.
- Rice is fried, steamed, and used for noodles; fish is served fresh, dried, or salted.

Suggest:

- Increased use of whole grain rice
- Encourage steaming vegetables, such as Chinese broccoli, bokchoy, and mustard greens
- Fruits in the Cambodian diet are generally sweet. Suggest limiting those portions or choosing alternatives, such as apples and oranges
- Encourage limiting or using sugar-free alternatives for desserts, such as coconut milk with bananas

Chinese Culture

Often an extended family with children, parents and grandparents living together. Major decisions usually require input from the male head of household.

- Many do not believe in preventive health measures. Prefer to seek care, whether traditional Chinese or Western, when they are symptomatic.
- Obtaining complete information may be difficult as it can be considered disrespectful to disagree with a healthcare provider.
- Encourage family support.
- Meal planning the role of female head of house.

Suggest:

- Explain the benefits of whole grains and fiber.
- Increase bokchoy, Chinese broccoli, mustard greens, bitter melons, tangerines, and pomelo
- Eliminate or reduce pastries and sweet buns, especially those with fillings high in fat and sugar
- Limit fried foods, soy sauce, fish sauce, and oil in stir-fries
- Switch to canola, safflower or olive oil
- Eat fresh fruits and vegetables daily

Filipino Culture

Speak to both the patient and the eldest family member, when possible, as this person is the family's chief spokesperson and caregiver. In the absence of parents, this will be the eldest child.

- Health is balance – illness is imbalance. Stress positive aspects of preventive care.
- Many believe that an overweight child is a healthy child. Focus on the connection between an overweight child and the risk of developing diabetes & other health problems.
- Traditional diet includes white rice and noodles, seafood, vegetables, fruits and meats. Canned and processed foods, such as corned beef, Spam® and Vienna sausages, are common items.

Suggest:

- Limiting rice and noodles and switching to whole grain rice and noodles
- Using Canola and olive oil
- Switch to light coconut milk
- Reduce processed foods as listed above
- Eat fresh fruits and vegetables daily

Hmong Culture

Family is important. Households often consist of married sons and their families. Family structure is patriarchal and major decisions may involve communal discussion.

- Patients may avoid eye contact with their health care providers, as many feel that direct and lengthy eye contact is rude.
- Illness is believed to be the result of the soul wandering from the body, angry ancestors, hostile spirits, spells, curses or the violation of taboos.
- Hmong may use a combination of Western medicine and Hmong shamans.
- Many Hmong are resistant to or uninformed about self-care and preventive care.
- Address meal planning with the female head of house. The traditional diet includes chicken, pork, rice, and vegetables in a broth.

Suggest:

- Encourage fresh fruits and vegetables daily
- Limit the use of oil in stir-fries and fried foods
- Switch to canola, safflower or olive oil
- Use low-salt replacements for soy sauce and fish sauce
- Limit rice or replace with brown rice

Korean Culture

Families of Korean descent are egalitarian in large part, although parents are closely involved in making decisions for their children. Women are often busy with work and childcare. As much as possible, confer with family members and check for understanding and agreement when delivering patient education.

- Many believe health to be the equilibrium between soul and physical being. There is a belief that illness is related to karma (past wrongdoing).
- Patients will avoid eye contact and may refuse advice at first. This is considered to be cultural politeness. Offer suggestions and advice numerous times, and allow ample time for questions, which may be slow in coming.
- Do not point or beckon patient with index finger. It is considered offensive.

Suggest:

- Reduce fried foods
- Encourage fresh fruits and vegetables daily
- Switch to lighter cooking methods using canola, safflower or olive oil
- Eat fresh fruits and vegetables daily

Latino Culture

Family is often involved in decision-making. It is important to develop a personal relationship with Latino patients to develop trust. Females may place their needs beneath those of the family, and males may not assume personal responsibility for their healthcare. Involve both females and males as often as possible in patient discussion. Food is an integral aspect of socialization among Latinos.

- Latinos are often deferential toward healthcare providers.
- Focus on small, achievable goals for patients. Give positive encouragement when these changes are met successfully.
- Aloe juice (jugo de savila), a staple in some Latino households, is very high in carbohydrates. Suggest alternatives.
- 7 Up® is a popular treatment for upset stomach. Suggest a sugar-free alternative.

Suggest incremental changes to diet, such as:

- Eat earlier in the evening to avoid late-night suppers
- Eat fresh fruits and vegetables daily
- Take a 15 to 30 minute walk after the evening meal
- Replace fats, including lard, with more healthful choices such as canola or olive oil
- Limiting tortillas (2 to 3 corn or 1½ flour per day)

Vietnamese Culture

Decisions are made by the father or eldest son. Family is informed and part of the decision-making process.

- Many Vietnamese believe that health maintenance is the equilibrium of two natural forces – hot (duong) and cold (am).
- Touching may be an issue, as the head is considered sacred (and the feet profane). Ask permission before touching the patient, especially on the head. Begin a physical exam at the top of the body and move down.
- White flour, pastries and white rice are popular elements of the Vietnamese diet. Address meal planning to female head of house.

Suggest:

- Whole grain and reduced-sugar alternatives
- Reduce red meat in favor of lean white meat, fish and more vegetables
- Encourage eating fruit daily
- Reduce the use of fried foods
- Limit use of coconut oil or coconut milk in foods; light coconut milk is preferable

These Snap Shots have been adapted from Health Net of California's "Diabetes and Culture A guide for Physicians"

There are a number of clinical interviewing and communication mnemonics that may help to improve skills in multicultural communications. Included in these are LEARN[46], ETHNIC [47]AND BATHE.[48]

Mnemonic	Application
LEARN **L**isten **E**xplain **A**cknowledge **R**ecommend **N**egotiate	Integral to history taking and helps to elicit a patient's perspective and explanation regarding the onset, etiology, duration, and treatment expectations for his or her illness or problem.
ETHNIC **E**xplanation **T**reatment **H**ealers **N**egotiate **I**ntervention **C**ollaborate	Framework to provide culturally appropriate care. Can be used to elicit and negotiate cultural issues during healthcare encounters with all patients.
BATHE **B**ackground **A**ffect **T**rouble **H**ealing **E**mpathy	Model for supplementing the biomedical clinical information gathered to assess the patient's psychosocial status. Helps healthcare providers connect with and develop a therapeutic rapport with their patients.

As an example a healthcare provider recommends that a teen patient increase his daily physical activity as one step to help achieve a healthy weight and the teen does not follow through. The healthcare provider can use the ETHNIC model to start a dialogue to discover:

1. Why the patient might be concerned about starting his daily physical activity routine.
2. If other options, such as addressing dietary changes are being tried to help achieve a healthy weight.
3. How to reach a mutually acceptable approach.
4. Whether family members, school or other community resources might be available to help the patient achieve and stay with his plan.

Incorporating the use of a mnemonic with an understanding of patient's cultural background helps the healthcare provider to work with the patient and his or her family as individuals, all working together to develop a more realistic plan to achieve their goal, in this case, achieving a healthy weight.

Health Care Communication Strategies and Attributes of Cross-Cultural Competency
(Summarized from Communication Between Cultures, Samovar, Porter and McDaniel)

1. *Do not assume your views and feelings concerning patient care are shared by your patients from different cultural backgrounds (Do not treat them the way YOU want to be treated)*
2. *Make sure there is a culturally diverse staff that reflects the patient population*
3. *Provide necessary language interpreters*
4. *Use formality that is culturally accepted by patient/family*
5. *Allow patients to be open and honest*
6. *Do not discount beliefs that include the intervention or involvement of the supernatural*
7. *Tactfully inquire into patients belief and/or use of nontraditional cures*
8. *Do not try to force change or compliance; create understanding and awareness of serious nature*
9. *Employ empathy when creating and delivering messages*
10. *Be restrained and compassionate in sharing bad news*
11. *Follow the patient's lead in Communication style verbal (interpreter) and nonverbal, eye contact, touching mores, modesty*
12. *Provide Cultural Competency training for providers*
13. *Make use of the LEARN Model (J. Luckman)*
    a. *Listen and ask questions*
    b. *Explain using simple terms*
    c. *Acknowledge the validity of differing views*
    d. *Recommend what patient should do*
    e. *Negotiate with patient and adapt your recommendations where you can*

Nonverbal Communications[49,50]

Nonverbal communications is the single most powerful form of communication. More than voice or words, nonverbal communications provides a focus on what another individual may be thinking or feeling. Nonverbal communication ranges from facial expressions to body language. Gestures and use of space are also elements of nonverbal communication.

Multicultural differences in facial expressions, hand and arm gestures, use of personal space, touching, eye contact and physical posture may occur. Understand the key nonverbal communication behaviors important to the significant groups in your practice.

Facial Expressions

- Although smiling is an expression of happiness in most cultures, it cal also signify other emotions. Some Chinese may smile when they are discussing something sad or uncomfortable.
- Some Filipinos will point to an object by shifting their eyes toward it or pursing their lips and point with their mouth, rather than use their hands.
- Expressions of pain or discomfort such as crying are also specific to various cultures. Some cultures may value a more stoic affect while others may encourage a more outgoing, emotive demeanor. Expressions of pain and discomfort are also learning from one's family illness experiences and expressions.

Personal Space

- Comfortable distance between people as they sit, stand, or talk varies. Most Latinos require less personal space and may feel uncomfortable with distance. Asians and Pacific Islanders require more personal space and may feel uncomfortable with closeness.
- People from the Middle East may stand quite close when talking with each other.
- In some Muslim cultures, a woman may be alarmed if a man, even a male physician, stands or sits too close to her.

Touching

- In some cultures, light touching of the arm or a light kiss on the cheek is very common, even among people who have just met. People from Latin America and Eastern Europe may be very comfortable with this kind of touching, whereas people from many Asian cultures may prefer less physical contact.
- Touching another person's head is considered offensive by some people from Asia and the Middle East, because the head is considered a sacred part of the body. It is therefore inappropriate to pat a child on the head.
- Some Chinese may be uncomfortable with physical contact early in a relationship. Although many Chinese will use a handshake to greet a Westerner, any other contact may be considered inappropriate. This is especially important to remember when dealing with older people and those in authority.
- Throughout the Middle East, it is the custom to reserve the left hand for bodily hygiene. For this reason, one should never offer the left hand to shake hands or accept a gift. This is also true of some African cultures.
- A Western woman should not initiate a handshake with a man in India. Many Indian women will shake hands with a foreign woman, but not a foreign man.

Eye Contact

- Making direct eye contact is a sign of disrespect in some cultures. In other cultures, refusing to make direct eye contact is a sign of disrespect. Many Asians may be reluctant to make eye contact with an authority figure. For example, when greeting a Chinese, it is best to avoid prolonged eye contact as a sign of respect.
- In Latin America, good eye contact is important in both social and business situations.
- In mainstream Western culture, eye contact is interpreted as attentiveness and honesty. We are taught that we should "look people in the eye" when talking. In many cultures, including Latino, Asian, Middle Eastern and Native American, eye contact is thought to be disrespectful or rude, and lack of eye contact does not mean that a person is not paying attention. Women may especially avoid eye contact with men because it can be taken as a sign of sexual interest.

Physical Posture

- In many cultures throughout the world, it is impolite to show the bottom of the shoe, which is often dirty. Therefore, one should not sit with the foot resting on the opposite knee.
- In some Latin American countries, standing with the hands on the hips suggests anger, or a challenge.
- In many cultures, slouching or poor posture is considered disrespectful. Good posture is important in Taiwan, with Taiwanese men usually sitting with both feet firmly fixed to the floor.

Gestures

- There are a number of gestures commonly used in the US that may have a different meaning and/or be offensive to those from other cultures. One common example is the use of a finger or hand to indicate "come here please". This is the gesture used to beckon dogs in some cultures and is very offensive.
- Pointing with one finger is also considered to be rude in some cultures and Asians typically use their entire hand to point to something.

Some key tips for healthcare providers to maximize their nonverbal communications include:

- Follow the patient's lead. If the patient moves closer or touches you in a casual manner, you may do the same.
- Use hand and arm gestures with great caution. Gestures can mean very different things in different cultures.
- Be careful in interpreting facial expressions.
- Don't force a patient to make eye contact with you. He or she may be treating you with greater respect by not making eye contact.

It is also important to monitor your voice tone and behaviors with limited English proficient patients who may not understand your words and must rely on tone and nonverbal signs of attitude.

Brief Negotiation

Assessing Readiness for Change

Determining a patient's readiness for change is essential for success. Discussing changes when a patient is not ready often leads to resistance, denial of problems and frustration that may hamper future efforts. The following tools provide a basis for starting discussions with patients. Using questionnaires may also provide valuable insight while saving valuable office visit time.

It is normal for patients to feel ambivalence in determining their readiness to make behavioral changes to improve their health. It is important to look at this ambivalence as normal, rather than an obstacle.

When you begin to discuss with your patient areas and opportunities for change, encourage them to express this ambivalence. As they do, you can help them explore the potential benefits of change. As you work with your patient, it is also important to recognize that:

- Your advice must match the motivational level the patient is experiencing.
- Your advice must seek out the main issues that underlie their concerns or health issue.
- Unwelcome advice will usually invite resistance, so you will need to gain permission to offer advice.

As you work with your patient, you will:

- Ask open-ended questions.
- Use reflective, active listening.
- Affirm their feelings and struggles.
- Explore the ambivalence they are feeling.
- Assess their readiness to change.
- Offer advice after gaining their permission.
- Work with them to set goals and make a plan.
- Summarize what has been agreed to as you close the dialogue.

Brief Negotiations Pocket Reference Card (2 sided)

For quick communication tips to assist in discussing weight, physical activity and proper nutrition with your patients, carry this Brief Negotiations reference card during exams to make the most of the discussion.

Reference Card: Brief Focused Advice

Step#1: Engage the Patient/Parent

- Can we take a few minutes together to discuss your health and weight?
- What do you feel about your health and weight?

Step#2: Assess Readiness

- On a scale of 0-10, how ready are you to consider a change___?
- Why a____? Why__and not a _____?
- What would it take to move you from a _____to a __?
- What might your next steps be?

Step #3: Share Information (Optional)

- Your weight puts you at risk for developing heart disease and diabetes. What do you make of this?
- Some ideas for staying healthy include…(use examples)
- What are your ideas for working toward a healthy weight?

Step #4: Make a Key Advice Statement

- I strongly encourage you to…
- Get up and exercise, 30-60 minutes a day
- Limit TV and computer time to 60 minutes or less a day
- Eat 5 or more servings of fruits and vegetables each day
- Limit sodas & juice drinks to 1 cup or less per day.

Step #5: Arrange For Follow-up

- Would you be interested in more information on ways to reach a healthy weight?
- Let's set up an appointment in weeks to discuss this further.

Source: Regional Health Education. Kaiser Permanente. 2004.

Sensitive Word Substitutions

Some patients maybe sensitive about discussing weight and lifestyle issues the following are word substitutes that may help to promote open discussions about healthy lifestyle change and weight management:

Obesity	→ Overweight
Ideal Weight	→ HealthierWeight
Personal Improvement	→ Family Improvement
Focus on Weight	→ Focus on Lifestyle
Diets or "Bad Foods"	→ Healthier Food Choices
Exercise	→ Physical Activity

Effective Communication with Families

Scott Gee, MD; Jodi Ravel, MPH; Sandra Roberts, RN; Amanda Wylie, Regional Health Education – Kaiser Permanente Northern California

Communication Techniques

Lifestyle Advice—Well Care or Urgent Visit

- < 1 minute
- Patient not currently at risk for overweight

Brief Focused Advice – Well Care Visit

- < 3 minutes
- Patients who are overweight or at risk for overweight

Brief Negotiation & Cognitive Behavioral Skills - Follow up Visit or Weight Management Intervention

- 10 + minutes: single or multiple sessions
- Patients who are overweight or at risk for overweight

Brief Negotiation Skills—

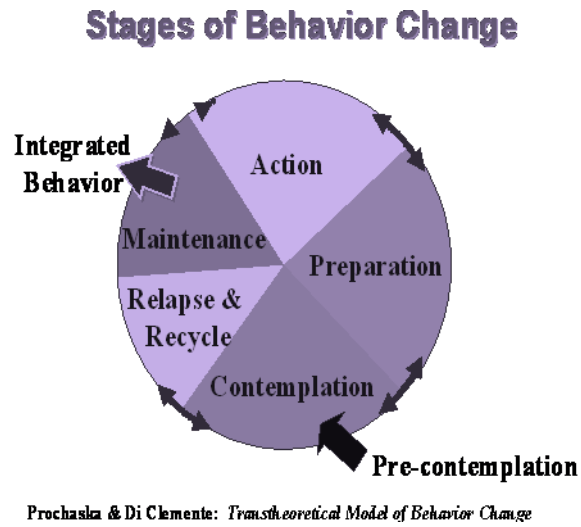
Particularly Effective for Contemplative/Ambivalent Patients

- Asking open ended questions
- Listening
- Summarizing
- Clinician Style: empathetic, accepting, collaborative

Cognitive Behavior Skills—

For Patients Ready and Willing to Make Changes

- Develop awareness of eating habits, activity and parenting behavior
- Identification of problem behaviors
- Problem solving and modification of problem behaviors
- Weekly goal setting for patients on dietary, activity and self-esteem/parenting goals
- Positive reward systems
- Record keeping
- Weight checks



Prochaska & Di Clemente: *Transtheoretical Model of Behavior Change*

Lifestyle Advice

To stay healthy and energized:

- *Get up and play hard, 30-60 minutes a day*
- *Limit TV and video games to 60 minutes or less a day*
- *Eat 5 helpings of fruits or vegetables every day*
- *Limit sodas & juice drinks to 1 cup or less a day*

Brief Focused Advice

Step # 1: Engage the Patient / Parent

- *Can we take a few minutes together to discuss your health and weight?*
- *How do you feel about your health and weight?*

Step # 2: Share Information (optional)

- *Your current weight puts you at risk for developing heart disease and diabetes.*
- *What do you make of this?*
- *Some ideas for staying healthy include…(see poster)*
- *What are your ideas for working toward a healthy weight?*

Step # 3: Make a Key Advice Statement

I strongly encourage you to...

- *Get up and play hard, 30-60 minutes a day*
- *Limit TV and video games to 60 minutes or less a day*
- *Eat 5 helpings of fruits or vegetables every day*
- *Limit sodas and juice drinks to 1 cup or less a day*
- *Use patient ideas from step # 2*

Step # 4: Arrange for Follow up

- *Would you be interested in more information on ways to reach a healthier weight? AND / OR*
- *Let's set up an appointment in __weeks to discuss this further.*

Motivational Interviewing[51]

Motivational interviewing is an approach to counseling and decision making intended to help patients come to their own decisions by exploring their uncertainties.

- The interviewer uses directive questions and reflective listening to encourage the patient to participate. It is about asking the patient provocative questions and discussing the responses, which can help to uncover important self-management issues.
- It generally requires some training, so if practitioners are not able/willing to get this training it might be best to develop an affiliation with someone who is trained in the technique.

Counseling techniques of motivational interviewing:

- Use nonjudgmental, nondirective questions and comments about the issues, e.g., a high BMI:
- "Your BMI is above the 95th percentile. What concerns, if any, do you have about your weight?"
- Next step depends on the response. This differs from a directive style, in which you inform the patient of the seriousness of the condition.
- "Your BMI is quite high, so it is important to get your weight under control before it becomes a bigger problem. What is your understanding of the potential problems?"
- Use active listening to convey sincerity and establish rapport
- Nonverbal communication is key; look into their eyes to express empathy
- Reflect the patient's emotional tone - shows that you understand how they feel
- Framing to show that you understand what your patients are telling you -- "Let me see if I have this right: …"
- Request clarification and confirmation to acknowledge that they are important partners -- e.g., "Is there anything I left out today?" or "Does that sound right to you?"
- Use reflective listening to uncover the beliefs and values:
- So, it sounds like you have a pretty good understanding of some of the potential health problems. Would you like to talk about some ways that you could get down to a healthier weight? How ready are you to try to make a change or two (1-10 scale)? Are there things that you would like to do to (lose some weight)?
- Use reflective listening again to uncover barriers to change:
- Summarize his/her comments without judgment
- For example: "If I heard you correctly, you know you need to get more exercise, but you really don't like to exercise, so you're not really ready."
- Reflections help build rapport and allow the patient to understand and to resolve ambivalence.
- Elicit concerns of patients.
- Compare values and current health practices:
- If the patient values being healthy, then help him/her examine some different types of activities that he/she might enjoy, and be willing to try.
- Use a shared decision approach - Evoke motivation, rather than trying to impose it.
- What might need to be different for you to consider making a change in the future?
- Could I give you some information about healthy activities [i.e. food choices] to help you think about this?
- Help patient put together a plan that is consistent with this/her values.
- This avoids the defensiveness created by a more-directive style.
- Make sure he/she understands the plan
- Use the "teach-back method" -- ask patients to explain to you what they have just been told, what their plan is.
- Close the Encounter:
- Summarize: "Let's look at what you've worked through"
- Show appreciation: "Thank you for being willing to discuss this!"
- Express confidence: "I know that you can do this!"
- Arrange follow-up

Brief Negotiation

Open the Encounter

Ask Permission

- "Would you be willing to spend a few minutes discussing your weight?"
    - "Are you interested in discussing ways to stay healthy and energized?"

Ask an Open-Ended Question — Listen — Summarize

- "What do you think / How do you feel about your weight?"
    - "What have you tried so far to work toward a healthier weight?"

Share BMI / Weight / Risk Factors (Optional)

- Your current weight puts you at risk for developing heart disease and diabetes.
    - Ask for the patient's interpretation: "What do you make of this?"
    - Add your own interpretation or advice as needed AFTER eliciting the patient's / parent's response

Negotiate the Agenda

- "There are a number of ways to achieve a healthy weight. They include (see poster)":
    - Get up and Play Hard
    - Eat 5 helpings of fruits and vegetables a day
    - Cut back on TV and Video Game
    - Cut down on soda and juice
- "Would you like to discuss any of these further today—or perhaps you have another idea that isn't listed here?"

Assess Readiness

- "On a scale from 0 to 10, how ready are you to consider (**option chosen above**)"
- Straight question: "Why a 5?"
- Backward question: "Why a 5 and not a 3?"
- Forward question: "What would it take to move you from a 5 to a 7?"

0 1 2 3 4 5 6 7 8 9 10

Explore Ambivalence

Step 1: Ask a pair of questions to help the patient explore the pros and cons of the issue:

- What are the things you like about_____? ***And*** What are the things you don't like about_____?
- What are the advantages of keeping things the same? ***And*** What are the advantages of making a change?

Step 2: Summarize Ambivalence:

- "Let me see if I understand what you've told me so far…"
- Begin with reasons for maintaining the status quo, end with reasons for making a change
- Ask: "Did I get it all? / Did I get it right?"

Tailor the Intervention

Stage of Readiness	Key Questions
Not Ready: 0 – 3 • Raise Awareness • Elicit Change Talk • Advise and Encourage	• Would you be interested in knowing more about reaching a healthy weight? • How can I help? • What might need to be different for you to consider a change in the future?
Unsure: 4 – 6 • Evaluate Ambivalence • Elicit Change Talk • Build Readiness	• Where does that leave you now? • What do you see as your next steps? • What are you thinking / feeling at this point? • Where does _____fit into your future?
Ready: 7 – 10 • Strengthen Commitment • Elicit Change Talk • Facilitate Action Planning	• Why is this important to you now? • What are your ideas for making this work? • What might get in the way? How might you work around the barriers? • How might you reward yourself along the way?

Close the Encounter

- Summarize: "Our time is almost up. Let's take a look at what you've worked through today…"
- Show Appreciation / Acknowledge willingness to discuss change: "Thank you for being willing to discuss your weight."
- Offer advice; emphasize choice, and express confidence: "I strongly encourage you to be more physically active. The choice to increase your activity, of course, is entirely yours. I am confident that if you decide to be more active you can be successful."
- Confirm next steps and arrange for follow up: "Are you able to come back in one month so we can continue to work together?"

Sample Dialogue of a Brief Negotiations Encounter

Before entering the exam room you note the patient's age, gender, BMI and percentile, blood pressure, and pulse which have been taken by your medical assistant.

Patient Info:

Name	Charles
Gender	Male
Age	40years
Ethnicity	Latino
Height	70inches
Weight	210 lbs
BMI	30.1
Waist Circumference	41inches

MD: Good morning! I see you are in for your annual physical. Do you have any concerns about your health?

Charles: No, I'm feeling pretty good.

MD: Would you be willing to take a few minutes together to talk about your health and weight?

Charles: I guess so.

MD: How do you feel about your weight?

Charles: I know I could stand to lose a few pounds. My wife nags me about it every day!

MD: She is probably just concerned about your health. Right now your body mass index, or BMI, is30.1. A healthy BMI is below 25. Also, your waist circumference is 41 inches. We consider a healthy waist circumference something less than 40 inches. Your current BMI and waist circumference put you at risk to develop conditions that I see run in your family, like diabetes and heart disease. What do you think about this?

Charles: It sounds like I have some work to do. I've watched my brother deal with diabetes and it doesn't look like much fun. How much weight do I need to lose?

MD: Any weight you lose will get you closer to a healthy weight .Have you ever tried anything to get to a healthier weight?

Charles: My wife tries to get me to eat salad and vegetables, but I'm more of a meat and potatoes guy.

MD: OK, well let's see if we can find a way to help you be healthy. Here are some ideas that my patients usually find helpful: eating at least 5 fruits and vegetables per day, cutting back on the number of sodas they drink, being physically active for 60 minutes or more, and reducing the amount of time they spend watching TV or on the computer. Do you want to talk about any of these, or do you have any other ideas?

Charles: I could try cutting back on sodas or switching to diet.

MD: Alright, that sounds like a good first step. On a scale from 1 to 10, how ready do you think you are to cut back on sodas?

Charles: Probably a 3.

MD: Why a 3?

Charles: I like my sodas! I don't drink coffee and I don't like the taste of water, so I drink soda.

MD: What do you think an advantage of cutting back on soda would be?

Charles: I guess it's a pretty easy way to get rid of a lot of calories.

MD: Are you interested in knowing more information on the nutritional value of soda?

Charles: It wouldn't hurt to know more.

(MD gives patient a brochure on portion size and calories.)

MD: What do you think your next step is?

Charles: I'll try to cut back on the sodas. I don't know if I can do it, but I'll try.

MD: Great–start with cutting back on one soda a day and I think you'll see that it can be easier than you think. This is a very healthy choice for yourself–your family will be happy. Thank you for being so willing to discuss this with me. When you come back for your next appointment I want to hear how things are going.

For additional training in these interviewing techniques, visit: http://kphealth.org/

The 3 Point Contract for Healthy Living

By Sophia Yen, MD, MPH, Adolescent Medicine Specialist, LPCH/Stanford

The 3 Point Contract for Healthy Living provides a mechanism to capture the discussion with your patient using the Brief Negotiation technique. This contract between the patient and healthcare provider memorializes the patient's commitment to change. The contract is put in the patient's chart and provides a vehicle for ongoing communications and monitoring of the patient's progress toward changing behaviors that can lead to reaching a healthy weight.

On a progress note that goes into the patient's permanent medical record write:

Contract for _____ (Patient's Name)'s Healthy Lifestyle

Based on your conversation with the patient, ask the patient to write out one goal under each of the following categories:

1. Increase healthy food choices
2. Decrease total screen and phone time
3. Increase physical activity

Have the patient sign and date the contract and provide a copy for the patient to take home and post somewhere they can see it daily.

Emphasize that the goals have to measurable - not vague.

e.g. "cut down on soda" = vague
Instead say "cut down to 1 soda/day"

Point 1

Give the example: "If you drink a glass of whole milk for breakfast, a glass of orange juice for lunch, and a soda for dinner, you will gain about a pound a week. Conversely, if you can switch to non-fat milk, lemonade made with a sugar substitute, and diet soda, you will lose a pound a week to a certain point."

Ask, "How many oranges does it take to make a glass of orange juice?" Tell the patient it takes 6 to 8 oranges. Then say, "I could drink 3 glasses of orange juice right now, no problem. How many oranges is that?" This tests their math and shows them how fast you can take in a lot of calories. Finish with "Eat your fruit, don't drink your fruit."

Point 2

Point 2 is based on Dr. Otten's study at the University of Vermont that examined the effects of TV reduction on energy expenditure (EE), energy balance, and BMI.[52]Restricting TV viewing time in overweight and obese adults produces increases in EE and a trend toward negative energy balance. It also decreases exposure to commercials that stir appetite and promote unnecessary or unhealthy snacks.

Point 3

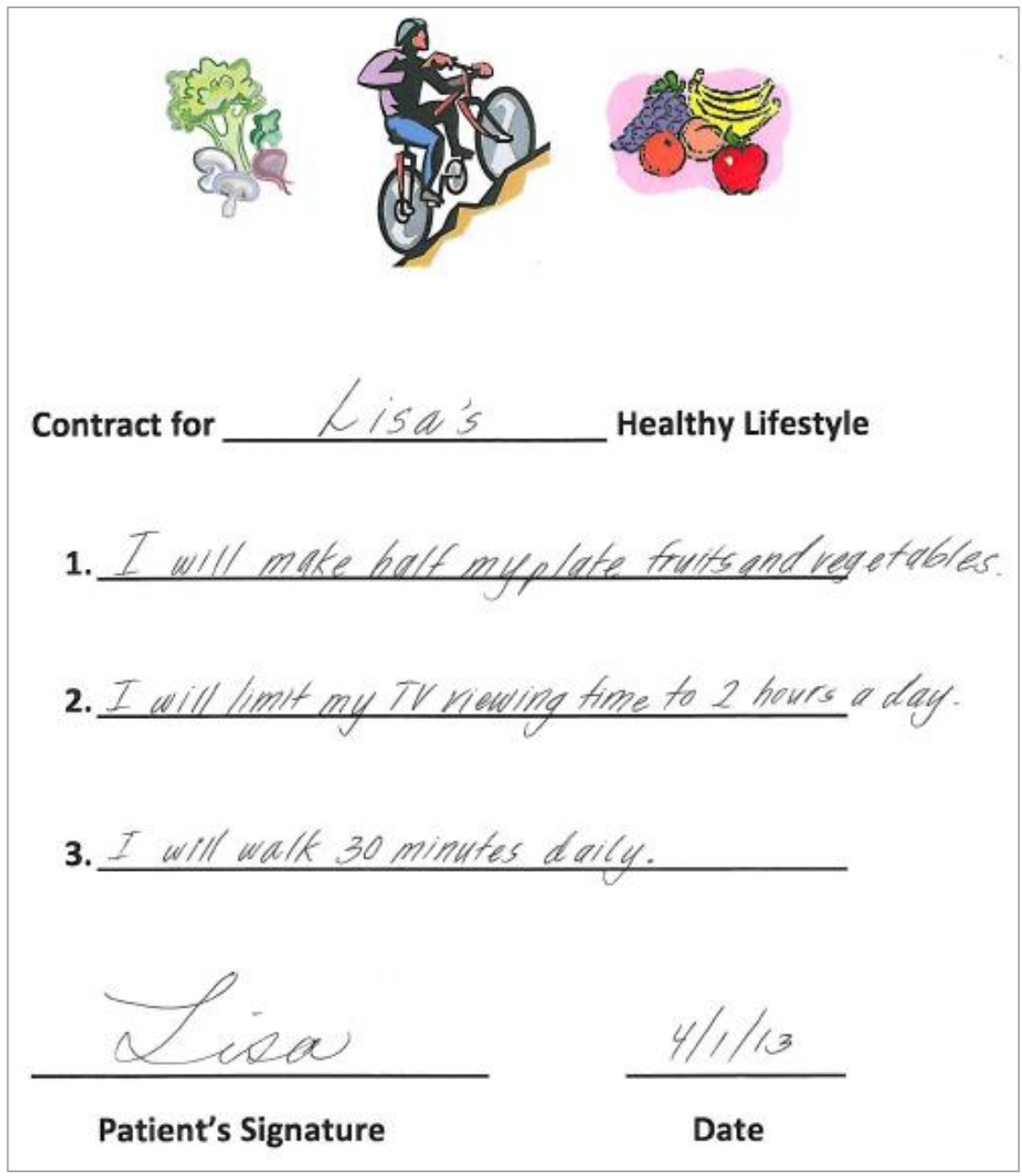
Ask the patient to start with as little as 5 minutes of physical activity a day, 3 times a week. A great resource is the book "8 Minutes in the Morning", by Jorge Cruise, which contains around 50 exercises. Ask the patients: "Who doesn't have 8 minutes sometime in their day—either in the morning or before bed?" Give the patient a handout that has muscle building exercises that can be done with only gravity and their body. Patients can say: "My neighborhood is not safe. It's raining outside. I can't afford to join a gym." As long as they have gravity and their body, they can do these exercises.

You can also tell them that working out muscles increases energy consumption thus burning up fat. The quads and gluts are the largest muscles so you could start with lunges or quad squats.

For all the points, you want to quantify and be specific. For example, don't contract to "decrease juice." Instead, it should be "decrease from 3 glasses a day to 2 glasses a day." For physical activity: "3 times a week on Monday, Wednesday, Friday for 5 minutes running or doing quad squats." Specific goals are better than general ideas.

Having the patient sign the contract is novel. Tell the patient, "don't write something down in the contract that you won't or can't do. I will see you in one month and remind you that you promised to do this. I don't want to set you up for failure, so don't write/sign something you can't do." This helps the contract be realistic.

Follow up each month and modify the points each time. For example, if they accomplished decreasing to 2 cups of juice a day, then next would be 1 cup a day. If they are doing well, increase the time between visits. If they are not doing well, move the visits closer together.



Contract for Lisa's **Healthy Lifestyle**

1. I will make half my plate fruits and vegetables.
2. I will limit my TV viewing time to 2 hours a day.
3. I will walk 30 minutes daily.

Lisa — 4/1/13

Patient's Signature **Date**

4 Assessment of the Overweight Adult Patient

- Assessing the Adult Overweight Patient
- Vital Signs
- Body Composition
- Body Mass Index (BMI)
- Office Procedures for Measuring BMI
- Waist Circumference
- Weight History
- Physical Activity Assessment
- Medical Examination
- Labs
- Patient Encounter Algorithm

Chapter 4 Assessment of the Overweight Adult Patient

Assessing the Overweight Adult Patient

Obesity is a chronic disease, body weight, and lifestyle. The primary care provider has a key role in the assessment and promotion of change toward a healthier lifestyle.[53] Disease management requires a multidisciplinary approach that includes using evidence based clinical guidelines to open discussions about weight management with patients, setting individual patient goals, providing information and resources (i.e. handouts and referrals), and providing follow-up.[54] The process includes assessment, discussion, and recommendations. The assessment should include utilizing vital signs, medical history, psychosocial evaluation, physical examination and laboratories to determine whether the patient is overweight or obese, and whether there are associated health and mental health risks such as type 2 diabetes, hypertension, dyslipidemias, and eating disorders.

Assessment of Risk Status

The patient's risk status should be assessed by determining the degree of overweight or obesity, based on BMI, presence of abdominal obesity (using waist circumference when indicated), and the presence of concomitant cardiovascular disease risk factors and/orco-morbidities. Obesity increases the risk for a variety of chronic diseases and excess body weight increases the risk of death from many causes.[55, 56]

Patients can be considered at high absolute risk for obesity related disorders if they have three or more of the following risk factors:[57,58]

- established coronary heart disease
- presence of other atherosclerotic heart disease
- type 2 diabetes
- sleep apnea

Other associated health risks include:

- certain forms of cancer,
- respiratory disease,
- gynecologic abnormalities,
- osteoarthritis,
- gallstones, and
- stress incontinence.

Vital Signs

Obtaining accurate measurement of a patient's vital signs is the first step to assessing an overweight patient. At each visit the following measures should be taken:

- Blood pressure
- Pulse
- Respiratory rate
- Temperature
- Height
- Weight

Also, additional assessments are necessary to determine a patient's level of overweight or obesity:

- Body Mass Index(BMI)
- Waist Circumference

Body Composition

Although the evaluation of body composition can involve advanced technologies such as dual energy x-ray absorptiometry, hydrostatic weighing, magnetic resonance imaging, and fat bioimpedance analysis, more practical office-based methods using anthropometry are considered adequate in the primary care office setting. For routine clinical use, anthropometric measurements utilizing height and weight have been preferred because of low cost and ease of measurement. Anthropometry is the study of systematic collection and correlation of body measurements. The National Institutes of Health and the World Health Organization have adopted similar body weight (adjusted for height) guidelines for defining overweight, obesity, and body mass index (BMI) criteria, and the U.S. Preventive Services Task Force found good evidence that BMI is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity.[59, 60]

Body Mass Index

An individual's degree of obesity can be assessed by calculating BMI. Physicians are encouraged to track a patient's BMI in the medical records for monitoring progress, and during patient discussions about weight management, promoting healthy lifestyles and necessary behavior changes. Body mass index does not account for individual proportions of muscle, bone/ cartilage, and water weight and is

not a direct measure of body fat. However it can be used as an indirect measure of body fat. Accuracy varies according age, race, and level of fitness. When necessary, a more accurate measure of body fat can be determined using various methods, including underwater weighing, bioelectrical impedance analysis and body fat meters.[61]

There are a number of methods available to assist clinicians with determining a patient's BMI, including long hand formulas, tables[62], commercially available wheels and computer based calculators, such as PDA software, online websites and desktop software. See the BMI Resource Links and Calculators section for an expanded Adult BMI Table, sample calculation, additional resources and informational website links.

How to determine BMI

1. Accurately measure standing height in inches. Ensure patients do the following:
   - Remove shoes (socks are acceptable to keep on)
   - Stand with feet flat and heels almost together
   - Keep legs straight and knees together
   - Stand straight with shoulder blades, buttocks and heels touching measurement surface
   - Relax shoulders
   - Keeps arms at sides
   - Look straight ahead
   - Remove hair braids, ornaments or buns to assure head piece reaches the top of the head

Measure all fractions of an inch to the nearest one-quarter (1/4) inch.

2. Accurately measure weight in pounds. Have patients do the following:
   - Remove shoes
   - Wear undergarments only (be mindful of patient privacy – offer a gown if available)
   - Stand on the center of the scale

   This may not be practical in the office setting and if patients wear their shoes and clothing you should can assume the patients weigh at least two pounds less without shoes and socks.

3. Determine BMI value by using one of the following:
   - Online BMI calculator
   - BMI wheel
   - Standard BMI equation
   - BMI tables

   Method 1: Online BMI calculator
   - Visit www.nhlbisupport.com/bmi
   - Enter the patient's height and weight to obtain the BMI value, and record to the nearest tenth (0.1)

   Method 2: BMI wheel
   - Choose the correct side of the BMI wheel according to patient's age (one side of the wheel is for adults and the other side is for children)
   - Align the height and weight values on the dials
   - Read the corresponding BMI value in the wheel window

   Method 3: BMI equation

Weight in kilograms (kg) divided by the square of height in meters (m^2)

$$BMI = \frac{\text{weight (kg)}}{\text{height squared } (m^2)}$$

Weight in pounds (lbs) divided by the square of height in inches (in^2), multiplied by 703

$$BMI = \frac{\text{weight (lbs)}}{\text{height squared } (in^2)} \times 703$$

   Method 4: BMI Table

BMI =

Adult Body Mass Index (BMI) Table

Height in Feet and Inches	Weight in Pounds																						
Height	80	90	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300
4'0"	24	27	31	34	37	40	43	46	49	52	55	58	61	64	67	70	73	76	79	82	85	88	92
4'2"	22	25	28	31	34	37	39	42	45	48	51	53	56	59	62	65	67	70	73	76	79	82	84
4'4"	21	23	26	29	31	34	36	39	42	44	47	49	52	55	57	60	62	65	68	70	73	75	78
4'6"	19	22	24	27	29	31	34	36	39	41	43	46	48	51	53	55	58	60	63	65	68	70	72
4'8"	18	20	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	65	67
4'10"	17	19	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61	63
5'0"	16	18	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59
5'2"	15	16	18	20	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53	55
5'4"	14	15	17	19	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	50	51
5'6"	13	15	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47	48
5'8"	12	14	15	17	18	20	21	23	24	26	27	29	30	32	33	35	36	38	40	41	43	44	46
5'10"	11	13	14	16	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	42	43
6'0"	11	12	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39	41
6'2"	10	12	13	14	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37	39
6'4"	10	11	12	13	15	16	17	18	19	21	22	23	24	26	27	28	29	30	32	33	34	35	37
6'6"	9	10	12	13	14	15	16	17	18	20	21	22	23	24	25	27	28	29	30	31	32	34	35
6'8"	9	10	11	12	13	14	15	16	18	19	20	21	22	23	24	25	26	27	29	30	31	32	33

Key — Healthy Weight — Overweight — Obese

Office Procedures for Measuring BMI
The Body Mass Index, or BMI, is to be recorded at each office visit. (See above for information on how to calculate the BMI.) The well care visit is the ideal time to address and counsel on issues relating to healthy eating, physical activity and ways to strengthen support for a healthy weight. The first step in this process is the calculation of the Body Mass Index (BMI).

Office staff will most likely be responsible for measuring and recording the patient BMI. Offices vary in the type of prompts that trigger a focus for the visit. It is important that staff gets in the habit of recording the patient's BMI at each visit.

Consider the BMI as A VITAL SIGN for all patients.

Electronic medical records make it easy to chart BMI. If a paper chart is being used, the receptionist can place a chart sticker or prompt to remind the medical assistant to calculate the patient's BMI. The sticker can include the BMI and where the patient fits in the continuum from healthy weight to obesity:

BMI: _____
Height: _____
Weight: _____
☐ Underweight
☐ Normal Weight Range
☐ Overweight
☐ Obese
☐ Severely Obese

Involving staff in the collection and recording of the BMI will be essential to increase its collection and accuracy in the practice. There are at least three ways staff can be involved with the BMI:

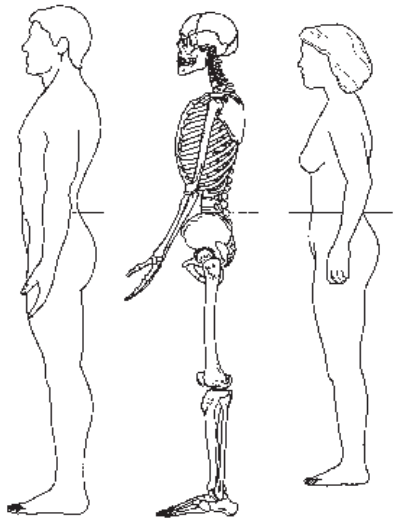
- **Step One - Hold a Daily Huddle**: Each morning in preparation for the day's visits, hold what's called a "Daily Huddle" between the healthcare provider and office manager to briefly review the schedule. This should take about five to seven minutes.
- During this time, those patients coming in for Well Care Visits and patients above a healthy weight can be identified. If a paper chart is being used, the Chart Prompt for the BMI can be placed on the outside of the chart to make sure the BMI is measured and recorded.
- **Step Two - Office Staff Meetings**: Staff meetings will provide the opportunity for staff and the healthcare provider to discuss ways to strengthen efforts to both accurately record and discuss the BMI with patients. Time can also be spent determining ways to most effectively reach out and stay in touch with those patients whose BMIs are increasing or have not decreased.

Waist Circumference[63]
Measurement of waist circumference is a second obesity assessment tool used by some practices to determine an individual's degree of excess abdominal fat. Abdominal fat poses a greater health risk than peripheral fat, and waist circumference may be more predictive of disease risk than BMI in normal or overweight patients. It is important to note that waist circumference is measured at the level of the iliac crest, not the umbilicus ("natural" waist). It may be necessary for clinical staff to explain the importance of waist circumference measurements as part of the medical assessment.

When to measure waist circumference[64]:
- As part of an initial patient assessment
- To monitor weight loss therapy in patients with BMI <35

To measure patient waist circumference:
1. Locate the upper hip bone and top of the iliac crest when patient is standing.
2. Place a measure tape in a horizontal plane at the level of the iliac crest around the abdomen ensuring the tape is snug and parallel with the floor.
3. The patient should be asked to breathe normally while the measurement is taken.
4. The measurement should be read at the end of patient exhalation.

Abnormal Waist Circumferences
- Greater than 40inches (102cm) for men
- Greater than 35 inches (88cm) for women



Guidelines on Overweight and Obesity: Electronic Textbook". National Heart, Lung, and Blood Institute. Retrieved December 2012.

BMI and Waist Circumference Classifications of Disease Risk*

Body mass index (BMI)		Disease Risk Relative to Normal Weight and Waist Circumference		
Category	**BMI (kg/m2)**	**Obesity Class**	**Men ≤ 40inches Women ≤ 35 inches**	**Men > 40inches Women >35 inches**
Underweight	<18.5			
Normal	18.5–24.9			
Overweight	25.0–29.9		Increased	High
Obesity	30.0–34.9	I	High	Very High
	35.0–39.9	II	Very High	Very High
Extreme Obesity	≥ 40	III	Extremely High	Extremely High

*Disease risk for type 2 diabetes, hypertension and cardiovascular disease

Source: "The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults". National Heart, Lung, and Blood Institute. October 2000.

Weight History

Once a diagnosis of overweight or obesity has been made, providers should integrate a weight history within the medical history or refer the patient to a qualified weight management program. A comprehensive weight history should include questions about birth weight, early childhood weight and a chronology of weights over the life cycle, including such milestones as lowest adult weight and maximum adult weight. It should also explore precipitating factors such as pregnancy, surgeries, and adverse life events, along with any indications of eating disorders, such as frequent binge eating, vomiting or use of laxatives. Another important component of the weight history is determining if there have been past attempts at weight loss, which types of programs, and whether they resulted in maintained weight loss. Providers should also identify family and social history events that may be relevant, such as family members with a history of obesity, cardiovascular disease, or diabetes; or low socioeconomic status. During the initial assessment providers may also want to address reasons for weight gain, the benefits of weight loss, and the benefits of preventing further weight gain.

Nutritional status, eating habits and physical activity patterns should be routinely evaluated, along with identifying risk factors for obesity within the family. For a detailed diet history it is recommended that you refer your patient to a registered dietitian. She can conduct a dietary 24 hour recall and can provide your patient with a 3 to 7 day food journal and ask more specific questions about diet. She can use this information to calculate an estimate of daily caloric intake and determine possible nutrient deficiencies. Most dietitians are also able to conduct a more detailed physical activity assessment.

It is important to ask open-ended questions. A question to open the discussion might be:

"How do you feel about us talking about your physical activity, TV viewing, and eating today?"

Next, follow up with more focused questions addressing both physical activity and nutrition.

Some general screening questions to consider include:

Weight History Questions

- When were you at your lowest weight? (Provide triggers such as: wedding, school reunion)
- How long were you at that weight?
- When were you at your highest weight? What was happening in your life at that point?
- Have you ever tried a weight loss program before? What program(s)? What was the duration?
- Have you ever tried to lose weight on your own? What method(s)? (e.g. OTC pills, fad diets)
- (if applicable) How much did you lose and how long did you maintain that weight?
- Do you feel ready and committed to achieving a healthy weight?
- What are your personal goals for losing weight?

Physical Activity Questions

- How many minutes a day are you physically active?
- What types of physical activity do you do?
- What are the barriers for you to be physically active?
- How many hours of television do you watch each day?
- How many hours do you spend on the computer and/or hand-held devices each day?
- How often do you get outside for physical activity (e.g. walking, biking, playing with your child)? Is it safe to do so in your neighborhood?
- Do you feel your family supports an active lifestyle?
- How easy is it to exercise during your workday?
- What types of physical activity do you want to do?

Eating &Nutrition Questions

- What did you eat yesterday? Is this what you normally eat?
- Do you eat breakfast?
- When eating at home, do you routinely eat while watching the TV?
- How often do you eat out each week?
- How often do you eat fruits and vegetables? Are they usually included in meals?
- What sort of snacks do you normally eat?
- How many sodas or sweetened beverages do you drink each day?
- Do you snack after supper? How big are they?

- Do you know how to read food labels?

Focused Family History

Does anyone in your immediate family have a history of…

- Overweight or obesity?
- Diabetes?
- Coronary heart disease?
- Hypertension (high blood pressure)?
- Dyslipidemia (high cholesterol)?
- Cancers?
- Genetic disorders (Gaucher's disease, Lysosomal Acid Lipase Deficiency)?

Mental Health Social History

- Have you ever been diagnosed with a mental health disorder?
- Have you ever induced vomiting or taken laxatives to lose weight?
- Do you have issues with eating late at night or during the night when you are sleeping?
- Have you ever been physically or sexually abused?
- Do you have any concerns about your family and/or living situation?

Physical Activity Assessment

Assess Patient Physical Activity Levels and Attitudes[65]

To assess patient physical activity levels and attitudes try the following methods:

Ask patients to complete a physical activity questionnaire.

- *The American Medical Association offers a physical activity questionnaire online at:* http://www.ama-assn.org/ama1/pub/upload/mm/433/phactivity.pdf

Ask open ended questions during the patient interview/exam.

- What types of activities do you enjoy?
- How often are you physically active or exercise?
- Have you thought about increasing your physical activity participation?
- Do you think physical activity will benefit you? How?
- What prevents you from being physically active or exercising? For example: work, lack of free time, etc.
- How active are you during an average work day?
- Are you willing or interested in changing your current level of physical activity?

Physical Activity Risk Assessment

Most healthy adults can pursue a regimen of moderate physical activity if they are appropriately screened and provided exercise that is progressed in a reasonable manner. For most patients, a risk assessment prior to providing a physical activity prescription can be done quickly and effectively.

The Patient-centered Assessment and Counseling for Exercise and Nutrition (PACE) manual provides quick and easy to use physical activity screening protocols and recommendations. The PACE Physical Activity Readiness Questionnaire (PAR-Q)© can be completed, while the patient is in the waiting room, in 1-2 minutes before seeing the provider.

PACE materials are available for a fee, a link is included in this toolkit. The PACE form is a modified version of the Health Canada "PAR-Q and You"© form, which is a validated and proven tool for screening individuals prior to commencing a physical activity program. The form includes screening questions about whether patients experience pain or problems when being physically active, and whether the patient is taking any prescription medications. The PAR-Q and You, plus additional screening forms, are available at: http://www.csep.ca/english/view.asp?x=698

The American College of Sports Medicine has established more extensive guidelines when medical screening and exercise testing are necessary. This type of screening is usually necessary when there are additional risk factors or medical conditions such as degenerative joint disease, heart disease and diabetes when the potential risk of a cardiovascular event or musculoskeletal injury is increased. For more information, Please visit the American College of Sports Medicine website at: http://acsm.org/

The Medical Examination

When a patient is diagnosed as overweight or obese, a more detailed medical evaluation should be performed to determine co-morbid conditions and the cause(s) of overweight/obesity. Certain populations, including pregnant women, seniors, people with eating disorders, etc. require special considerations and more individualized weight

management programs outside the scope of these general guidelines.

After assessing a patient's weight management status by documenting baseline measures, be sure to note any medications or psychiatric conditions that could be contributing to weight gain. In addition, monitor any co-morbid conditions.

Labs

The following screening labs are suggested to determine health conditions associated with a patient's weight. Please note that ranges and values will vary by lab and measurement tool:

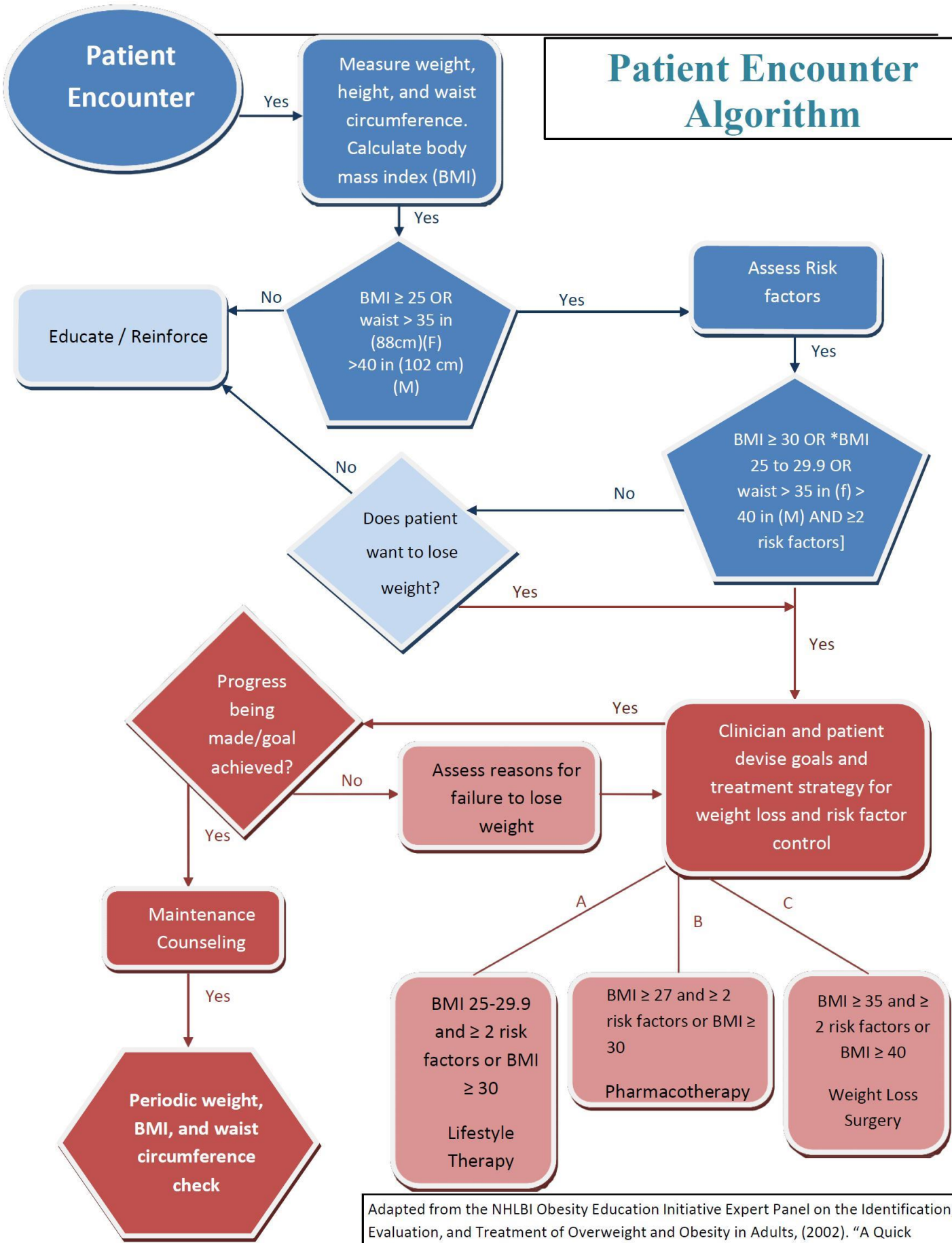
Test	Healthy Range for Results
HDL(High Density Lipoprotein)[66]	Women>40mg/dL Men>50mg/dL
LDL(Low Density Lipoprotein)	<100mg/dL
Total cholesterol	<200mg/dL
Triglycerides	<150mg/dL
Fasting Blood Glucose	<110mg/dl* 70-130mg/dl** 70-100 mg/dl***
Fasting Insulin	<110mg/dl
Albumin/ Creatinine Ratio[67]	Normal:0-30µg/mg creatinine Microalbuminuria:30-300µg/mg creatinine Clinical albuminuria:>300µg/mg creatinine3
Total Protein[68]	6.0to 8.3gm/dl
BUN (Blood Urea Nitrogen)	Adult:6-20mg/100ml
ALP (Alkaline Phosphatase)[69]	44to 147IU/L (international units per liter)
ALT (Alanine Aminotransferase)	167to 667nkat/L(10to 40U/L)
AST (Aspartate Aminotransferase)[70]	10to 34U/L (units per liter) or 5 to 40 IU/L
Bilirubin[71]	Bilirubin (direct): 0 - 0.3 mg/dL Bilirubin (total): 0.3 to 1.9 mg/dL mg/dL
TSH (Thyroid Stimulating Hormone)	0.4to 4.0mIU/L

*American Association of Clinical Endocrinologists
**American Diabetes Association
*** Mayo Clinic

Weight Assessment Questionnaire

Overweight and obese patients should be given a weight assessment questionnaire to determine factors contributing to their weight gain as well as their eating and physical activity behaviors. A sample weight assessment questionnaire is located in the Provider Resources section of this toolkit for your *reference*.

Patient Encounter Algorithm



Adapted from the NHLBI Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, (2002). "A Quick Reference Tool ACT." National Institutes of Health, 79-80.

5 Weight Management

- Weight Loss and Maintenance
- Weight Loss Goals
- Weight Management Goals
- Weight Management Program Components
- Treatment Considerations
- Adult Treatment Panel III (Guidelines)
- Dietary Therapy
- Physical Activity
- Behavior Management
- Pharmacotherapy
- Weight Loss Surgery

Chapter 5 Weight Management

Weight Loss and Maintenance

The National Institute of Health's National Heart Blood and Lung Institute recommends weight management treatment for patients with a BMI of 25.0 to 29.9 kg/m^2 or a waist circumference greater than 88 cm for females or greater than 102cm for males AND two risk factors or more. Treatment is also recommended for patients with a BMI of 30 kg/m^2 or more, regardless of risk factors. (Please refer to the Patient Encounter Decision Tree on page 55 for further details). Once the provider and patient agree to treatment they should then set goals for weight loss and risk factor control. Realistic short and long-term goals should be encouraged by a discussion about healthy weight versus ideal body weight.[72]Weight loss and maintenance programs that include combination therapy consisting of dietary, physical activity, and behavioral therapy have been found to be more effective than one component alone. Frequent clinical encounters with professional counselors during the first six months may promote weight loss and maintenance. Patients should also be aware that weight management will be an ongoing commitment that may require participation in a long-term weight maintenance program.

Nearly 80 percent of patients who lose weight will gradually regain it if they are not supported by a weight maintenance program. The keys to a successful weight maintenance program are patient motivation and team support from health care providers. Effective management of overweight and obesity can be delivered by a variety of health care professionals including primary care providers, registered dietitians, nutritionists, exercise physiologists, nurses and psychologists.

Achieving and maintaining an appropriate body weight requires daily effort, good dietary behaviors and adequate physical activity. Combined management approaches (diet, exercise and behavior modification) are likely to produce better results than any single approach.[73]

Clinicians should encourage patients to consult their health plan for weight loss/maintenance programs that may be covered by their policy.

Exclusion from Weight Loss Therapy

Weight loss therapy may or may not be appropriate for:

- most pregnant and lactating women
- those with serious psychiatric illness
- patients with a variety of serious illnesses in whom caloric restriction might exacerbate the illness

They may need specialized weight loss treatment.

Weight Loss Goals

An initial weight loss goal 10 percent of body weight over a six-month period is realistic for most patients.

Starting BMI	Daily Calorie Reduction	Estimated Weekly Weight Loss
27–35	300–500k/cal	½ - 1 pound
>35	500–1000k/cal	1 – 2 pounds

Weight Management Goals[74]

The goals of weight management go well beyond numbers on a scale, whether or not weight change is one of the management objectives. The development of healthful lifestyles with behavior modification is important for overall fitness and health. Realistic expectations should be defined during an intake interview in terms of a more healthful weight versus the normal BMI range. In addition, it is important to set realistic expectations about the time required to make a sustainable behavior change.

Goals of weight management interventions may include:

- prevention of weight gain or stopping weight gain in an individual who has been seeing a steady increase in his or her weight;
- varying degrees of improvements in physical and emotional health;
- small maintainable weight losses or more extensive weight losses achieved through modified eating and exercise behaviors; and
- improvements in eating, physical activity, and other behaviors.

Health care providers must help patients to accept a modest, sustainable weight change that can be

realistically achieved. Appearance, in many patients, will be an important motivator; however, it is critical that health care providers emphasize the goal of achieving a more healthful weight and lifestyle while de-emphasizing cosmetic goals.

Patients should be encouraged to set realistic weight loss and behavior changing goals to promote healthy lifestyles including the following:

- My goal will be to limit my sweetened beverage intake to 1 a day.
- My goal is to drink water instead of sugary drinks.
- My goal is to switch to fat free or 1% milk.
- My goal is to make half my plate fruits and vegetables.
- My goal is to make at least half my grains whole.
- My goal is to limit screen time to 2 hours a day.My physical activity goal is ____ minutes ____ days of the week for the next _____ weeks. I plan to do the following physical activities_____ (ex. Walking, bike riding, etc.)

Weight Management Program Components

The U.S. Preventive Services Task Force recommends that providers screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss in obese adults.[75] According to the National Institutes of Health a reduced calorie diet combined with increased physical activity with an emphasis on long-term weight management produces weight loss, decreased abdominal fat and increases cardio respiratory fitness.[76] A comprehensive weight maintenance program must be followed to sustain weight loss. Each of the following components should be adapted accordingly to fit the needs of specific social or cultural groups.

- Dietary therapy
- Physical activity plan
- Behavior therapy
- Pharmacotherapy
- Bariatric surgery

Treatment Considerations[77]

- Has the patient had prior weight loss attempts? Consider any successes, failures, and/or barriers.
- Assessment of past weight loss attempts should include questions or a questionnaire that identifies the following:
  - Type of weight loss program including dates and duration
  - Amount of weight lost over a period of how long
  - How long was weight loss maintained
  - What made keeping the weight off difficult
- Is the patient motivated to make the behavior and lifestyle changes necessary for successful weight loss?
- Does the patient have any lifestyle, relationship or work stresses that will prevent successful weight loss including time availability?
- Does the patient have any eating disorders or psychological disorders that may be contributing to their obesity and/or weight management issues?
- Is the patient capable of following recommendations?
- How much weight does the patient want/expect to lose? Is the goal realistic?
- Are there medical conditions contributing to the obesity?
- Are any over-the-counter or prescribed medications contributing to the obesity?(i.e. herbs or dietary supplements)

Adult Treatment Panel III Guidelines[78]

The ATP III guidelines are evidence based recommendations for intensive cholesterol-lowering therapy. The ATPIII guidelines focus on primary prevention of Coronary Heart Disease (CHD) in persons with multiple risk factors by managing elevated patient cholesterol levels to achieve the following optimal levels:

Optimal Adult Cholesterol Levels

LDL Cholesterol (Primary Therapy Target)	< 100mg/dL
HDL Cholesterol	> 40mg/dL
Triglycerides	< 150mg/dL
Total Cholesterol	< 200mg/dL

Dietary Therapy[79]

Sensible eating, in combination with realistic physical activity goals can play an important part in helping obese patients achieve a healthy weight. Physicians should be aware that overly restrictive

approaches towards eating or extreme dieting can sometimes be detrimental to a healthy eating plan and may lead patients to weight cycle. Ideally dietary therapy should be provided by a registered dietitian (RD), as part of a comprehensive weight management plan. A proper dietary assessment should be conducted prior to making recommendations.

Role of Registered Dietitian[80]

Some health care providers and offices employ the services of registered dietitians, for assistance in educating patients about nutrition and healthy diets. RDs can provide medical nutrition therapy through guidance about diet options, discuss behavioral motivations and promote healthy eating in conjunction with physical activity by separating 'fads' from facts.

Here are just a few of the benefits of working with a registered dietitian:

- **Expert training in nutrition counseling:** Anyone can call him- or herself a nutritionist, but only a registered dietitian (or RD for short) has completed multiple layers of education and training established by the Academy of Nutrition and Dietetics.
- **Personally tailored advice:** When patients see an RD, the last thing they'll get is one-size-fits-all diet advice. A dietitian is like an investigator seeking to learn about patient's current and desired state of health. After learning about patient health history, favorite foods, eating and exercise habits, an RD will help patients set goals and prioritize. Follow-up visits will focus on maintenance and monitoring patient progress.
- **Help managing chronic diseases:** If patients have high cholesterol, high blood pressure, diabetes or cancer it can be hard to know what to eat. An RD can review patient lab results with patients, help them understand their condition and provide education about the nutrients that affect it. Then, the RD will help patients create an eating plan that includes all the important nutrients that can help manage their condition.
- **Guidance navigating food allergies, sensitivities and intolerances:** When patients suffer from conditions like celiac disease, food allergies or lactose intolerance, it's easy to be overwhelmed by what they think can't eat. An RD can teach patients how to read food labels so they'll know which ingredients to avoid and a help them find substitutions to keep their diet balanced and tasty, too.
- **A weight-loss program that really works:** Fad diets may sound like the quick ticket to weight loss but they rarely work for very long. A registered dietitian will partner with patients to develop a safe, effective weight-loss plan that they can stick with for the long haul. To guide and motivate patients, a registered dietitian will use creative and out-of-the-box strategies to help with meal planning, grocery shopping, food journaling and mindful eating.

Medical Nutrition Therapy (MNT)[81]

Medical Nutrition Therapy is an essential component of comprehensive health care. Individuals with a variety of conditions and illnesses can improve their health and quality of life by receiving medical nutrition therapy.

Medical Nutrition Therapy includes:

1. Performing a comprehensive nutrition assessment determining the nutrition diagnosis;
2. Planning and implementing a nutrition intervention using evidence-based nutrition practice guidelines;
3. Monitoring and evaluating an individual's progress over subsequent visits with the RD.

RDs and Medical Nutrition Therapy Services[82]

Health professionals agree that nutrition services are one of the first treatments that individuals should receive to improve conditions such as diabetes, heart disease and hypertension.

Many registered dietitians (RDs) work in the treatment and prevention of disease by providing medical nutrition therapy. The RD often acts as part of a medical team, in various practice settings, such as hospitals, physician offices, private practice and other health care facilities. During an MNT intervention, RDs counsel clients on behavioral and lifestyle changes required to impact long-term eating habits and health.

Together with the registered dietitian, patients will set nutrition goals to improve their health.

Medical nutrition therapy provided by an RD includes:

- Review of what patients eat and their eating habits
- Thorough review of their nutritional health
- Personalized nutrition treatment plan

The first visit with the registered dietitian will take approximately one hour. After the first session, the RD will schedule follow-up appointments to check on patient progress goals and see if changes are needed in their nutrition and treatment plan.

Insurance Coverage for MNT[83]

Please refer to Chapter 8 - Billing & Prevention Procedure Codes for more details.

Regulation of Food Intake[84]

A negative energy balance is the most important factor affecting weight loss amount and rate. The first recommendation in obesity treatment is usually a reduction in energy intake:

A reduction of 500 to 1,000 kcal/day is advised to achieve a 1 to 2 lb weight loss per week

Keep in mind this is just a general guideline for calorie restriction. Women have different calorie needs than men and usually will require a different calorie reduced diet than men for weight loss. Dietary energy reduction strategies may vary from a focus solely on energy (i.e., "calorie counting"), macronutrient composition and/or energy density, or a combination of energy and macronutrient composition along with form considerations such as consistency (e.g., meal replacements, very-low-energy diets). In addition, strategies have included changes to meal frequency, meal timing (e.g., breakfast) and guidance on food portions.

Diet Composition

ChooseMyPlate.gov: USDA Food Model[85]

MyPlate is a nutrition guide published by the United States Department of Agriculture. MyPlate illustrates the five food groups that are the building blocks for a healthy diet using a familiar mage—a place setting for a meal. MyPlate is based on the following five food groups: fruits, vegetables, grains, protein foods and dairy. It also includes advice on oils and empty calories. MyPlate prompts consumers to think differently about their food choices, helps individuals meet nutrient and calorie needs, and makes individuals choose positive eating choices. The ChooseMyPlate.gov website provides information for both the public and health professionals. It includes information about recommended daily amounts for each of the food groups but also provides information for physical activity and weight management. It has a SuperTracker and other tools to assist with monitoring diet and setting goals for a healthy weight.

Some of the core recommendations for healthy eating are as follows:

- make half your plate fruits and vegetables
- Make at least half of your grains whole grains
- Switch to fat-free or low-fat (1%) milk
- Go lean with protein
- drink water instead of sugary drinks

DASH Diet[86]

Dietary Approaches to Stop Hypertension (DASH) eating plan is designed to help treat or prevent high blood pressure (hypertension). DASH follows heart healthy guidelines to limit saturated fat and cholesterol. It focuses on increasing intake of foods rich in nutrients that are expected to lower blood pressure, mainly minerals (like potassium, calcium, and magnesium), protein, and fiber. It includes nutrient-rich foods so that it meets other nutrient requirements as recommended by the Institute of Medicine.

The DASH eating plan also has other benefits, such as lowering LDL ("bad") cholesterol, which, along with lowering blood pressure, can reduce your risk for getting heart disease.

The DASH eating plan can be adopted to promote weight loss. It is rich in lower-calorie foods, such as fruits and vegetables. You can make it lower in calories by replacing higher calorie foods such as sweets with more fruits and vegetables.

DASH Eating Plan – Number of Daily Serving for Other Calorie Levels

Food Groups	Servings/Day		
	1,600 calories/day	2,600 calories/day	3,100 calories/day
Grains*	6	10–11	12–13
Vegetables	3–4	5–6	6
Fruits	4	5–6	6
Fat-free or low-fat milk and milk products	2–3	3	3–4
Lean meats, poultry, and fish	3–6	6	6–9
Nuts, seeds, and legumes	3/week	1	1
Fats and oils	2	3	4
Sweets and added sugars	0	≤2	≤2

**Whole grains are recommended for most grain servings as a good source of fiber and nutrients.*

Low Calorie Diet[87]

Appropriate caloric intake will vary by gender, age, and daily levels of physical activity. A low-calorie diet is usually used to achieve weight loss of 1 lb (0.5 kg) to 2 lb (0.9 kg) per week. Most experts do not recommend losing more than 2 lb (0.9 kg) per week unless you are participating in a medically-supervised weight loss plan.

General recommendations for a low-calorie diet include:

- Reducing calorie intake to 1,200 to 1,500 calories per day for women and 1,500 to 1,800 calories per day for men. Women should not restrict themselves to fewer than 1,000 calories per day and men to fewer than 1,200 calories per day without medical supervision.
- Limiting fat intake to no more than 20% to 35% of your total calorie intake. For a person following a 1,500-calorie diet, this means eating no more than 35 to 60 grams of fat per day. Eating foods that are made with fat substitutes (such as olestra) might help decrease your daily fat intake, but they have not been shown to lead to weight loss.
- Choosing complex carbohydrates, such as whole grains, vegetables, and fruits. About 45% to 65% of your total calorie intake should come from carbohydrate. For someone following a 1,500-calorie diet, this means eating between 170 to 240 grams of carbohydrate per day.
- Choosing low-fat protein sources, such as fish, poultry, and legumes (for example, pinto beans, lentils, and split peas). About 15% to 25% of your total calorie intake should come from protein. For someone following a 1,500-calorie diet, this means eating between 55 to 95 grams of protein per day.
- Eating 20 to 35 grams of fiber per day.
- Having no more than 1 alcoholic drink for women and 2 for men per day. A standard-size alcoholic drink is:
  - One 12 fl oz. (355 mL) bottle of beer or wine cooler.
  - One 5 fl oz. (148 mL) glass of wine.
  - One mixed drink containing 1.5 fl oz. (44 mL) of 80-proof hard liquor, such as gin, whiskey, or rum.
- A low-fat, reduced-energy diet is the best studied weight-loss dietary strategy and is most frequently recommended by governing health authorities. Fat is the most energy-dense macronutrient but is known to have a weak effect on both satiation and satiety. These attributes make fat a useful target for reducing energy intake.
- An individualized reduced calorie diet is the basis of the dietary component of a comprehensive weight management program. Reducing dietary fat and/or carbohydrates is a practical way to create a caloric deficit of 500 to 1,000 kcal below estimated energy needs and should result in a weight loss of 1 to 2 lb per week.

Very Low-Calorie Diets (VLCD)[88]

VLCDs are medically-supervised diets that typically use commercially prepared formulas and foods to promote rapid weight loss in obese patients. Such diets typically involve the consumption of liquid shakes or bars to replace all food intake for several weeks or months. Other VLCD methods involve diets composed almost entirely of lean protein foods, such as fish and chicken. People on a VLCD consume about 800 calories per day or less and require supplemental vitamins and micronutrients to ensure daily nutritional requirements are met.

Unlike meal replacements, which are designed to replace only one or two meals per day, a VLCD is designed to be the only food source, usually for a period of 1-6 months, during active weight loss. A VLCD is typically a liquid formulation that supplies

about 800 kcal (or 6 to 10 kcal/kg) or less per day, is enriched with high biologic value protein and provides at least 100% of the Daily Value of essential vitamins and minerals. The purpose of using a VLCD is to quickly achieve a large weight loss while providing adequate nutrition and preserving lean body mass as much as possible. Medical monitoring is necessary during the rapid weight loss phase and the medical risk makes a VLCD inappropriate for individuals with a BMI <30. While adherence to a VLCD may result in a significant initial weight loss, studies report varying levels of weight regain based on differences in weight maintenance strategies.

Meal Replacements

For people who have difficulty with self selection and/or portion control, meal replacements (e.g., liquid meals, meal bars, or calorie-controlled packaged meals) may be used as part of the diet component of a comprehensive weight management program. Substituting one or two daily meals or snacks with meal replacements is a successful weight loss and weight maintenance strategy.

High-protein, Low-carbohydrate diets[89]

High-protein, low-carbohydrate diets generally recommend dieters receive 30% to 50% of their total calories from protein. By comparison, the American Heart Association, the National Cholesterol Education Program, and the American Cancer Society all recommend a diet in which a smaller percentage of calories are derived from protein (nutrients essential to the building, maintenance, and repair of tissues in the body). Weight loss results from this type of diet may not be sustained over time.

High protein, low-carb diets can cause a number of health problems, including kidney failure, kidney disease, high cholesterol, osteoporosis and kidney stones, cancer and unhealthy metabolic state (ketosis).

Commercial Weight Management Program Options

- Counseling by registered dietitians or nutritionists may be part of a medically supervised or commercial weight management program.
- Commercial weight loss programs –some health plans provide member incentives to enroll in commercial programs including reimbursement and discounts.
- Internet based programs and resources
- Meal Replacements (MR) are pre-packaged food items that provide calorie and portion controlled meals

Diet Education Efforts

Patients should be educated to pay particular attention to the following:

- Calorie value of different foods
- How to read food nutrition labels and food composition(fats, carbohydrates and proteins)
- Developing new purchasing habits in favor of low-calorie foods
- Using healthier food preparation methods (i.e. broiling, baking, steaming)
- Avoiding consumption of high calorie foods
- The importance of drinking water
- Reducing portion sizes
- Limiting alcohol consumption

Recommended Strategies to Lose Weight or Maintain Weight Loss

- Tell patients to eat more healthy foods including fruits and vegetables, whole grains, and lean meats
- Emphasize the importance of regular meals
- Recommend dietary substitutions
- Discuss portion control
- Encourage eating trigger awareness
- Review and discuss weekly food and activity diaries (when available)
- Provide patient with dietary information and handouts (as appropriate)

Strategies for Losing Weight

Eating Frequency

Total caloric intake should be distributed throughout the day, with the consumption of four to five meals/snacks per day including breakfast. Consumption of greater energy intake during the day may be preferable to evening consumption.

Portion Control

Effectively reducing portion sizes appears to be an important weight gain prevention strategy for everybody (regardless of weight) as marketplace food and drink portions now exceed standard serving sizes by a factor of at least twofold. Portion distortion is a term created to describe this perception of large portions as appropriate

amounts to eat at a single eating occasion. This distortion is reinforced by packaging, dinnerware, and serving utensils that have also increased in size.

Portion control should be included as part of a comprehensive weight management program.

Portion control at meals and snacks results in reduced energy intake and weight loss. WebMD's Portion Size Plate provides an online easy-to-understand guideline on portion control and size guide to help patients avoid some common portion-size pitfalls: http://www.webmd.com/diet/healthtool-portion-size-plate.

Food Proportion Tips[90]

- Serve meals on smaller plates
- Share a meal when eating out
- Avoid second helpings
- Gradually cut back on portion sizes
- Avoid filling extra plates pace with additional helpings

Better Eating Habit Tips[91]

- Eat 3 balanced meals daily with planned snacks.
- Plan family meals to get him/her at a table.
- Do not eat in front of the TV.
- Keep healthy food within easy reach and junk foods out of the house.
- Eat slowly and stop when full or satisfied.
- Eat fruits and vegetables for snacks.
- Choose lower fat, lower calorie foods.
- Prepare food by broiling, baking, and barbeque instead of frying.
- Eat lean meats without skin including beef, fish and poultry.
- Limit fast food consumption–especially "super-sized" meals.
- Drink six to eight glasses of water each day.
- Limit drinks high in calories, sugar and fructose corn syrup such as soda and juices.
- Limit alcoholic beverages.

Physical Activity

Patients should make physical activity part of everyday life by planning enjoyable activities. Physical activity has been shown to prevent weight regain when initiated slowly and increased gradually. The following section provides basic information about the importance of being active.

How Much Physical Activity is Needed?[92]

Adults (18 to 64 years) should do at least 2 hours and 30 minutes each week of aerobic physical activity at a moderate level OR 1 hour and 15 minutes each week of aerobic physical activity at a vigorous level. Being active 5 or more hours each week can provide even more health benefits. Spreading aerobic activity out over at least 3 days a week is best. Also, each activity should be done for at least 10 minutes at a time. Adults should also do strengthening activities, like push-ups, sit-ups and lifting weights, at least 2 days a week.

Patients should be encouraged to get 30 - 60 minutes of moderate physical activity most or all days of the week.

10 Minutes at a time is fine

We know 150 minutes each week sounds like a lot of time, but you don't have to do it all at once. Not only is it best to **spread your activity out during the week**, but you can **break it up into smaller chunks of time during the day**. As long as you're doing your activity at a moderate or vigorous effort for **at least 10 minutes at a time**.

Give it a try

Try going for a 10-minute brisk walk, 3 times a day, 5 days a week. This will give you a total of 150 minutes of moderate-intensity activity.

Potential Benefits of Physical Activity[93]

- Reduced risk of the following:
  - Coronary heart disease
  - Type 2 diabetes and metabolic syndrome
  - Certain cancers
  - Depression
  - Premature mortality
- Improved blood pressure
- Reduced cholesterol
- Improved energy and stamina
- Increase fitness levels
- Helps build and maintain bones, muscles, and joints
- Improve mental health and mood
- Increases flexibility
- Helps manage weight
- Improve your ability to do daily activities and prevent falls, if you're an older adult

Target Heart Rate and Estimated Maximum Heart Rate[94]

One way of monitoring physical activity intensity is to determine whether a person's pulse or heart rate is within the target zone during physical activity. Inform your patient of their target heart rate for physical activity and teach them how to take their own pulse.

(220–Age) x (%Intensity) = Target Heart Rate

The maximum rate is based on the person's age. An estimate of a person's maximum age-related heart rate can be obtained by subtracting the person's age from 220. For example, for a 50-year-old person, the estimated maximum age-related heart rate would be calculated as 220 - 50 years = 170 beats per minute (bpm).

220– Age = Estimated Maximum Heart Rate

For moderate-intensity physical activity, a person's target heart rate should be 50 to 70% of his or her maximum heart rate. The 50% and 70% levels would be:

50% level: 170 x 0.50 = 85 bpm, and
70% level: 170 x 0.70 = 119 bpm

Thus, moderate-intensity physical activity for a 50-year-old person will require that the heart rate remains between 85 and 119 bpm during physical activity.

For vigorous-intensity physical activity, a person's target heart rate should be 70 to 85% of his or her maximum heart rate. For example, for a 35-year-old person, the estimated maximum age-related heart rate would be calculated as 220 - 35 years = 185 beats per minute (bpm). The 70% and 85% levels would be:

70% level: 185 x 0.70 = 130 bpm, and
85% level: 185 x 0.85 = 157 bpm

Thus, vigorous-intensity physical activity for a 35-year-old person will require that the heart rate remains between 130 and 157 bpm during physical activity.

Taking Your Heart Rate

Generally, to determine whether you are exercising within the heart rate target zone, you must stop exercising briefly to take your pulse. You can take the pulse at the neck, the wrist, or the chest. We recommend the wrist. You can feel the radial pulse on the artery of the wrist in line with the thumb. Place the tips of the index and middle fingers over the artery and press lightly. Do not use the thumb. Take a full 60-second count of the heartbeats, or take for 30 seconds and multiply by 2. Start the count on a beat, which is counted as "zero." If this number falls between 85 and 119 bpm in the case of the 50-year-old person, he or she is active within the target range for moderate-intensity activity.

The Physical Activity Prescription

- Discuss appropriate physical activities with individual patients. Recommend physical activities to match the patient's abilities and health status.
- Patient activity goals should be realistic and accompanied by an action plan.
- Patients should be advised to progressively increase intensity and duration.
- Physical activities can be divided into short periods of activity to accommodate barriers.
- Patients should engage in activities they enjoy.
- Recommendations should address over coming any barriers.
- Patients should been courage to enlist a work out buddy as part of the activity.
- The goal should be to make physical activity part of the daily routine.
- Patients should be encouraged to decrease sedentary behaviors including watching televisions, sitting at a desk, etc.

Physical Activity Tips

- Set reasonable exercise goals
- Start slow building up your level and duration of activity gradually
- Warm up by stretching before any physical activities
- Wear comfortable shoes and dress appropriately and comfortably
- Breathe in and out, taking deep breathes while exercising
- Drink plenty of water before and after physical activities
- Try substituting the stairs instead of taking the elevator
- Try parking further away and walking
- Take your pulse to set and monitor intensity of activity

Physical Activity Ideas and Intensity*

	Moderate Physical Activity	**Vigorous Physical Activity**
Leisure activities	Walking at a brisk pace, ballroom dancing, leisurely bicycling, roller skating, canoeing	Jogging, running, bicycling fast or uphill, jumping rope, swimming continuous laps
Sports	Golfing, softball, badminton, downhill skiing, Frisbee playing, water aerobics^	Singles tennis, beach volleyball on sand, basketball game, soccer, cross-country skiing
Home activities	Pushing a power lawn mower, gardening, raking leaves, shoveling light snow, moderate housework, hand washing/waxing a car, actively playing with children, riding a stationary bike	Pushing a hand mower, heavy or rapid shoveling (more than 10 pounds per minute), carrying items weighing 25 pounds or more up a flight of stairs
Occupational Activity	Maid service, waiting tables, feeding or grooming farm animals, manually milking cows, picking fruits or vegetables, walking while carrying a mailbag	Teaching an aerobic dance class, heavy farm work

**Patient's should consult with their primary care provider before engaging in physical activities due to individual physical limitations and/or health status.*

^ Recommended by the Arthritis Foundation for patients with arthritis or mobility limitations.

Physical Activity and Calories[95]

The following chart, adapted from the American Heart Association, shows the approximate calories spent per hour by a 100-, 150- and 200- pound person doing a particular activity.

Calories burned per hour of activity by weight range:

Activity	100 lb	150lb	200 lb
Bicycling, 6 mph	160	240	312
Bicycling, 12 mph	270	410	534
Jumping rope	500	750	1,000
Running, 5.5mph	440	660	962
Running, 7mph	610	920	1,230
Running, 10 mph	850	1,280	1,664
Swimming, 25yds/min	185	275	358
Swimming, 50yds/min	325	500	650
Tennis Singles	265	400	535
Walking, 2 mph	160	240	312
Walking, 3mph	210	320	416
Walking, 4.5mph	295	440	572

Behavior Management[96]
Behavior therapy focuses on approaches to overcoming barriers to compliance necessary for the management of overweight and obesity and is also necessary for long-term weight maintenance. Including behavioral therapy helps with compliance and promotes the adoption of changes in diet and physical activity. Common behavior therapies include:

- **Self Monitoring**-involves observing and recording behavior aspects including calorie intake, exercise/physical activity, medication use, and changes in body weight.
- **Rewards** –Can be used to encourage attainment of goal. Effective rewards can be both tangible (e.g. a movie, music CD, etc.) and intangible (e.g. time off from working or quiet time away from the family)
- **Stimulus Control** – involves learning social or environmental cues that trigger undesirable eating habits and/or sedentary behaviors.
- **Stress Management** – involves using a variety of approaches to identify, reduce or eliminate individual stressors. Such therapies also including changing how the individual reacts to stressful situations and events.
- **Social Support** – involves including family and friends in the obesity treatment process, participating in community support groups or involvement in social activities or clubs. Peer support is often useful in helping patients become more self-accepting, manage stress, and successfully maintain weight loss.
- **Cognitive Behavior Therapy** - a short-term, focused psychotherapy used to treat a wide range of problems including eating disorders. The therapy focuses on present thinking, behavior, and communication rather than on past experiences with an orientation toward problem solving. Patients are taught practical and rational self help skills used to change thoughts, feelings and behaviors.
- **Motivational Interviewing** - Motivational interviewing is a client-centered, directive method for improving intrinsic motivation to change by exploring and resolving ambivalence. It is patient-focused, encourages the provider to look for and choose suggestions that promote change and helps the client resolve ambivalence which often stands in the way of action.[97,98]
- **Psychological Aspects of Obesity** – Clients who are assessed to have clinical depression, psychotic disorders such as bipolar disorder, schizophrenia or schizoaffective disorders or other psychiatric disorders should be referred to a mental health professional.
- **Problem Solving** – include identifying weight-related problems, generating or brainstorming possible solutions and choosing one, planning and implementing the healthier alternative, and evaluating the outcome of possible changes in behavior. Patients should be encouraged to reevaluate setbacks in behavior and to ask "What did I learn from this attempt?" rather than punishing themselves.

Patient motivation is a key component for success in a weight loss program.

Pharmacotherapy Overview[99]
The cornerstone of obesity treatment is lifestyle management that incorporates dietary management, physical activity, and behavioral modifications. However some patients find difficulty in adopting and maintaining lifestyle changes. Pharmacological treatment of overweight and obesity should be reserved for patients who have failed at least 6 months of dietary and behavioral modifications resulting in suboptimal weight loss. Regardless of medication, all pharmacological treatments should be prescribed in combination with dietary and behavioral regimens that sustain weight loss.

Weight-loss medicines might be suitable for adults who are obese (a BMI of 30 or greater). People who have BMIs of 27 or greater, and who are at risk for heart disease and other health conditions, also may benefit from weight-loss medicines.[100]

Most weight loss drugs that suppress the appetite are known as anorexiants. Some weight loss drugs contain stimulant medication that are scheduled controlled substances by the Drug Enforcement Agency. In 2012, the FDA approved the first two new weight loss drugs in over a decade - Belviq and Qsymia.

Common Weight Loss Drugs[101]			
Brand Drug Name	**Generic Name**	**Description**	**Controlled Substance?**
Adipex-P	Phentermine	Appetite suppressant; anorectic	Yes, DEA schedule IV
Alli	Orlistat	Lipase inhibitor; nonprescription (OTC) product that inhibits fat absorption in the intestine	No
Belviq	Lorcaserin	Selective serotonin 2C receptor agonist; promotes a feeling of fullness or satiety	Yes, DEA schedule not determined
Bontril PDM, Bontril SR	Phendimetrazine	Appetite suppressant; anorectic	Yes, DEA schedule III
Desoxyn	Methamphetamine	Appetite suppressant; use cautiously if prescribed for weight loss due to high potential for abuse, illegal distribution	Yes, DEA schedule II
Didrex	Benzphetamine	Appetite suppressant; anorectic	Yes, DEA schedule III
Diethylpropion	Diethylpropion	Appetite suppressant; anorectic	Yes, DEA schedule IV
Qsymia	Phentermine and topiramate extended-release capsules	Combination appetite suppressant-anorectic; exact action of topiramate on weight loss is not known	Yes, DEA schedule IV
Suprenza	Phentermine	Appetite suppressant; anorectic	Yes, DEA schedule IV
Xenical	Orlistat Also available over the counter as ALLI	Lipase inhibitor; prescription form of Alli (OTC); higher dose than Alli; inhibits fat absorption in the intestine	No
Contrave (Investigational drug, not available)	Bupropion hydrochloride/naltrexone hydrochloride	Increases metabolism, suppresses appetite, affects central reward center (proposed mechanism)	Investigational

Please be advised that some of these drugs are specifically for short term use.

Other Medicines[102]

Some prescription medicines are used for weight loss, but aren't FDA-approved for treating obesity. They include:

- Medicines to treat depression. Some medicines for depression cause an initial weight loss and then a regain of weight while taking the medicine.
- Medicines to treat seizures. Two medicines used for seizures, topiramate and zonisamide, have been shown to cause weight loss. These medicines are being studied to see whether they will be useful in treating obesity.
- Medicines to treat diabetes. Metformin may cause small amounts of weight loss in people who have obesity and diabetes. It's not known how this medicine causes weight loss, but it has been shown to reduce hunger and food intake.

Over-the-Counter Products[103]

Some OTC products claim to promote weight loss. The FDA doesn't regulate these products because they're considered dietary supplements, not medicines with the exception of Alli® which is available as a prescription weight loss medication.

Many of these products have side effects and generally are not vigorously evaluated scientifically for safety and efficacy. Some of these, by no means all of these, OTC products include:

- Alli®. Alli® is orlistat and is FDA approved. It is available in 60 mg capsules and is a lipase inhibitor. When used in conjunction with a calorie reduced diet it can result in about a 5-10% weight loss over time. Weight may be regained with discontinuation of the drug. Because Alli® is a lipase inhibitor it can lead to gastrointestinal side effects and fat soluble vitamin deficiencies.
- Ephedra (also called ma huang). Ephedra comes from plants and has been sold as a dietary supplement. The active ingredient in the plant is called ephedrine. Ephedra can cause short-term weight loss, but it also has serious side effects. It causes high blood pressure and stresses the heart. **In 2004, the FDA banned the sale of dietary supplements containing ephedra in the United States.**
- Chromium. This is a mineral that's sold as a dietary supplement to reduce body fat. While studies haven't found any weight-loss benefit from chromium, there are few serious side effects from taking it.
- Diuretics and herbal laxatives. These products cause you to lose water weight, not fat. They also can lower your body's potassium levels, which may cause heart and muscle problems.

- Hoodia. Hoodia is a cactus that's native to Africa. It's sold in pill form as an appetite suppressant. However, no firm evidence shows that hoodia works. No large-scale research has been done on humans to show whether hoodia is effective or safe.

Patients should be encouraged to seek the advice of a medical provider before considering the use of over the counter products for weigh loss.

Integration of Medical Nutrition Therapy and Pharmacotherapy[104]

MNT is a growing and changing area of practice. At the same time, pharmacotherapy is also expanding. As more is learned about the influence of MNT, it is anticipated that MNT applications will expand and that integration of pharmacotherapy and MNT will continue to be needed. Continuing education in the integration of MNT and pharmacotherapy will be needed as this area of practice evolves. As the providers of MNT services, RDs use MNT to prevent disease and to manage chronic disease by increasing medication effectiveness, maintaining nutrition status, and preventing adverse complications.

Weight Loss Surgery[105]

Bariatric surgery is an operation on the stomach and/or intestines that helps patients with extreme obesity to lose weight. This surgery is an option for people who cannot lose weight by other means or who suffer from serious health problems related to obesity. The surgery restricts food intake, which promotes weight loss and reduces the risk of type 2 diabetes. Some surgeries also interrupt how food is digested, preventing some calories and nutrients, such as vitamins, from being absorbed. Recent studies suggest that bariatric surgery may even lower death rates for patients with severe obesity. The best results occur when patients follow surgery with healthy eating patterns and regular exercise.

Currently, bariatric surgery may be an option for adults with severe obesity. Body mass index (BMI), a measure of height in relation to weight, is used to define levels of obesity. Clinically severe obesity is a BMI > 40 or a BMI > 35 with a serious health problem linked to obesity. Such health problems could be type 2 diabetes, heart disease, or severe sleep apnea (when breathing stops for short periods during sleep).

Patients considering bariatric surgery as a treatment option may need referral to a bariatric surgeon for further consultation and evaluation.

There are four types of operations that are commonly offered in the United States: Adjustable Gastric Banding (AGB), Roux-en-Y Gastric Bypass (RYGB), Biliopancreatic Diversion with a Duodenal Switch (BPD-DS), and Vertical Sleeve Gastrectomy (VSG). Each surgery has its own benefits and risks. The patient and provider should work together to select the best option by considering the benefits and risks of each type of surgery. Other factors to consider include the patient's BMI, eating habits, health conditions related to obesity, and previous stomach surgeries.

The **CMA Foundation and CAHP's Pre/Post-Bariatric Surgery Provider Toolkit** contains additional information on the following aspects of Bariatric Surgery:

- An overview of common bariatric surgery procedure types, categories and approaches
- Pre-operative evaluation of patients including selection criteria and referral considerations
- Special populations including over 65 years of age, adolescent, women of child bearing age, and public program beneficiaries
- Post-operative patient care
- Potential surgical complications
- Repeat procedures
- Post operative phases overview
- Appendices containing BMI information, a surgical procedure advantages/ disadvantages table, additional bariatric surgery resources and related website links.

Additional resources and information links are available on the Obesity Provider Project website at:
http://www.thecmafoundation.org/projects/obesityProject.aspx

6 Patient Education Resources

- Daily Food and Activity Log
- Read It Before You Eat It
- What's on Your Plate? (MyPlate Food Model)
- Que hay en suplato? (MyPlate Food Model - Spanish)
- Choose MyPlate - 10 Tips to a Great Plate
- Eating Better on a Budget
- What is Physical Activity
- Why is Physical Activity Important?
- Tips for Increasing Physical Activity
- Physical Activity and Your Heart

Daily Food and Activity Log

FOOD & BEVERAGE LOG					
Date:		**Weight:**	**Glasses of Water: 1 2 3 4 5 6 7 8**		
	Time	**Food/Beverage**	**Amount**	**Calories In**	**Location/Mood**
Meal					
Snack					
Meal					
Snack					
Meal					
Snack					
Activity Level Throughout Day: Sedentary Moderate Active				**Total Calories In:**	

PHYSICAL ACTIVITY LOG				
Time	**Physical Activity**	**Minutes Active**	**Level of Intensity**	**Calories Out**
			Low/ Moderate/ High	
			Low/ Moderate/ High	
			Low/ Moderate/ High	
			Low/ Moderate/ High	
Total Time Active:		**Total Calories Out:**		

Daily Food and Activity Log adapted from: Hill, J.O., Wyatt, H. (2002).*Outpatient Management of Obesity: A Primary Care Perspective* .Obesity Research (Vol . 10). Retrieved March28, 2007 from http://www.obesityresearch.org/cgi/reprint/10/suppl_2/124S.pdf.
NAASO, The Obesity Society. Self Monitoring: Food Diary. In *The Role of behavior modification in obesity therapy* (Slide8). Retrieved March28, 2007 from http://www.obesityonline.org/slides/slide01.cfm?tk=35&dpg=6.
National Heart, Lung, and Blood Institute. Daily Food and Activity Diary. In *Obesity Education Initiative*. Retrieved March 28, 2007 from http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/diaryint.htm.

READ IT *before you EAT IT!*

How many servings are you eating?

Nutrition Facts

Serving Size 1 cup (228g)
Servings Per Container 2

Amount Per Serving	
Calories 250	Calories from Fat 110
	% Daily Value*
Total Fat 12g	18%
Saturated Fat 3g	15%
Cholesterol 30mg	10%
Sodium 470mg	20%
Total Carbohydrate 31g	10%
Dietary Fiber 0g	0%
Sugars 5g	
Protein 5g	

Vitamin A	4%	• Vitamin C	2%
Calcium	20%	• Iron	4%

* Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

What food would have this Nutrition Facts label? *Answer below.**

Get What You Need!

Get LESS
5% or less is low
20% or more is high

Get ENOUGH
5% or less is low
20% or more is high

What's the Best Choice for You?

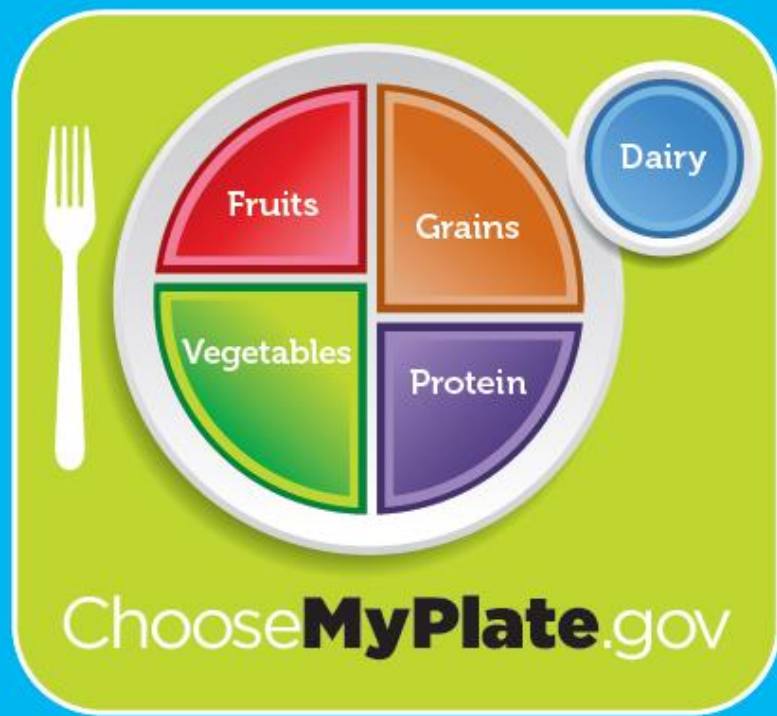
*Use the **5%-20% Guide to Daily Values** to choose foods.*

***Answer:**
Box of macaroni and cheese.

How do your choices stack up? The photos show approximate serving sizes from the five major food groups of the Food Guide Pyramid. This combination of food choices shows the servings from the Pyramid for an older child, a teen girl, an active woman, and most men, for one day. Teen boys and active men may need more servings of food.

www.fns.usda.gov/tn

What's on your plate?



Before you eat, think about what and how much food goes on your plate or in your cup or bowl. Over the day, include foods from all food groups: vegetables, fruits, whole grains, low-fat dairy products, and lean protein foods.

Make half your plate fruits and vegetables.

Make at least half your grains whole.

Switch to skim or 1% milk.

Vary your protein food choices.

Vegetables	Fruits	Grains	Dairy	Protein Foods
Eat more red, orange, and dark-green veggies like tomatoes, sweet potatoes, and broccoli in main dishes. Add beans or peas to salads (kidney or chickpeas), soups (split peas or lentils), and side dishes (pinto or baked beans), or serve as a main dish. Fresh, frozen, and canned vegetables all count. Choose "reduced sodium" or "no-salt-added" canned veggies.	Use fruits as snacks, salads, and desserts. At breakfast, top your cereal with bananas or strawberries; add blueberries to pancakes. Buy fruits that are dried, frozen, and canned (in water or 100% juice), as well as fresh fruits. Select 100% fruit juice when choosing juices.	Substitute whole-grain choices for refined-grain breads, bagels, rolls, breakfast cereals, crackers, rice, and pasta. Check the ingredients list on product labels for the words "whole" or "whole grain" before the grain ingredient name. Choose products that name a whole grain first on the ingredients list.	Choose skim (fat-free) or 1% (low-fat) milk. They have the same amount of calcium and other essential nutrients as whole milk, but less fat and calories. Top fruit salads and baked potatoes with low-fat yogurt. If you are lactose intolerant, try lactose-free milk or fortified soymilk (soy beverage).	Eat a variety of foods from the protein food group each week, such as seafood, beans and peas, and nuts as well as lean meats, poultry, and eggs. Twice a week, make seafood the protein on your plate. Choose lean meats and ground beef that are at least 90% lean. Trim or drain fat from meat and remove skin from poultry to cut fat and calories.
For a 2,000-calorie daily food plan, you need the amounts below from each food group. To find amounts personalized for you, go to Choose**MyPlate**.gov.				
Eat 2½ cups every day **What counts as a cup?** 1 cup of raw or cooked vegetables or vegetable juice; 2 cups of leafy salad greens	**Eat 2 cups every day** **What counts as a cup?** 1 cup of raw or cooked fruit or 100% fruit juice; ½ cup dried fruit	**Eat 6 ounces every day** **What counts as an ounce?** 1 slice of bread; ½ cup of cooked rice, cereal, or pasta; 1 ounce of ready-to-eat cereal	**Get 3 cups every day** **What counts as a cup?** 1 cup of milk, yogurt, or fortified soymilk; 1½ ounces natural or 2 ounces processed cheese	**Eat 5½ ounces every day** **What counts as an ounce?** 1 ounce of lean meat, poultry, or fish; 1 egg; 1 Tbsp peanut butter; ½ ounce nuts or seeds; ¼ cup beans or peas

U.S. Department of Agriculture • Center for Nutrition Policy and Promotion
August 2011
CNPP-25
USDA is an equal opportunity provider and employer.

Cut back on sodium and empty calories from solid fats and added sugars

Look out for salt (sodium) in foods you buy. Compare sodium in foods and choose those with a lower number.

Drink water instead of sugary drinks. Eat sugary desserts less often.

Make foods that are high in solid fats—such as cakes, cookies, ice cream, pizza, cheese, sausages, and hot dogs—occasional choices, not every day foods.

Limit empty calories to less than 260 per day, based on a 2,000 calorie diet.

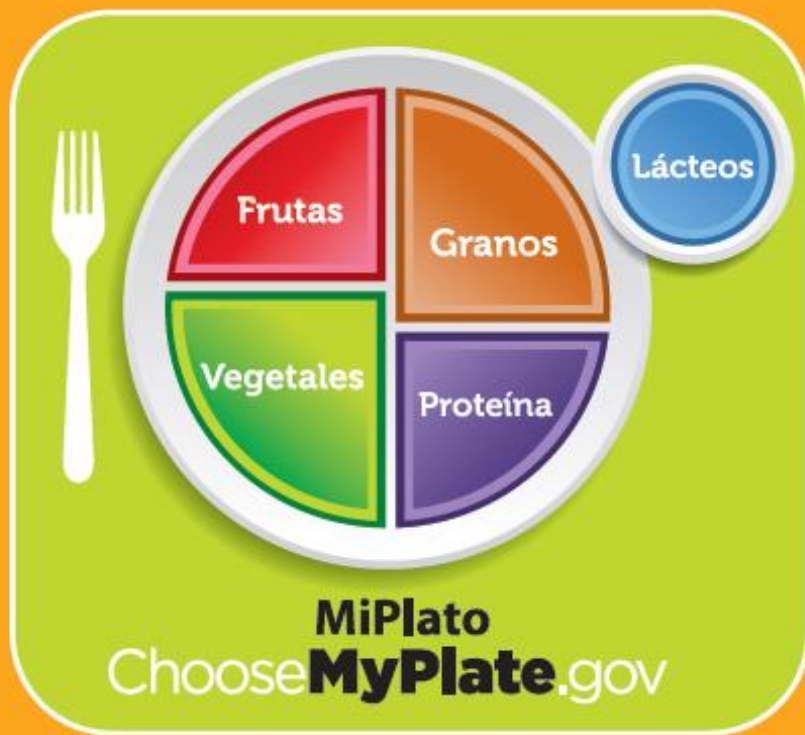
Be physically active your way

Pick activities you like and do each for at least 10 minutes at a time. Every bit adds up, and health benefits increase as you spend more time being active.

Children and adolescents: get 60 minutes or more a day.

Adults: get 2 hours and 30 minutes or more a week of activity that requires moderate effort, such as brisk walking.

¿Qué hay en su plato?



Antes de comer, piense qué y cuánto va a servir en el plato, tazón o vaso. Durante el transcurso del día, incluya alimentos de todos los grupos: vegetales, frutas, granos integrales, lácteos bajos en grasa y alimentos que contengan proteína y sean bajos grasas.

Haga que la mitad de su plato contenga frutas y vegetales.

Asegúrese de que por lo menos la mitad de los granos consumidos sean integrales.

Cambie a leche descremada o con 1% de grasa.

Varíe sus fuentes de proteína.

Vegetales	Frutas	Granos	Lácteos	Proteínas
Coma más vegetales rojos, anaranjados y verde oscuro como tomates, camotes (batatas) y brócoli como parte de los platos principales. Agregue legumbres a las ensaladas (frijoles o garbanzos), sopas (guisantes o lentejas) y a los platos de acompañamiento (frijoles pintos o cocidos en salsa dulce), o sírvalos como plato principal. Considere todo tipo de vegetales: frescos, congelados y enlatados. Elija vegetales enlatados con "sodio reducido" o "sin sal agregada" ("reduced sodium" o "without added salt").	Use frutas como bocadillos, en ensaladas y postres. En el desayuno agregue bananas o fresas a su cereal; agregue arándanos a sus panqueques. Compre frutas secas, congeladas o enlatadas (en agua o 100% jugo), así como frutas frescas. Al seleccionar jugos, elija jugos 100% de fruta.	Elija opciones de panes, roscas de pan, panecillos, cereales para el desayuno, galletas, arroz, y fideos y tallarines hechos de granos integrales en lugar de granos refinados. Busque en la lista de ingredientes de las etiquetas de los productos por las palabras "integral" o "grano integral" ("whole grain") antes del nombre del ingrediente. Elija productos que incluyan algún grano integral como el primer ingrediente de la lista.	Beba leche descremada (sin grasa) o de 1% de grasa (baja en grasa). Esta contiene la misma cantidad de calcio y otros nutrientes esenciales que la leche entera, pero con menos grasa y calorías. Use yogur bajo en grasa como aderezo para ensaladas de fruta y papas. Si no tolera la lactosa, pruebe leche sin lactosa o leche de soja enriquecida (bebida de soja).	Coma variedad de alimentos del grupo de la proteína cada semana, como: pescado, mariscos, legumbres y nueces; así como carnes magras de res y ave, y huevos. Haga que la proteína en su plato provenga de pescado y mariscos, dos veces por semana. Elija carnes magras y carne molida que sea por lo menos 90% magra. Recorte o escurra la grasa de las carnes y quíteles el pellejo a las carnes de ave para reducir la grasa y las calorías.
Para llevar un plan de alimentación de 2,000 calorías al día, usted necesita las cantidades indicadas de los siguientes grupos de alimentos. Para encontrar las cantidades indicadas para usted, visite Choose**MyPlate**.gov.				
Consuma 2½ tazas al día **¿Cómo se calcula una taza?** 1 taza de vegetales crudos o cocidos, o de jugo de vegetales; 2 tazas de vegetales de hoja crudas	**Consuma 2 tazas al día** **¿Cómo se calcula una taza?** 1 taza de frutas crudas o cocidas, o de jugo 100% de fruta; ½ taza de frutas secas	**Consuma 6 onzas al día** **¿Cómo se calcula una onza?** 1 rebanada de pan; ½ taza de arroz, cereal, o fideos o tallarines cocidos; 1 onza de cereal listo para comer	**Consuma 3 tazas al día** **¿Cómo se calcula una taza?** 1 taza de leche, yogur, o leche de soja fortificada; 1½ onzas de queso natural; 2 onzas de queso procesado	**Consuma 5½ onzas al día** **¿Cómo se calcula una onza?** 1 onza de carne de res o ave magra, pescado o mariscos; 1 huevo; 1 cucharada de mantequilla de cacahuate (maní); ½ onza de nueces o semillas; ¼ de taza de legumbres

USDA Departamento de Agricultura de los EE.UU. Centro para Políticas y Promoción de la Nutrición
Agosto de 2011
CNPP-25-S
EL USDA es un proveedor y empleador que ofrece igualdad de oportunidades para todos.

Reduzca el sodio y las calorías sin valor nutritivo provenientes de las grasas sólidas y los azúcares agregados

Vea cuánta sal (sodio) contienen los alimentos que compra. Compare el sodio en los alimentos y elija los que tengan menos.

Beba agua en lugar de bebidas con azúcar. Coma alimentos azucarados con menos frecuencia.

Haga que las comidas con grandes cantidades de grasas saturadas, como pasteles, galletas dulces, helado, pizza, queso, chorizo y salchichas, sean opciones ocasionales y no comidas diarias.

Limite las calorías sin valor nutritivo a menos de 260 al día, para una dieta de 2,000 calorías al día.

Esté físicamente activo a su manera

Elija actividades que le gusten y haga cada una de ellas por lo menos durante 10 minutos por vez. Todo ello se acumula y los beneficios de salud aumentan a medida que dedica más tiempo a estar activo.

Niños y adolescentes: 60 minutos o más al día.

Adultos: 2 horas y 30 minutos o más por semana de una actividad que requiera esfuerzo moderado, como caminar a paso rápido.

Choose my Plate - 10 tips to a great plate

10 tips
Nutrition Education Series

choose MyPlate

10 tips to a great plate

Making food choices for a healthy lifestyle can be as simple as using these 10 Tips.
Use the ideas in this list to *balance your calories*, to choose foods to *eat more often*, and to cut back on foods to *eat less often*.

1 balance calories

Find out how many calories YOU need for a day as a first step in managing your weight. Go to www.ChooseMyPlate.gov to find your calorie level. Being physically active also helps you balance calories.

2 enjoy your food, but eat less

Take the time to fully enjoy your food as you eat it. Eating too fast or when your attention is elsewhere may lead to eating too many calories. Pay attention to hunger and fullness cues before, during, and after meals. Use them to recognize when to eat and when you've had enough.

3 avoid oversized portions

Use a smaller plate, bowl, and glass. Portion out foods before you eat. When eating out, choose a smaller size option, share a dish, or take home part of your meal.

4 foods to eat more often

Eat more vegetables, fruits, whole grains, and fat-free or 1% milk and dairy products. These foods have the nutrients you need for health—including potassium, calcium, vitamin D, and fiber. Make them the basis for meals and snacks.

5 make half your plate fruits and vegetables

Choose red, orange, and dark-green vegetables like tomatoes, sweet potatoes, and broccoli, along with other vegetables for your meals. Add fruit to meals as part of main or side dishes or as dessert.

6 switch to fat-free or low-fat (1%) milk

They have the same amount of calcium and other essential nutrients as whole milk, but fewer calories and less saturated fat.

7 make half your grains whole grains

To eat more whole grains, substitute a whole-grain product for a refined product—such as eating whole-wheat bread instead of white bread or brown rice instead of white rice.

8 foods to eat less often

Cut back on foods high in solid fats, added sugars, and salt. They include cakes, cookies, ice cream, candies, sweetened drinks, pizza, and fatty meats like ribs, sausages, bacon, and hot dogs. Use these foods as occasional treats, not everyday foods.

9 compare sodium in foods

Use the Nutrition Facts label to choose lower sodium versions of foods like soup, bread, and frozen meals. Select canned foods labeled "low sodium," "reduced sodium," or "no salt added."

10 drink water instead of sugary drinks

Cut calories by drinking water or unsweetened beverages. Soda, energy drinks, and sports drinks are a major source of added sugar, and calories, in American diets.

USDA United States Department of Agriculture
Center for Nutrition Policy and Promotion

Go to www.ChooseMyPlate.gov for more information.

DG TipSheet No. 1
June 2011

10 tips
Nutrition Education Series

eating better on a budget

10 tips to help you stretch your food dollars

Get the most for your food budget! There are many ways to save money on the foods that you eat. The three main steps are planning before you shop, purchasing the items at the best price, and preparing meals that stretch your food dollars.

1 plan, plan, plan!

Before you head to the grocery store, plan your meals for the week. Include meals like stews, casseroles, or stir-fries, which "stretch" expensive items into more portions. Check to see what foods you already have and make a list for what you need to buy.

2 get the best price

Check the local newspaper, online, and at the store for sales and coupons. Ask about a loyalty card for extra savings at stores where you shop. Look for specials or sales on meat and seafood—often the most expensive items on your list.

3 compare and contrast

Locate the "Unit Price" on the shelf directly below the product. Use it to compare different brands and different sizes of the same brand to determine which is more economical.

4 buy in bulk

It is almost always cheaper to buy foods in bulk. Smart choices are family packs of chicken, steak, or fish and larger bags of potatoes and frozen vegetables. Before you shop, remember to check if you have enough freezer space.

5 buy in season

Buying fruits and vegetables in season can lower the cost and add to the freshness! If you are not going to use them all right away, buy some that still need time to ripen.

6 convenience costs... go back to the basics

Convenience foods like frozen dinners, pre-cut vegetables, and instant rice, oatmeal, or grits will cost you more than if you were to make them from scratch. Take the time to prepare your own—and save!

7 easy on your wallet

Certain foods are typically low-cost options all year round. Try beans for a less expensive protein food. For vegetables, buy carrots, greens, or potatoes. As for fruits, apples and bananas are good choices.

8 cook once...eat all week!

Prepare a large batch of favorite recipes on your day off (double or triple the recipe). Freeze in individual containers. Use them throughout the week and you won't have to spend money on take-out meals.

9 get your creative juices flowing

Spice up your leftovers—use them in new ways. For example, try leftover chicken in a stir-fry or over a garden salad, or to make chicken chili. Remember, throwing away food is throwing away your money!

10 eating out

Restaurants can be expensive. Save money by getting the early bird special, going out for lunch instead of dinner, or looking for "2 for 1" deals. Stick to water instead of ordering other beverages, which add to the bill.

USDA United States Department of Agriculture
Center for Nutrition Policy and Promotion

Go to www.ChooseMyPlate.gov for more information.

DG TipSheet No. 16
December 2011

What is Physical Activity?

Physical activity simply means movement of the body that uses energy. Walking, gardening, briskly pushing a baby stroller, climbing the stairs, playing soccer, or dancing the night away are all good examples of being active. For health benefits, physical activity should be moderate or vigorous intensity.

Moderate physical activities include:

- Walking briskly (about 3 ½ miles per hour)
- Bicycling (less than 10 miles per hour)
- General gardening (raking, trimming shrubs)
- Dancing
- Golf (walking and carrying clubs)
- Water aerobics
- Canoeing
- Tennis (doubles)

Vigorous physical activities include:

- Running/jogging (5 miles per hour)
- Walking very fast (4 ½ miles per hour)
- Bicycling (more than 10 miles per hour)
- Heavy yard work, such as chopping wood
- Swimming (freestyle laps)
- Aerobics
- Basketball (competitive)
- Tennis (singles)

You can choose moderate or vigorous intensity activities, or a mix of both each week. Activities can be considered vigorous, moderate, or light in intensity. This depends on the extent to which they make you breathe harder and your heart beat faster.

Only moderate and vigorous intensity activities count toward meeting your physical activity needs. With vigorous activities, you get similar health benefits in half the time it takes you with moderate ones. You can replace some or all of your moderate activity with vigorous activity. Although you are moving, light intensity activities do not increase your heart rate, so you should not count these towards meeting the physical activity recommendations. These activities include walking at a casual pace, such as while grocery shopping, and doing light household chores.

Why Is Physical Activity Important?

Regular physical activity can produce long term health benefits. People of all ages, shapes, sizes, and abilities can benefit from being physically active. The more physical activity you do, the greater the health benefits.

Being physically active can help you:

- Increase your chances of living longer
- Feel better about yourself
- Decrease your chances of becoming depressed
- Sleep well at night
- Move around more easily
- Have stronger muscles and bones
- Stay at or get to a healthy weight
- Be with friends or meet new people
- Enjoy yourself and have fun

When you are *not* physically active, you are more likely to:

- Get heart disease
- Get type 2 diabetes
- Have high blood pressure
- Have high blood cholesterol
- Have a stroke

Physical activity and nutrition work together for better health. Being active increases the amount of calories burned. As people age their metabolism slows, so maintaining energy balance requires moving more and eating less.

Some types of physical activity are especially beneficial:

- *Aerobic activities* make you breathe harder and make your heart beat faster. Aerobic activities can be moderate or vigorous in their intensity. Vigorous activities take more effort than moderate ones. For **moderate activities**, you can talk while you do them, but you can't sing. For **vigorous activities**, you can only say a few words without stopping to catch your breath.
- *Muscle-strengthening activities* make your muscles stronger. These include activities like push-ups and lifting weights. It is important to work all the different parts of the body - your legs, hips, back, chest, stomach, shoulders, and arms.
- *Bone-strengthening activities* make your bones stronger. Bone strengthening activities, like jumping, are especially important for children and adolescents. These activities produce a force on the bones that promotes bone growth and strength.
- *Balance and stretching activities* enhance physical stability and flexibility, which reduces risk of injuries. Examples are gentle stretching, dancing, yoga, martial arts, and t'ai chi.

Tips for Increasing Physical Activity

Make physical activity a regular part of the day

Choose activities that you enjoy and can do regularly. Fitting activity into a daily routine can be easy — such as taking a brisk 10 minute walk to and from the parking lot, bus stop, or subway station. Or, join an exercise class. Keep it interesting by trying something different on alternate days. Every little bit adds up and doing something is better than doing nothing.

Make sure to do at least 10 minutes of activity at a time, shorter bursts of activity will not have the same health benefits. For example, walking the dog for 10 minutes before and after work or adding a 10 minute walk at lunchtime can add to your weekly goal. Mix it up. Swim, take a yoga class, garden or lift weights. To be ready anytime, keep some comfortable clothes and a pair of walking or running shoes in the car and at the office.

More ways to increase physical activity at home:

- Join a walking group in the neighborhood or at the local shopping mall. Recruit a partner for support and encouragement.
- Push the baby in a stroller.
- Get the whole family involved — enjoy an afternoon bike ride with your kids.
- Walk up and down the soccer or softball field sidelines while watching the kids play.
- Walk the dog — don't just watch the dog walk.
- Clean the house or wash the car.
- Walk, skate, or cycle more, and drive less.
- Do stretches, exercises, or pedal a stationary bike while watching television.
- Mow the lawn with a push mower.
- Plant and care for a vegetable or flower garden.
- Play with the kids — tumble in the leaves, build a snowman, splash in a puddle, or dance to favorite music.
- Exercise to a workout video.

At work:

- Get off the bus or subway one stop early and walk or skate the rest of the way.
- Replace a coffee break with a brisk 10-minute walk. Ask a friend to go with you.
- Take part in an exercise program at work or a nearby gym.
- Join the office softball team or walking group.

At play:

- Walk, jog, skate, or cycle.
- Swim or do water aerobics.
- Take a class in martial arts, dance, or yoga.
- Golf (pull cart or carry clubs).
- Canoe, row, or kayak.
- Play racquetball, tennis, or squash.
- Ski cross-country or downhill.
- Play basketball, softball, or soccer.
- Hand cycle or play wheelchair sports.
- Take a nature walk.
- Most important — have fun while being active!

National Heart,
Lung, and Blood Institute

AT-A-GLANCE:

Physical Activity and Your Heart

Physical activity is part of a healthy lifestyle. It's good for many parts of your body and can lower your risk for many health problems.

Many Americans aren't active enough. The good news, though, is that even modest amounts of physical activity are good for your health, especially your heart health. The more active you are, the more you will benefit.

Types of Physical Activity

The four main types of physical activity are aerobic, muscle-strengthening, bone strengthening, and stretching.

- **Aerobic** activity is the type of physical activity that benefits your heart the most. This type of activity moves your large muscles and makes your heart beat faster than usual. Running, swimming, and dancing are aerobic activities.
- **Muscle-strengthening** activities improve the strength, power, and endurance of your muscles. Doing pushups and situps, lifting weights, and climbing stairs are muscle-strengthening activities.
- With **bone-strengthening** activities, your feet, legs, or arms support your body's weight, and your muscles push against your bones. Running, walking, and jumping rope are bone-strengthening activities.
- **Stretching** helps improve your flexibility and your ability to move your joints. Touching your toes, doing side stretches, and doing yoga are examples of stretching.

U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

You can do physical activity with light, moderate, or vigorous intensity. The level of intensity depends on how hard you have to work to do the activity.

To do the same activity, people who are less fit usually have to work harder than people who are more fit. So, what is light-intensity activity for one person may be moderate-intensity for another.

Physical Activity Recommendations

Doing some physical activity is better than doing none. People gain some health benefits from as little as 60 minutes of moderate-intensity aerobic activity per week.

For major health benefits, adults should do at least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic activity or 75 minutes (1 hour and 15 minutes) of vigorous-intensity aerobic activity each week. Another option is to do a combination of both.

You don't have to do the activity all at once. You can break it up into shorter periods of at least 10 minutes each.

If you have a heart problem or chronic disease, talk to your doctor about what types of physical activity are safe for you. You also should talk to your doctor about safe physical activities if you have symptoms such as chest pain or dizziness.

Benefits of Physical Activity

One of the major benefits of physical activity, particularly aerobic, is that it reduces coronary heart disease risk factors. (Risk factors are conditions or habits that make it more likely that you will develop a disease.) Some risk factors, such as age and family history, can't be controlled. But lack of physical activity is a major risk factor that you can control.

Doing physical activity regularly can directly reduce your heart disease risk and your chances of developing other heart disease risk factors, such as high blood pressure, high blood cholesterol, diabetes, and overweight or obesity. In fact, inactive people are nearly twice as likely to develop heart disease as those who are more active.

If you already have heart disease, regular aerobic physical activity can help your heart work better and may reduce the risk of a heart attack.

Physical activity also has many other benefits. It can strengthen your heart and improve lung function, and it may help prevent certain types of cancer. Physical activity also tones and strengthens your muscles, builds your stamina, keeps your joints in good condition, improves your balance, may slow bone loss, and can improve your emotional health.

Getting Started and Staying Active

Physical activity is part of a healthy lifestyle that also includes staying at a healthy weight, following a healthy diet, and not smoking. To get started and stay active, do activities that you enjoy and make them part of your daily routine.

If you haven't been active in a while, start slowly and build up over time. Make everyday tasks more active, such as taking the stairs instead of the elevator. Be active with friends and family, and keep track of your progress.

Learn More

More information about physical activity is available from the National Heart, Lung, and Blood Institute (NHLBI) Web site at www.nhlbi.nih.gov (under Health Information for the Public). Podcasts and Spanish-language articles also can be found in the online Diseases and Conditions Index at www.nhlbi.nih.gov/health/dci.

You also can order or download information on physical activity from the NHLBI Web site or by calling the NHLBI Health Information Center at 301–592–8573 (TTY: 240–629–3255).

Also see the U.S. Department of Health and Human Services' "2008 Physical Activity Guidelines for Americans" and "Be Active Your Way: A Guide for Adults" at www.health.gov/PAGuidelines/.

Want More Information?
These NHLBI publications will help you reach your physical activity goals!

Your Guide to Physical Activity and Your Heart (#06-5714)
This easy-to-read booklet uses science-based information to help adults develop a safe and effective program of physical activity that can be sustained.

In Brief: Your Guide to Physical Activity and Your Heart (#06-5847)
Critical messages from "Your Guide to Physical Activity and Your Heart" are provided in this easy-to-read fact sheet.

Also of interest:

- **Aim for a Healthy Weight Patient Booklet (#05-5213)**
  This booklet for adults provides practical, easy-to-use guidance for losing and maintaining weight.
- ***We Can!* Families Finding the Balance: A Parent Handbook (#08-5273 English, #05-5274 Spanish)**
  Learn fun and practical tips to help your family find the right balance of eating well and being physically active to maintain a healthy weight with this colorful, easy-to-read handbook.

U.S. Department of Health and Human Services
National Institutes of Health

National **Heart**
Lung and Blood Institute

NIH Publication No. 09-7425
August 2009

To Order: Visit **www.nhlbi.nih.gov** or **http://emall.nhlbihin.net** or call **301–592–8573**

7 Provider Resources

- BMI Resources Links and Calculators
- Adult Body Mass Index (BMI) Table
- Draft Cover Letter for Adult Weight Questionnaire
- Adult Weight Questionnaire
- AIM for a Healthy Weight (NHLBI)
- Patient-centered Assessment and Counseling for Exercise and Nutrition (PACE)
- Rx for Health
- MyPlate USDA Dietary Guidelines
- ReThink Your Drink Teaching Tool/Poster
- MyPlate Teaching Tool/Poster
- Daily Food Plans & Worksheets
- Sample Meal Plans
- CME Resources
- Informational Website Links
- Ethnic Provider Organizations
- Culturally Appropriate Resources
- California Health Plan Interpreter Services

BMI Resource Links and Calculators

Sample BMI Calculation

Weight in kilograms (kg) divided by the square of height in meters (m^2).	**BMI = Weight (kg) / Height squared (m^2)**
Weight in pounds (lbs) divided by the square of height in inches (in^2) multiplied by 703.	**BMI = Weight (lbs) / Height squared (in^2) x 703**

Sample Calculation

Charles is a 40-year-old male who is 5'10" tall and weighs 210 pounds. What is Charles' BMI?

BMI = (weight [lbs] / [height (inches)]^2) x 703
BMI = (210/[70]^2)x703
BMI = 30.1

What does a BMI of 30.1 for Charles represent? According to the CDC, Charles would be considered obese.

BMI Weight Classification

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese

Online BMI Calculators and Information Links

Centers for Disease Control and Prevention:

- Information about BMI, online calculators (Adults, Child/Teen), and links to additional BMI resources, and growth charts
- http://www.cdc.gov/nccdphp/dnpa/bmi/index.htm

National Heart, Lung and Blood Institute – Obesity Education Initiative

- Online BMI calculator and information on assessing risk
- http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm

BMI Calculator iPhone App

One of the most popular tools on the NIH's National Heart, Lung, and Blood Institute (NHLBI) Web site is the BMI (Body Mass Index) calculator. BMI is a reliable indicator of total body fat, which is related to the risk of disease and death. The NHLBI BMI calculator receives 1.6 million visitors a month and ranks #1 on Google. This mobile application provides results right on your phone along with links to healthy weight resources on the NHLBI Web site: http://apps.usa.gov/bmi-app.shtml

Adult Body Mass Index (BMI) Table

Height in Feet and Inches	Height	Weight in Pounds																					
		80	90	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300
	4'0"	24	27	31	34	37	40	43	46	49	52	55	58	61	64	67	70	73	76	79	82	85	88	92
	4'2"	22	25	28	31	34	37	39	42	45	48	51	53	56	59	62	65	67	70	73	76	79	82	84
	4'4"	21	23	26	29	31	34	36	39	42	44	47	49	52	55	57	60	62	65	68	70	73	75	78
	4'6"	19	22	24	27	29	31	34	36	39	41	43	46	48	51	53	55	58	60	63	65	68	70	72
	4'8"	18	20	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	65	67
	4'10"	17	19	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61	63
	5'0"	16	18	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59
	5'2"	15	16	18	20	22	24	26	27	29	31	33	35	37	38	40	42	44	46	48	49	51	53	55
	5'4"	14	15	17	19	21	22	24	26	27	29	31	33	34	36	38	39	41	43	45	46	48	50	51
	5'6"	13	15	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47	48
	5'8"	12	14	15	17	18	20	21	23	24	26	27	29	30	32	33	35	36	38	40	41	43	44	46
	5'10"	11	13	14	16	17	19	20	22	23	24	26	27	29	30	32	33	34	36	37	39	40	42	43
	6'0"	11	12	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39	41
	6'2"	10	12	13	14	15	17	18	19	21	22	23	24	26	27	28	30	31	32	33	35	36	37	39
	6'4"	10	11	12	13	15	16	17	18	19	21	22	23	24	26	27	28	29	30	32	33	34	35	37
	6'6"	9	10	12	13	14	15	16	17	18	20	21	22	23	24	25	27	28	29	30	31	32	34	35
	6'8"	9	10	11	12	13	14	15	16	18	19	20	21	22	23	24	25	26	27	29	30	31	32	33

Key — Healthy Weight — Overweight — Obese

Organization Letterhead

DRAFT COVER LETTER FOR ADULT WEIGHT QUESTIONNAIRE

Welcome!

You have set up an appointment for help with your weight. This is the first step to achieve a healthy weight. You should feel good about taking it.

There are many ways to lose weight. You may have tried things before without success. To best help you this time, we are asking for some information. Your answers to the questions on the enclosed questionnaire will help us find the best way to help you achieve a healthy weight. All people are not the same. What works for one person may not work for another.

You may find that some of the questions are very personal. You may read a question and think to yourself, "This has nothing to do with me!" This is OK. You can skip that question. You can choose to not answer any of the questions. This is a voluntary survey. Just remember your answers help us find the best method for you. The survey may also help you learn more things about yourself. Together we will work out a plan that will help you reach your goal.

Give your survey to your provider or put your completed survey in the prepaid envelope. Check with your medical assistant. Pat yourself on the back for taking this first brave step! See you soon.

Sincerely,

Physician Name

Organization Logo **CONFIDENTIAL**

Member Survey

Please fill out this survey so we can best help you. All your answers will be kept private. Your answers will help us find you the best method for you to achieve a healthy weight.

Date: _____

Name: _____ Medical Record Number: _____

Personal

1. What do you do for a living? : _____ Age_____

2. On a scale from one (1) to ten (10) how happy are you with your job?

1 2 3 4 5 6 7 8 9 10
Very Unhappy Very Happy

3. What is the most you have even weighed? (For women, write in this weight when you were not pregnant.)

_____ Lbs. at _____ years old

4. What is the lowest weight you have been at for at least one year? (This should be after 21 years of age.)

_____ Lbs. at _____ years old

5. Is there any time in your life for which you have no memory?
No _____ Yes _____ If Yes, When? :_____

6. Please fill in the following as best you can.

Most people have tried diets in the past. Please tell us your answers for the ones you have tried.

Type of Diet/Program	When?	For how long?	Pounds lost?	How long was weight off?
Low Calorie Diet				
Protein Diet				
Weight Watchers				
Overeaters Anonymous				
Obesity / Diet Center				
Diet Pills				
Herbal Diet Pills				
Physician supervised fast				
Slim-Fast				
Nutrisystem				
Other:				
Other:				

7. Can you accept compliments about your weight loss?
No _____ Yes _____

8. Can you accept compliments from the opposite sex?
No _____ Yes _____

9. How do you think your life will change if you lose weight?

_____

_____

10. Do you smoke cigarettes?
No _____ Yes _____ If Yes, How many packs per day? _____

11. Think about how often you drink beer, wine or mixed drinks. Which is true? (Fill in one answer only.)

____ I never drink any alcohol.

____ I seldom drink more than 8 drinks per week.

____ I often drink more than 8 drinks per week.

____ I binged in the past three months. (I drank more than three drinks in three hours.)

12. Think about the availability of drugs today. Which is true? (Fill in one answer only.)

____ I never tried any illegal drugs.

____ I experimented in the past but no longer use.

____ I enjoy drugs only at an occasional party.

____ I use drugs often.

____ I have a problem with drugs now.

Eating Habits

13. **A.** After eating, have you ever forced yourself to vomit?
No _____ Yes _____

B. Have you ever had a problem with binge eating?
No _____ Yes _____

14. Answer this question if you answered yes to 13A or 13B.
Do you recall the feeling that caused these actions? If so, tell us what you were feeling. Also write down the last time you did vomit or binge.

A. Vomiting _____

B. Binge eating _____

15. Do you use diuretics or laxatives now to help control your weight?
No _____ Yes _____

Physical Activity

16. Do you get any physical activity now (This might be walking, swimming, housework, gardening, exercise classes.)?
No _____ Yes _____

A. If yes, please write in below the activities you do. Also write down the number of minutes and the number of times a week for each one.

Type of Activity _____
# of minutes_____ # times/ wk _____

Type of Activity _____
# of minutes_____ # times/ wk _____

Type of Activity _____
# of minutes_____ # times/ wk _____

Type of Activity _____
# of minutes_____ # times/ wk _____

B. If you are not physically active on a regular basis are you willing to start an exercise program? (Please check one.)
No _____ Yes _____ Maybe _____

17. What prevents you from exercising more? (Fill in one answer only.)
_____ I think I do get enough exercise.
_____ I have no time.
_____ My health is not good (such as asthma, arthritis).
_____ The neighborhood is too unsafe to be outside.
_____ We cannot afford gym memberships.
_____ I do not have anyone to keep me encouraged.
_____ I do not think that exercise is important
Other _____

Family and Childhood History

18. Are any of your family members obese? If yes, please circle those members that are obese.
_____ Father _____ Mother
_____ Sister(s) (note number) _____ Brother(s) (note number)

Father's side:
_____Grandmother _____ Grandfather _____ Aunts _____ Uncles

Mother's side:
_____ Grandmother _____ Grandfather _____ Aunts _____ Uncles

19. How do you describe yourself?
_____ Asian _____ Black _____ Caucasian
_____ Hispanic _____ Native American

20. Who lives with you in your home? Tell us their relationship if it's not obvious.

_____

_____

_____

21. Who will support your efforts to lose weight? _____

22. Who will hinder your efforts to lose weight? _____

23. Do you have someone with whom you share your innermost thoughts and feelings?
_____ No _____ Yes If yes, who? _____

24. Think about the family in which you were raised. Check the words that best describe it.
_____ warm _____distant _____ cruel _____battling _____destructive
_____loving _____uninterested _____ rigid

25. How do you think how you were raised effected you?

_____

_____

_____

26. Were the people who raised you (answer yes or no to each item)…

Concerned about your worries?	_____ No	_____ Yes
Interested in how you did in school?	_____ No	_____ Yes
Made you feel wanted?	_____ No	_____ Yes
Often critical of you?	_____ No	_____ Yes
Interested in who your friends were?	_____ No	_____ Yes
There if you need help or support?	_____ No	_____ Yes

27. Were you raised by <u>both</u> of your biological parents?
_____ Yes _____ No

28. How has this affected you?

_____

_____

_____

29. Have you ever been sexually molested?
_____ Yes _____ No

30. If yes, how old were you at the time? _____

31. How has this affected you later in life?

_____

_____

_____

Stress in Your Life:

32. Read each of the items below. Please circle if you are currently experiencing stress in your life related to any of them.

A. Work	**F.** Legal / Financial Trouble
B. Health	**G**. School
C. Spouse – Friend	**H.** Moving
D. Children	**I.** Jealousy or Infidelity
E. Parents	**J**. Other

33. What do you think is the cause of your weight problem?

_____

_____

_____

34. How much would you like to weigh? _____ Lbs.

35. Please use the space below to tell us anything else you think is important in understanding your weight problem or your successful participation in the program.

_____

_____

_____

Signature_____

NHLBI - Aim For A Healthy Weight

Information and Resources for Health Professionals

Web Sites and Interactive Web Applications:
• Aim for a Healthy Weight Web Site
• Clinical Guidelines on Overweight and Obesity Continuing Education
• Clinical Guidelines on Overweight and Obesity Electronic Textbook
• Hearts n' Parks
• Menu Planner
• Physical Activity: Your Heart Your Life--A Lay Health Educator's Program/La actividad física: sucorazónsuvida--un programa para promotores de salud (bilingual English, Spanish)
• Portion Distortion
• Clinical Guidelines on Overweight and Obesity for Palm OS
Body Mass Index (BMI) Calculator:
• English Language Version
• Spanish Version/Versión en español

Detailed Information	**View Online**
Aim for a Healthy Weight	
• Aim Patient Booklet	PDF
• Patients Tips Tear Pad	PDF
• Provider Kit	
• Talking Tips for Physicians	PDF
• Healthy Weight Community Outreach Initiative Strategy Development Workshop Report	PDF
Hearts n' Parks	
• Community Mobilization Guide	PDF
• Hearts n' Parks Video	Video
• Kit (includes Guide and Video)	
Obesity Guidelines (more)	
• Evidence Report	PDF
• Practical Guide	PDF
• Strategic Plan for NIH Obesity Research	
• Strategic Plan for NIH Obesity Research Summary	
• Strategy Development Workshop for Public Education on Weight and Obesity	HTML
• The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity	
• Think Tank on Enhancing Obesity Research at the National Heart, Lung, and Blood Institute - Executive Summary	PDF
• Think Tank on Enhancing Obesity Research at the National Heart, Lung, and Blood Institute - Full Report	PDF
• We Can Post Card - Who can make maintaining a healthy weight fun?	
Slideshows:	
• Clinical Guidelines on Overweight and Obesity Slide Set	
• Portion Distortion Quiz Slide Show	
See Also:	
• NHLBI Obesity Education Initiative (OEI)	
• NIH Obesity Research Web Site	

PACE : Patient- Centered Assessment & Counseling for Exercise & Nutrition

PACE Adults

PACE written materials can help you to offer effectively tailored weight loss, nutrition, and physical activity information and tips to patients and other healthcare consumers, with minimal financial and time investment.

PACE

Patient-centered Assessment and Counseling for Exercise and Nutrition is a well-organized binder containing crucial background information and detailed guidelines to help medical providers effectively counsel adult patients about making physical activity and nutrition improvements. As with many of the PACE online programs, the evidence-based written PACE materials emphasize four key behaviors that are strongly correlated with overweight, general health, and/or disease risk:

1. Improving caloric balance (calories consumed compared to calories expended)
2. Increasing consumption of fruits, vegetables, and fiber
3. Decreasing dietary fat consumption
4. Increasing vigorous and/or moderate activity

The PACE provider print-based program is largely based upon Prochaska and DiClemente'sTranstheoretical (Stage of Change) Model and Social Cognitive Theory, and has been scientifically proven to be effective and highly acceptable to both patients and providers. The PACE Medical Provider materials include:

1. **Brief Assessment Forms**, which triage patients into one of three groups, based upon current dietary and activity guidelines and self-reported readiness to make changes
2. **Brief Protocol Forms**, which guide patient counseling and behavioral recommendations based upon their current status and Stage of Change
3. **Stage-Based Tip Sheets**, which are handouts that busy providers can give to patients needing additional information. These forms are offered in paper versions or via site licenses to electronic forms
4. **Chart Stickers** for insertion into the patient's medical record

Materials Order Form 2.16.2011 (pdf)

Call 858-453-4948 for more information or to place an order. Shipping and handling charges may apply.
http://www.santechhealth.com/products/detail/pace-adults

RX for Health!

Patient Name: _____

_____ _____
Medical Record Number Date

Physical Activity Agreements:

☐ Walking ☐ Bike riding

☐ Dance/ Aerobics ☐ Flexibility/Yoga

☐ Other: _____

How long and how often:

_____minutes _____ times per week

5-A-Day Agreement – Add a serving of:

☐ **Fruit** ☐ **Vegetables**

☐ Breakfast ☐ Lunch

☐ Lunch ☐ Dinner

☐ Snack ☐ Snack

☐ **Have <u>less</u>**

☐ Soft drinks (soda) and sweets

☐ Snack foods (fries, chips, etc.)

☐ Other: _____

Rx for Health – Description to Providers:

Physical Activity Agreement:

Briefly assess patient's interests and current activity. Check one of the choices listed, or identify another physical activity the patient is most motivated to undertake.

How long/how often: Using your assessment of the patient's current activity, negotiate with them how much time and how many occasions per week they are motivated to engage in the physical activity identified, and fill in these blanks.

5-A-Day Agreement:

Asses the patient's daily fruit/vegetable consumption practices (e.g. "How many times each day do you usually eat fruit?" "How many different vegetables do you eat most days?") and whether they're interested in making a change. If they express motivation to eat more fruit and/or vegetables, complete this section with the patient. Depending on the patient's health conditions and motivation to change, you may also want to negotiate reducing soda, sweets, or other foods (try to identify specific foods with the patient).

Agreement to: This section is for action *other* than physical activity or nutrition (e.g. negotiate joining a support group, seeing the R.D., daily meditation, blood sugar monitoring, etc.)

Ask about follow-up: Ask the patient if they are willing to have CCHA nutrition staff call them, and if YES, get a phone number.

Make Half Your Plate Fruits and Vegetables

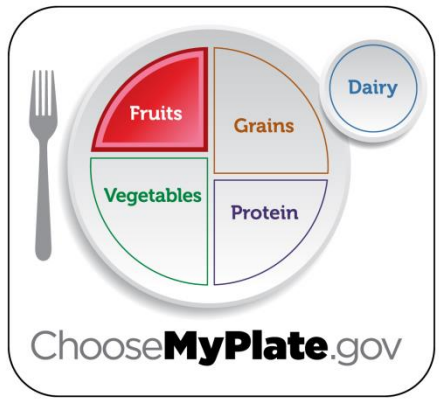
How much fruit is needed daily?

The amount of fruit you need to eat depends on age, sex, and level of physical activity. Recommended daily amounts are shown in the chart.

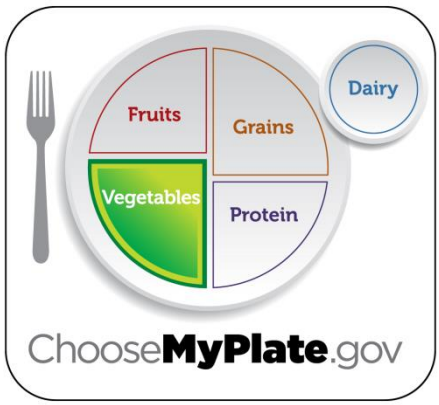
Recommended amounts are shown in the table below.

Daily recommendation*		
Women	19-30 years old	2 cups**
	31-50 years old	1 ½ cups**
	51+ years old	1 ½ cups**
Men	19-30 years old	2 cups**
	31-50 years old	2 cups**
	51+ years old	2 cups**

**These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.*
** Click here to see what counts as a cup of fruit.



How many vegetables are needed daily or weekly?



Vegetable choices should be selected from among the vegetable subgroups. It is not necessary to eat vegetables from each subgroup daily. However, over a week, try to consume the amounts listed from each subgroup as a way to reach your daily intake recommendation.

The amount of vegetables you need to eat depends on your age, sex, and level of physical activity. Recommended total daily amounts are shown in the first chart. Recommended weekly amounts from each vegetable subgroup are shown in the second chart.

Vegetable subgroup recommendations are given as amounts to eat WEEKLY. It is not necessary to eat vegetables from each subgroup daily. However, over a week, try to consume the amounts listed from each subgroup as a way to reach your daily intake recommendation.

Daily recommendation*		
Women	19-30 years old	2½ cups**
	31-50 years old	2½ cups**
	51+ years old	2 cups**
Men	19-30 years old	3 cups**
	31-50 years old	3 cups**
	51+ years old	2½ cups**

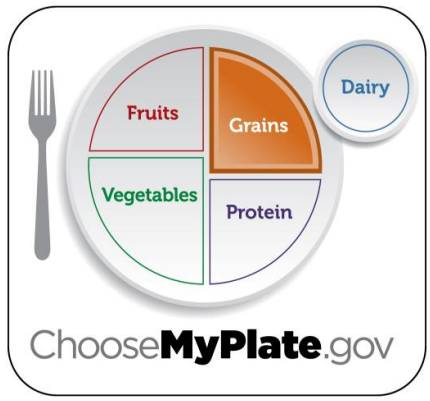
**These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.*
** Click here to see what counts as a cup of vegetables.

		Dark green vegetables	Red and orange vegetables	Beans and peas	Starchy vegetables	Other vegetables
			AMOUNT PER WEEK**			
Women	19–30 yrs old	1½ cups	5½ cups	1½ cups	5 cups	4 cups
	31–50 yrs old	1½ cups	5½ cups	1½ cups	5 cups	4 cups
	51+ yrs old	1½ cups	4 cups	1 cup	4 cups	3½ cups
Men	19–30 yrs old	2 cups	6 cups	2 cups	6 cups	5 cups
	31–50 yrs old	2 cups	6 cups	2 cups	6 cups	5 cups
	51+ yrs old	1½ cups	5½ cups	1½ cups	5 cups	4 cups

** Click here to see what counts as a cup of vegetables.

Any food made from wheat, rice, oats, cornmeal, barley or another cereal grain is a grain product. Bread, pasta, oatmeal, breakfast cereals, tortillas, and grits are examples of grain products.
Grains are divided into 2 subgroups, **whole grains** and **refined grains**. Whole grains contain the entire grain kernel — the bran, germ, and endosperm. Examples include:

- whole-wheat flour
- bulgur (cracked wheat)
- oatmeal
- whole cornmeal
- brown rice



Refined grains have been milled, a process that removes the bran and germ. This is done to give grains a finer texture and improve their shelf life, but it also removes dietary fiber, iron, and many B vitamins. Some examples of refined grain products are:

- white flour
- de-germed cornmeal
- white bread
- white rice

Most refined grains are enriched. This means certain B vitamins (thiamin, riboflavin, niacin, folic acid) and iron are added back after processing. Fiber is not added back to enriched grains. Check the ingredient list on refined grain products to make sure that the word “enriched” is included in the grain name. Some food products are made from mixtures of whole grains and refined grains.

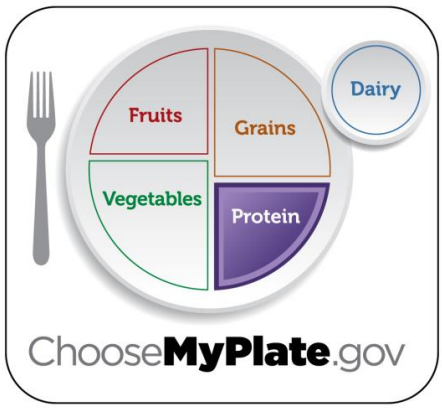
How many grain foods are needed daily?

The amount of grains you need to eat depends on your age, sex, and level of physical activity. Recommended daily amounts are listed in the chart. Most Americans consume enough grains, but few are whole grains. **At least half of all the grains eaten should be whole grains.**

		Daily recommendation*	Daily minimum amount of whole grains
Women	19-30 years old	6 ounce equivalents**	3 ounce equivalents**
	31-50 years old	6 ounce equivalents**	3 ounce equivalents**
	51+ years old	5 ounce equivalents**	3 ounce equivalents**
Men	19-30 years old	8 ounce equivalents**	4 ounce equivalents**
	31-50 years old	7 ounce equivalents**	3 ½ ounce equivalents**
	51+ years old	6 ounce equivalents**	3 ounce equivalents**

**These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.*
**Click here to see what counts as an ounce-equivalent of grains

The Protein Group – ¼ of Your Plate



All foods made from meat, poultry, seafood, beans and peas, eggs, processed soy products, nuts, and seeds are considered part of the Protein Foods Group. Beans and peas are also part of the Vegetable Group

Select a variety of protein foods to improve nutrient intake and health benefits, including at least 8 ounces of cooked seafood per week. Young children need less, depending on their age and calories needs. The advice to consume seafood does not apply to vegetarians. Vegetarian options in the Protein Foods Group include beans and peas, processed soy products, and nuts and seeds. Meat and poultry choices should be lean or low-fat.

How much food from the Protein Foods Group is needed daily?

The amount of food from the Protein Foods Group you need to eat depends on age, sex, and level of physical activity. Most Americans eat enough food from this group, but need to make leaner and more varied selections of these foods. Recommended daily amounts are shown in the chart.

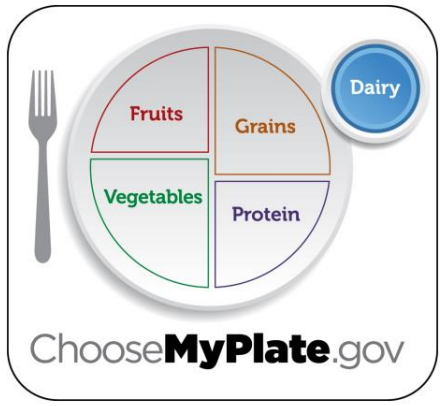
Vegetarians get enough protein from this group as long as the variety and amounts of foods selected are adequate. Protein sources from the Protein Foods Group for vegetarians include eggs (for ovo-vegetarians), beans and peas, nuts, nut butters, and soy products (tofu, tempeh, veggie burgers).

Daily recommendation*		
Women	19-30 years old	5 ½ ounce equivalents**
	31-50 years old	5 ounce equivalents**
	51+ years old	5 ounce equivalents**
Men	19-30 years old	6 ½ ounce equivalents**
	31-50 years old	6 ounce equivalents**
	51+ years old	5 ½ ounce equivalents**

**These amounts are appropriate for individuals who get less than 30 minutes per day of moderate physical activity, beyond normal daily activities. Those who are more physically active may be able to consume more while staying within calorie needs.*

**Click here to see what counts as one ounce equivalent in the Protein Foods Group.

The Dairy Group - Switch to fat-free or low-fat (1%) milk.



All fluid milk products and many foods made from milk are considered part of this food group. Most Dairy Group choices should be fat-free or low-fat. Foods made from milk that retain their calcium content are part of the group. Foods made from milk that have little to no calcium, such as cream cheese, cream, and butter, are not. Calcium-fortified soymilk (soy beverage) is also part of the Dairy Group.

How much food from the Dairy Group is needed daily?

The amount of food from the Dairy Group you need to eat depends on age. Recommended daily amounts are shown in the chart.

Daily recommendation		
Women	19-30 years old	3 cups
	31-50 years old	3 cups
	51+ years old	3 cups
Men	19-30 years old	3 cups
	31-50 years old	3 cups
	51+ years old	3 cups

Choose fat-free or low-fat milk, yogurt, and cheese. If sweetened milk products are chosen (flavored milk, yogurt, drinkable yogurt, desserts), the added sugars also count against your maximum limit for "empty calories" (calories from solid fats and added sugars with few or no nutritional value).

Rethink Your Drink

Health Net®

L.A. COLLABORATIVE for HEALTHY ACTIVE CHILDREN

CHOOSE HEALTH LA!

rethink YOUR DRINK

Rethink *Your Drink*

20 oz. soda

=

22 packs of sugar!

20 oz.
sports drink

=

12 packs of sugar!

6 oz.
juice drink

=

6 packs of sugar!

For more information
Health Net of California
Health Education
Department
1-800-804-6074
www.healthnet.com/shp

LA Collaborative for
Healthy Active Children
www.lacollaborative.org

Choose Health
Los Angeles
www.choosehealthla.com

Drink more of these

- Water *(try it with a slice of fruit, cucumber or mint)*
- Low-fat milk

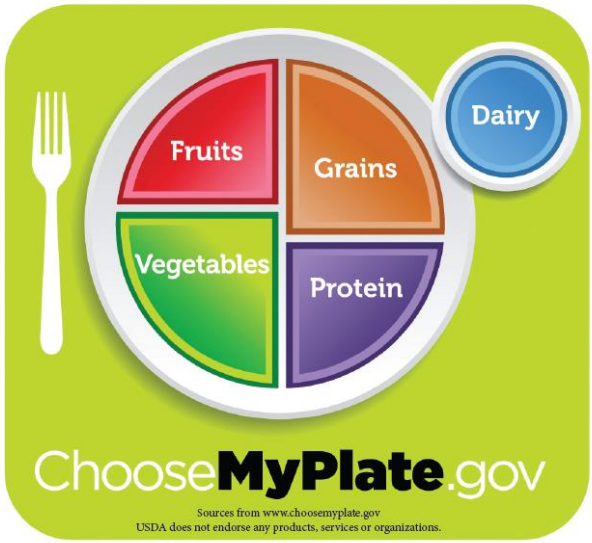
Drink less of these

- Sodas
- Sports drinks
- Energy drinks
- Coffee drinks
- Juice drinks

MyPlate Teaching Tool/Poster

Health Net® | L.A. COLLABORATIVE FOR HEALTHY ACTIVE CHILDREN | CHOOSE HEALTH LA! | rethink YOUR DRINK

What's on Your Plate?



Focus on fruits

- Try new fruits, and mix the colors.
- Limit 100% fruit juice to 1/2 cup per day – eat whole fruit instead!
- Apples, bananas, oranges, kiwi and grapes are tasty choices.

Vary your veggies

- Eat different colored vegetables.
- May be fresh, cooked, frozen or canned.
- Choose 100% vegetable juice.
- Try carrots, broccoli, spinach and eggplant.

Get enough dairy

- Choose low-fat or fat-free milk, yogurt and cheese.

Eat more whole grains

- Choose 100% whole wheat bread.
- Look for foods with "whole grain" listed as the first ingredient.
- Try oatmeal, plain popcorn, corn tortillas, brown rice and whole wheat pasta.

Go lean with protein

- Choose lean beef, seafood and chicken *(baked or grilled)*.
- Don't forget the beans, lentils and eggs.
- Unsalted nuts and seeds are great snacks.
- Soy products and tofu are good too.

Other healthy habits

Don't forget!

- **Kids and teens: Exercise for 1 hour every day!**
- **Adults: Exercise for 30 minutes every day!**
- **Limit computer, smartphone and video game time to 2 hours total per day!**

Daily Food Plans & Worksheets

The Daily Food Plan shows the food group targets – what and how much to eat within patient calorie allowance. The food plan can be personalized, based on age, gender, height, weight, and physical activity level. A helpful Worksheet is also available to help patients keep track.

For a more advanced experience, patients can create a personal daily food plan using the SuperTracker's MyPlan. Patients will be asked to create a profile, and can register to save it if they want. Patients can then use some or the entire SuperTracker's other features.

For professional reference, all of the Daily Food Plans and their associated Worksheets are available below. To view, download, or print, cross reference the calorie level and the age group in the tables below. Based on the age group, Food Plans at a specific calorie level may differ in an amount of Dairy foods or physical activity recommendations.

Daily Food Plans

Calorie Level of Food Plan	Age Group for Food Plan			
1000 calories	2 year olds			
1200 calories	3 year olds	4-5 year olds	6-8 year olds	
1400 calories	3 year olds	4-5 year olds	6-8 year olds	
1600 calories	4-5 year olds	6-8 year olds	9-17 year olds	18+ year olds
1800 calories	6-8 year olds	9-17 year olds	18+ year olds	
2000 calories	6-8 year olds	9-17 year olds	18+ year olds	
2200 calories	9-17 year olds	18+ year olds		
2400 calories	9-17 year olds	18+ year olds		
2600 calories	9-17 year olds	18+ year olds		
2800 calories	9-17 year olds	18+ year olds		
3000 calories	9-17 year olds	18+ year olds		
3200 calories	9-17 year olds	18+ year olds		

Daily Food Plan Worksheets

Calorie Level of Food Plan	Age Group for Food Plan			
1000 calories	2 year olds			
1200 calories	3 year olds	4-5 year olds	6-8 year olds	
1400 calories	3 year olds	4-5 year olds	6-8 year olds	
1600 calories	4-5 year olds	6-8 year olds	9-17 year olds	18+ year olds
1800 calories	6-8 year olds	9-17 year olds	18+ year olds	
2000 calories	6-8 year olds	9-17 year olds	18+ year olds	
2200 calories	9-17 year olds	18+ year olds		
2400 calories	9-17 year olds	18+ year olds		
2600 calories	9-17 year olds	18+ year olds		
2800 calories	9-17 year olds	18+ year olds		
3000 calories	9-17 year olds	18+ year olds		
3200 calories	9-17 year olds	18+ year olds		

Sample Meal Plans

Sample Meal Plans

These samples show just a few ways to combine meals and snacks to meet your daily food group targets.

Meal Plan A (based on a 2000 Calorie Plan)

Breakfast

- 1 ounce(s) Grains
- ½ cup(s) Fruits
- ½ cup(s) Dairy

Morning Snack

- 1 ounce(s) Grains
- 1 cup(s) Fruits

Lunch

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- ½ cup(s) Fruits
- 1 cup(s) Dairy
- 2½ ounce(s) Protein Foods

Afternoon Snack

- ½ cup(s) Vegetables
- ½ cup(s) Dairy

Dinner

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- 1 cup(s) Dairy
- 3 ounce(s) Protein Foods

Meal Plan B (based on a 2000 Calorie Plan)

Breakfast

- 1 ounce(s) Grains
- 1 cup(s) Dairy
- 1½ ounce(s) Protein Foods

Morning Snack

- 1 cup(s) Fruits
- ½ cup(s) Dairy

Lunch

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- ½ cup(s) Dairy
- 2 ounce(s) Protein Foods

Afternoon Snack

- 1 ounce(s) Grains
- ½ cup(s) Vegetables

Dinner

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- 1 cup(s) Fruits
- 1 cup(s) Dairy
- 2 ounce(s) Protein Foods

Meal Plan C (based on a 2000 Calorie Plan)

Breakfast

- 1 cup(s) Fruits
- 1 cup(s) Dairy

Morning Snack

- 1 ounce(s) Grains
- ½ cup(s) Dairy
- 1½ ounce(s) Protein Foods

Lunch

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- 1 cup(s) Dairy

Afternoon Snack

- 1 ounce(s) Grains
- ½ cup(s) Vegetables
- ½ cup(s) Dairy
- 2 ounce(s) Protein Foods

Dinner

- 2 ounce(s) Grains
- 1 cup(s) Vegetables
- 1 cup(s) Fruits
- 2 ounce(s) Protein Foods

USDA United States Department of Agriculture

Go to www.ChooseMyPlate.gov for more information.

USDA is an equal opportunity provider and employer.

CME Resources

American Medical Association (AMA) - www.ama-assn.org
Roadmaps for Clinical Practice –Assessment and Management of Adult Obesity

10 Booklet CME program

- Book 1: Introduction and Clinical Considerations
- Book 2: Evaluating Your Patients for Overweight and Obesity
- Book 3:Assessing Readiness and Making Treatment Decisions
- Book 4: Dietary Management
- Book 5: Physical Activity Management
- Book 6: Pharmacological Management
- Book 7: Surgical Management
- Book 8: Communication and Counseling Strategies
- Book 9: Setting Up the Office Environment
- Book 10:Resources for Physicians and Patients

American Diabetes Association (ADA) - www.diabetes.org
Quality education for healthcare professionals that provide for persons with diabetes.
http://professional.diabetes.org/Congress_Display.aspx?TYP=9&CID=71060

Discovery Health CME - www.discoveryhealthcme.com
See. Hear. Learn. Like Never Before.
Welcome to Discovery Channel CME, an entirely new way to earn free CME credit brought to you by the leader in health media, the Discovery Channel. Join us as we go beyond static journal articles and didactic lecture presentations to deliver CME right to your television that's credible, dynamic, and relevant, with the quality and depth you've come to expect from Discovery Channel.

AUDIO DIGEST CME RESOURCES
Audio-Digest has compiled all of your state-mandated requirements in one convenient package. You can listen to your audio CDs or MP3s at your convenience. All courses are *AMA PRA Category 1 Credit*™ approved.
http://www.audio-digest.org/pages/htmlos/current/index.htm

Informational Website Links

Resource Name	Web Link	Details
Aetna InteliHealth Database	www.intelihealth.com/IH/ihtIH/WSIHW000/408/408.html	Provides consumer-friendly health information.
American Academy of Family Physicians(AAFP)	http://familydoctor.org/online/famdocen/home/healthy/food/improve/788.html	This section offers a range of practical ideas for dealing with overweight and obesity.
American Association of Clinical Endocrinologists (ACE)	www.aace.com	Professional community of physicians specializing in endocrinology, diabetes, and metabolism.
American College of Physicians (ACP)	http://www.doctorsforadults.com/topics/dfa_obes.htm	Health care topics related to overweight/obesity and weight control
American Diabetes Association (ADA)	http://www.diabetes.org/food-and-fitness/fitness/weight-loss/?loc=DropDownFF-weightloss	Links to resources on weight loss and exercise
American Dietetic Association	http://www.eatright.org/Public/content.aspx?id=5527	Links to resources related to food and nutrition
American Medical Association (AMA)	http://www.ama-assn.org/ama/pub/category/10931.html	Roadmaps for Clinical Practice in the assessment and management of adult obesity
California Medical Association Foundation – Obesity Prevention Project	http://www.thecmafoundation.org/projects/obesityProject.aspx	Provides information on Education & Community Outreach, Policy Advocacy, and Provider Resources.
Center for Disease Control and Prevention - *Division of Nutrition and Healthy Weight (DNPAO)*	http://www.cdc.gov/nccdphp/dnpao/	Public health information that addresses the role of nutrition and physical activity in improving the public's health and preventing and controlling chronic diseases.
Center for Medicare & Medicaid Services	www.cms.hhs.gov	Information on Medicare and Medicaid Services
Fruit and Veggies, More Matters - PBH	www.fruitsandveggiesmorematters.org	Resources on meal planning & shopping, recipes, community, etc.
Institute of Medicine (IOM) - *Reports*	http://www.iom.edu/Reports.aspx	IOM reports provide objective and straightforward advice to decision makers and the public.
Mayo Clinic	www.mayoclinic.com	Research and education for everyone from the public to medical professionals.
My Plate (USDA)	http://www.choosemyplate.gov/	USDA Food Guidance System
National Heart Lung and Blood Institute	http://www.nhlbi.nih.gov/health/dci/Diseases/obe/obe_whatare.html	Index of topics on overweight and obesity

National Diabetes Education Program (NDEP)	http://ndep.nih.gov/resources/diabetes-healthsense/index.aspx	Educational resources on diabetes and pre-diabetes
National Eating Disorders Organization	http://www.nationaleatingdisorders.org/	Eating disorders information
Nutrition Action Healthletter	www.cspinet.org/nah/index.htm	Health and Nutrition newsletter.
Nutrition.Gov	www.nutrition.gov	Government information on food and human nutrition for consumers.
Obesity Action Coalition (OAC)	http://www.obesityaction.org/	OAC is an education and advocacy organization, involved with all issues related to obesity. Free educational resources on obesity, severe obesity and childhood obesity are offered.
Obesity Society	http://www.obesity.org/	Research and Information on obesity
Obesityhealth.com	www.obesityhealth.com	Links to information about obesity
Obesity Help	www.obesityhelp.com	Information about Gastric Bypass, LAP-BAND and non-surgical weight loss solutions
SNAP-Ed Connection	http://snap.nal.usda.gov/	Dynamic online resource center for State and local SNAP-Ed Providers.
US Department of Agriculture (USDA)	www.nutrition.gov	Information on food and human nutrition for consumers
US Food and Drug Administration (FDA)	http://www.fda.gov/Food/default.htm	Information about food safety and nutrition

Ethnic Provider Organizations

American Association of Physicians of Indian Origin	http://aapiusa.org/
Association of American Indian Physicians	www.aaip.org
Association of Philippine Physicians of America	www.aboutappa.org
National Coalition of Ethnic Minority Nurse Organizations	www.ncemna.org
National Council of Asian Pacific Islander Physicians	http://ncapip.org/
National Hispanic Medical Association	www.nhmamd.org
National Medical Association	http://nmanet.org/
Philippine Academy of Family Physicians	http://thepafp.org/
Vietnamese American Medical Association	http://vamausa.org/cms2/index.php
AMA International Medical Graduates	www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates.page

Culturally Appropriate Resources[106]

Cultural Competency Resources

Center for Healthy Families and Cultural Diversity (CHFCD) *at UMDNJ-Robert Wood Johnson Medical School* http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/index.html	The Center for Healthy Families and Cultural Diversity serves as a multicultural education resource center for information about family-centered health care and ethnic and cultural diversity.
DHHS Office of Minority Health http://minorityhealth.hhs.gov/	OMH programs address disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care and works in partnership with communities and organizations in the public and private sectors. These collaborations support a systems approach for eliminating health disparities, national planning to identify priorities, and coordinated responses through focused initiatives. OMH provides funding to state offices of minority health, multicultural health, and health equity; community and faith-based organizations, institutions of higher education, tribes and tribal organizations; and other organizations dedicated to improving health.
Think Culturally, *sponsored by the Office of Minority Health* www.thinkculturalhealth.hhs.gov	Think Culturally offers the latest resources and tools to promote cultural competency in health care. You may access free online courses accredited for continuing education credit as well as supplementary tools to help you and your organization promote respectful, understandable, and effective care to your increasingly diverse patients. **A Physician's Practical Guide to Culturally Competent Care** is a free online educational program accredited for physicians, physician assistants, and nurse practitioners.
National Standards on Culturally and Linguistically Appropriate Services (CLAS) http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15	The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

National Center for Cultural Competence (NCCC) *of the Georgetown University Center for Child and Human Development (GUCCHD)*http://nccc.georgetown.edu/	The NCCC provides training, technical assistance, and consultation, creates tools and resources to support health and mental health care providers and systems, contributes to knowledge through publications and research and supports leaders to promote and sustain cultural and linguistic competency, and collaborates with an extensive network of private and public entities to advance the implementation of these concepts.
The Provider's Guide to Quality & Culture http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&ggroup=&mgroup	Provides information that health care professionals can use to improve the quality of their interactions with patients whose culture may differ from their own. Video resources available**:** Clinical Exchanges are video scenarios illustrating patient provider interactions accompanied by learning exercises to help viewers recognize the effect of provider behavior on clinical outcomes. http://erc.msh.org/mainpage.cfm?file=4.1.0.htm&module=provider&language=English
Disparities Solutions Center (DSC) *at Massachusetts General Hospital* http://www2.massgeneral.org/disparitiessolutions/index.html	The Disparities Solutions Center provides publications that highlight practical solutions to identify and address disparities within hospitals and other health care organizations and other resources related to health care disparities elimination.

Resources with Items in Multiple Languages

EthnoMed http://ethnomed.org	Cultural Competency Resources and Patient Education Materials for: Amharic, Cambodian, Chinese, Eritrean, Ethiopian, Oromo, Somali, Spanish, Tigrean, Vietnamese and others.
Foundation for Healthy Communities www.healthynh.com/fhc/resources/translateddocuments.php	Access to documents created and translated by New Hampshire health agencies and organizations; languages include Albanian, Arabic, Bosnian, Chinese, English, French, Indonesian, Portuguese, Russian, Somali, Spanish, Swahili and Vietnamese.
Health Info Translations www.healthinfotranslations.com	Use the drop-down box to choose a language - Chinese Simplified and Traditional, French, Japanese, Korean, Russian, Somali, Spanish, Ukrainian, Hindi, Vietnamese, and Arabic.
Healthy Roads Media www.healthyroadsmedia.org	Provides audio, written and multimedia versions of resources in English, Spanish, Vietnamese, Arabic, Somali, Bosnian, Russian, Hmong, and Khmer.
How to Order NIH Publications in Languages Other Than English http://nnlm.gov/mcr/resources/community/multilingualNIH.html	Contains links to National Institutes of Health publications in languages other than English.
Maternal and Child Health Library at Georgetown University Non-English Materials and Resources www.mchlibrary.info/nonenglish.html	Includes materials for consumers and professionals in numerous languages other than English, and the Organizations Database identifies additional sources for these materials.
MedlinePlus Health Information in Multiple Languages www.nlm.nih.gov/medlineplus/languages/languages.html	Information in over 40 languages from the National Library of Medicine's premier consumer health website.
New Americans Health Information Portal http://palantir.lib.uic.edu/nahip/	Information in 19 languages, includes audio, multimedia, podcast and video format.

New South Wales Multicultural Health Communication Service www.mhcs.health.nsw.gov.au	A rich resource with numerous health topics that provide health information in 50 languages.
Non-English Guides to PubMed http://nnlm.gov/training/resources/intlpubmedlinks.html	Learn to use PubMed, languages: French, German, Italian, Japanese, Norwegian, Portuguese, Russian, Spanish and Vietnamese.
Ohio State University Medical Center Patient Education Materials http://medicalcenter.osu.edu/patientcare/patient_education/	Copyrighted materials; includes handouts in Spanish and Somali.
Refugee Health Information Network www.rhin.org	Multilingual information for health professionals, refugees and asylees (in print, audio and video formats)
Refugee Health - Immigrant Health http://bearspace.baylor.edu/Charles_Kemp/www/refugee_health.htm	Covers issues in refugee and immigrant health and includes general background information on numerous incoming populations.

Resources for Specific Languages

American Sign Language

DeafMD.org www.deafmd.org	Provides accurate, concise, and valuable health information in American Sign Language using health information created by the Centers for Disease Control and the National Institutes of Health.

Arabic

Urban Health Partners www.lib.wayne.edu/shiffman/urbanhealth/	From the Shiffman Medical Library and Learning Resources Centers of Wayne State University. See the Arabic Language Health Materials links.
Minhaal www.minhaal.ae/portal/portal/mhp/HomeAE www.minhaal.ae/portal/portal/mhp/HomeEN (English Language Portal)	Minhaal (the source) is the first dual-language Arab portal that provides healthcare related information.

Cambodian/Khmer

SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/khmer.shtml	Provides consumer information in Cambodian/Khmer, (in addition to Chinese, Hmong, Korean, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Chinese

Asian Pacific Islanders Women's Health www.apanet.org/~fdala/	This multi-lingual site offers several languages to help Asian Pacific Islander women understand the importance of having mammograms and pap smears at regular intervals. There is information about how to make appointments and prepare for the procedures. Clinicians will find special materials they can use to personally recommend mammography and pap smears to their patients.
Health Information Translations www.healthinfotranslations.com/	From the Ohio State Medical Center, includes health information and hospital signage documents. Languages include: Arabic, Chinese Simplified, Chinese Tradition, English, French, Hindi, Japanese, Korean, Marshallese, Portuguese Brazilian, Russian, Somali, Spanish, Tagalog, Ukrainian and Vietnamese.
SPIRAL: Selected Patient Information	Provides consumer information in Chinese, (as well as

Resources in Asian Languages http://spiral.tufts.edu/chinese.shtml	Cambodian/Khmer, Hmong, Korean, Laotian, Thai, and Vietnamese and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

French

Public Health Agency of Canada www.phac-aspc.gc.ca/index-fra.php	PHAC's primary goal is to strengthen Canada's capacity to protect and improve the health of Canadians and to help reduce pressures on the health-care system.
Heart and Stroke Foundation of Canada http://ww2.heartandstroke.ca/	Information in English and French on heart disease, stroke, healthy living, and more is available on this Canadian non-profit's website.
CiSMeF Patients www.chu-rouen.fr/cismef/	Catalog and Index of French Language Health Resources on the Internet is a quality-controlled health gateway to catalog and index the most important and quality-controlled sources of institutional health information in French.

German

Welt der Gesundheit www.gesundheit.com	From AIDS to Zappelphilipp syndrome (or ADHD), this site gives information on hundreds of health topics in German.
Patienten-Informationsdienst www.patienten-information.de	The portal offers over 1000 reliable sources of consumer health information in German.
Medicine-Worldwide www.medicine-worldwide.de	Medicine and health topics in German. Read everything about illnesses, therapies, diagnosis procedures, health and a lot more.

Hmong

Hmong Health Website www.hmonghealth.org	The goal of the Hmong Health Education Network's website is to provide access to health information for Hmong people and those who provide health, education and social services to the Hmong community. Categories of topics include family health, healthy living, traditional healing, talking with health providers, and more.
SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/hmong.shtml	Provides consumer information in Hmong (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Korean

SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/korean.shtml	Provides consumer information in Korean (as well as Cambodian/Khmer, Chinese, Hmong, Laotian, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Laotian

SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/laotian.shtml	Provides consumer information in Laotian (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Thai, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Russian

Eurasia Health (Links to Central and Eastern Europe and the former Soviet Union languages) www.eurasiahealth.org/index.jsp?lng=ru	Online clearinghouse featuring a library of multilingual health resources, databases, and interactive forums.

Spanish

Agency for Healthcare Research and Quality en español	www.ahcpr.gov/consumer/espanoix.htm
CDC -- Centers for Disease Control and Prevention en español	www.cdc.gov/spanish
Community Tool Box/Caja de Herramientas Comunitarias	http://ctb.ku.edu/es/
Consumer Health Materials in Spanish	http://nnlm.gov/outreach/consumer/chspanish.html
Denver Public Library Salud y Medicina	http://espanol.denverlibrary.org/health/index.html
Familydoctor.org Pamphlets in Spanish	http://familydoctor.org/online/famdoces/home.html
FDA Center for Food Safety and Applied Nutrition	www.cfsan.fda.gov/~mow/sinterna.html
Substance Abuse and Mental Health Services Administration en español	www.hablemos.samhsa.gov/espanol/
Healthfinder en español	www.healthfinder.gov/espanol
InfoSIDA	http://aidsinfo.nih.gov/infoSIDA/
MedlinePlus en español	http://medlineplus.gov/esp
Merck Manual of Medical Information -- Home Edition	www.msd.es/publicaciones/mmerck_hogar/index.html
MiPiramide	www.mypyramid.gov/sp-index.html Unite States Department of Agriculture's food pyramid Spanish language portal.
Multimedia Medical Spanish Translator	http://polyglot.topsailmultimedia.com/polyglot.html Includes audio files so you can listen to the translated words and phrases.
National Institute of Diabetes and Digestive and Kidney Diseases	www.niddk.nih.gov/health/spanish.htm
National Institute of Neurological Disorders and Stroke	http://espanol.ninds.nih.gov/
National Institutes of Health en español	http://salud.nih.gov/
National Women's Health Information Center en español	www.4women.gov/espanol/
National Library of Medicine's Tox Town en español	http://toxtown.nlm.nih.gov/espanol/
National Library of Medicine's Tox Mystery (select the español tab)	http://toxmystery.nlm.nih.gov/
NOAH -- New York Online Access to Health	www.noah-health.org
Oficina de Salud de lasMinorias/ Office of Minority Health	www.omhrc.gov/espanol/
University of Michigan Health Systerm Health Topics A-Z; en español	http://health.med.umich.edu/healthcontent.cfm?id=294

Thai

SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/thai.shtml	Provides consumer information in Thai (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, and Vietnamese) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

Vietnamese

SPIRAL: Selected Patient Information Resources in Asian Languages http://spiral.tufts.edu/vietnamese.shtml	Provides consumer information in Vietnamese (as well as Cambodian/Khmer, Chinese, Hmong, Korean, Laotian, and Thai) and on a wide variety of Internet resources including National Library of Medicine and Tufts University resources.

California Health Plan Interpreter Services Directory - June 2011

Plan Name	Phone
Aetna Health of California, Inc.	Customer Service: 800-756-7039 TTY/TDD number: 877-688-9891
Alameda Alliance for Health	In-person: (510) 747-4567 - 3 days in advance TTY/TDD (510) 747-4501 By Telephone: 877-263-0939 during appointment
Anthem Blue Cross Partnership Plan	In-person: (800) 407-4627 -3 days in advance TTY/TDD (888) 757-6034 By Telephone: 800-407-4627 during appointment After Hours: 800-224-0336
Blue Shield of California	In-person: (800) 424-6521 - 5 days in advance TTY/TDD 800-241-1823 By telephone: 800-424-6521 during appointment
Cal Optima	In-Person: (888) 587-8088 - 3 days in advance TTY/TDD (714) 246-8523 By Telephone: Cal Optima Kids Plan call: 800-530-2899 during appointment
Care 1st Partner Plan, LLC	In-person: (800) 605-2556 - 5 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-605-2556 during appointment
Care1st Health Plan	In-person: 800-847-1222 - 5 days in advance By Telephone: 800-847-1222 during appointment
Central California Alliance for Health	In-person: (800) 700-3874 ext. 5505 (4877) - 4 days in advance TTY/TDD (877) 548-0857 By Telephone: 800-523-1786 during appointment
CenCal Health	In-person: (877) 814-1861 TTY/TDD (805) 685-4131
Chinese Community Health Plan	Customer service: 415-834-2118 or 1-866-HMO-CCHP TTY/TDD number: 877-681-8898
CIGNA HMO	Customer service: 1-888-992-4462 TTY/TDD number: 711 (state relay service)
Community Health Group Partnership Plan	In-person: (800) 224-7766 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-224-7766 during appointment
Contra Costa Health Plan	In-person: (877) 661-6230 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 877-661-6230 during appointment
Family Mosaic Project (No Website)	In-person: (415) 206-7600 - 1 week in advance By Telephone: (415) 206-7600 1 week in advance
Health Net Community Solutions, Inc.	**Medi-Cal:** In-person: (800) 675-6110 – 3-5 days prior to member's appointment TTY/TDD (800) 431-0964 By Telephone: 800-675-6110 during appointment (24hours a day, seven days a week)
Health Plan of San Joaquin	In-person: (888) 936-7526 - 1 week in advance TTY/TDD (209) 942-6306 By Telephone: 800-874-9426 during appointment
Health Plan of San Mateo	In-person: (650) 616-0050 or (800) 750-4776 - 10 days in advance TTY/TDD (650) 616-8037 By Telephone: 800-750-4776 during appointment

Inland Empire Health Plan	In-person: (800) 440-4347 - 5 days in advance TTY/TDD (800) 718-4347 By Telephone: 800-440-4347 during appointment
Kaiser Permanente	In-person: 877-886-3885 helpful to call ahead but not necessary (800) 464-4000 English (800) 788-0616 Spanish (800) 757-7585 Chinese Dialects TTY/TDD (800) 777-1370 By Telephone: 877-866-3885 during appointment
Kern Family Health Care	In-person: (800) 391-2000 - 1 day in advance TTY/TDD (800) 735-2929 By Telephone: 800-391-2000 during appointment
L. A. Care Health Plan	In-person: (888) 839-9909 OR 213-694-1250 - 3 days in advance TTY/TDD (866) 522-2731 By Telephone: 800-259-4521 during appointment
Molina Healthcare of California Partner Plan, Inc.	In-person: (888) 665-4621 - 5 days in advance TTY/TDD (800) 479-3310 By Telephone: 888-665-4621 during appointment
PacifiCare of California	Customer service: 800-624-8822 TTY/TDD number: 800-442-8833
Partnership Health Plan of California	In-person: Solano or Napa County call: 707-863-4120 - 2 days in advance Yolo County call: (800) 863-4155 - 2 days in advance TTY/TDD (800) 226-2140 By Telephone: 800-874-9426 during appointment
Premier Access	By Telephone: 888-584-5830 during appointment
San Francisco Health Plan	In-person: (800) 288-5555 before appointment date TTY/TDD (888) 833-7347 By Telephone: 800-288-5000 during appointment
Santa Clara Family Health Plan	In-person: (800) 260-2055 - 2 days in advance TTY/TDD (800) 735-2929 By Telephone: 800-324-8033 during appointment
Sharp Health Plan	In-person: 800-359-2002 - 1 week in advance By Telephone: 800-359-2002 during appointment
Universal Care Medical & Dental	In-person: 800-635-6668 - 5 days in advance By Telephone: 800-635-6668 during appointment
Ventura County Healthcare Plan	In-person: 800-600-8247 OR 805-677-8787 - 2 days in advance By Telephone: 800-600-8247 OR 805-677-8787 during appointment
Western Health Advantage	In-person: 916-734-2321 when you schedule appointment By Telephone: 916-734-2321 during appointment
Delta Dental	In-person: 877-580-1042 - 2 days in advance By Telephone: 877-580-1042 during appointment
Safeguard Dental Plan	By Telephone: 800-880-3080 during appointment
Healthy Families Vision Program/VSP	In-person: 800-877-7239 - 1 day in advance By Telephone: 800-877-7239 - 1 day in advance

Multicultural Patient Communications Vignette

Patient Overview

Juan is a 20 year old male referred to your office for ER follow-up after presenting with chest pain. He had a negative cardiac workup in the ER and elevated random blood sugar of 196 mg/dl. He was born in San Diego. Both of his parents are of Mexican descent. English is the primary language spoken at home.

Juan's father is morbidly obese and has type 2 diabetes and hypertension. Juan is obese with a height of 70 inches, weight of 220 pounds. He has acanthosisnigricans and labs consistent with pre-diabetes. Juan also has no health insurance.

What are possible challenges to successful multicultural communications?

Health Access Needs

- In your communication with Juan, be aware that there may be some reluctance to get health insurance due to the citizenship process or repayment concerns. Lack of insurance is likely why Juan and his family went to the emergency room for care. The family will need assistance in finding health care coverage and the best ways to utilize the health care system.

Perception of Healthcare Providers

- Direct disagreement with a healthcare provider is very uncommon. The more usual response to a decision with which the patient or family disagrees is silence and noncompliance. Reinforcing verbally, writing down instructions and asking open-ended questions as to their understanding is important. For example, is there anything you see as a barrier for you to doing "this action."

Cultural Perception of Illness

- Within the Latino community, there may be a fatalistic sense of health – "Fatalismo". This reflects a belief that individuals can do little to alter fate. The patient may delay in seeking medical treatment. Be aware of this to have a dialogue with the patient about treatment and proposed interventions.

Traditional & Folk Remedies

- Among Latinos it is not uncommon for traditional and folk remedies not to be shared with the patient's healthcare provider as well as the use of herbs and other alternative healing methods. You should ask about alternative remedies.

Utilize the patient communication mnemonic, LEARN, in your discussion with Juan.

L	•**L**isten with sympathy and understanding to Juan's perception of his obesity.
E	•**E**xplain your perceptions of this situation and your strategy for initiating treatment options.
A	•**A**cknowledge and discuss with Juan the differences and similarities between yours and his perception of his obesity and its health impacts.
R	•**R**ecommend treatment to Juan and his family while remembering his cultural parameters.
N	•**N**egotiate agreement for the solution and steps Juan can take to reduce his weight and lower his BMI.

8 Billing & Prevention Procedure Codes

- ICD9-CM Codes: International Classification of Diseases, 9th Revisions, Clinical Modifications
- Health care Common Procedure Coding System (HCPCS) Level I — CPT 4 Procedure Codes & Level II Procedure, Counseling & Supply Codes
- Insurance Coverage for MNT

Chapter 8 Billing & Prevention Procedure Codes

Medical coding involves the use of universal alpha-numeric codes to describe medical diagnoses and procedures for the purpose of tracking disease and submission to public and private health insurance carriers for their imbursement of medical services rendered by medical providers to patients. Appropriate use of coding types for reimbursement will vary by insurance carrier and services rendered.

ICD9-CM Codes: International Classification of Diseases, 9th Revisions, Clinical Modifications

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.[107]

Diagnosis	ICD-9 Code
Thyroid (Hypothyroidism)	244.8,244.9
Diabetes Mellitus	250.00–250.03
Pituitary, Fröhlich's (adiposogenital dystrophy)	253.8
Adrenal	255.8
Endocrine NEC, Endogenous	259.9
Nutritional deficiencies, unspecified	269.9
Hypercholesterolemia	272.0
Hyperglyceridemia	272.1
Hyperlipidemia	272.4
Metabolic syndrome	277.7
Metabolism disorder	277.9
Obesity (constitutional, exogenous, familial, nutritional, simple)	278.00
Morbid Obesity (BMI over40,over35-39 with co-morbid conditions)	278.01
Overweight(BMI 26-29)	278.02
Hyper alimentation, specified	278.8
Chronic depression	296.12
Eating disorder, unspecified	307.50
Bulimia nervosa	307.51
Other and unspecified disorders of eating	307.59
Hypertension	401.0,401.1
Essential hypertension unspecified	401.9
Cardiovascular disease	414.9
Chronic venous insufficiency, venousstasis	459.81
Chronic Respiratory Disease	519.9
Gastro-esophageal reflux(GERD)	530.81
Constipation unspecified	564.00
Pregnancy Related Obesity	646.1
Osteoarthritis	715.9
Sleep Disturbance unspecified Insomnia with sleep apnea, unspecified Hyper somnia with sleep apnea, unspecified Hypersomnia, unspecified Sleep apnea unspecified	780.50 780.51 780.53 780.54 780.57

Abnormal Weight Gain	783.1
Other symptoms concerning nutrition, metabolism, and development	783.9
Urinary stress incontinence	788.32,625.6
Impaired glucose tolerance test (oral)	790.22
Other abnormal glucose; pre-diabetes	790.29
Hyperglycemia, other abnormal blood chemistry	790.60

V Codes[108]

In the primary care setting supplemental ICD9-CMV code scan be used to indicate a reason for health screening and health related counseling encounters. V codes are also used to classify circumstance or problems influencing a person's health status resulting from a current illness or injury. They are not procedure codes and must accompany the corresponding procedure code.

Code series (V85) pertaining to Body mass index[109]

•V85.0 Body mass index less than 19, adult
•V85.1 Body mass index between 19-24, adult
•V85.21 Body mass index 25.0-25.9, adult
•V85.22 Body mass index 26.0-26.9, adult
•V85.23 Body mass index 27.0-27.9, adult
•V85.24 Body mass index 28.0-28.9, adult
•V85.25 Body mass index 29.0-29.9, adult
•V85.30 Body mass index 30.0-30.9, adult
•V85.31 Body mass index 31.0-31.9, adult
•V85.32 Body mass index 32.0-32.9, adult
•V85.33 Body mass index 33.0-33.9, adult
•V85.34 Body mass index 34.0-34.9, adult
•V85.35 Body mass index 35.0-35.9, adult
•V85.36 Body mass index 36.0-36.9, adult
•V85.37 Body mass index 37.0-37.9, adult
•V85.38 Body mass index 38.0-38.9, adult
•V85.39 Body mass index 39.0-39.9, adult
•V85.4 Body mass index 40 and over, adult

Bariatric Surgery Related V Codes

•V45.3 Post-surgical Status of Intestinal by pass

Healthcare Common Procedure Coding System (HCPCS) - Level I (CPT-4) and Level II Procedure, Counseling and Supply Codes[110]

LevelI -CPT-4 Procedure Codes

The CPT is a uniform coding system consisting of descriptive terms and identifying codes primarily used to identify medical services and procedures for the purposes of billing public or private health insurance programs.

Procedure	CPT-4 Code
Collection of venous blood by venipuncture	36415
Collection of capillary blood specimen	36416
Oxygen uptake, expired gas analysis (calorimetry)	94690, 94799
Glucose monitoring for up to 72hours	95250
Health and behavior assessment, initial	96150
Health and behavior assessment, follow-up	96151
Health and behavior intervention, individual	96152
Health and behavior intervention, group (2 or more patients	96153
Health and behavior intervention, family (with patient present)	96154
Health and behavior intervention, family (without patient present)	96155
Medical Nutrition Therapy; initial assessment and intervention, individual	97802
Medical Nutrition Therapy; follow-up assessment and intervention, individual	97803
Medical Nutrition Therapy; group (2 or more patients)	97804

CPT-4 Codes-Surgical Treatment of Obesity

Procedure	CPT-4
Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (rouxlimb 150 cm or less).	43644
With gastric bypass and small intestine reconstruction to limit absorption.	43645
Placement of adjustable gastric band (gastric band and subcutaneous port components)	43770
Revision of adjustable gastric band component only	43771
Removal of adjustable gastric band component only	43772
Removal and replacement of adjustable gastric band component only	43773
Removal of adjustable gastric band and subcutaneous port components	43774
Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical- banded gastroplasty	43842
Other than vertical-banded gastroplasty	43843
Gastric restrictive procedure with partial gastrectomy, pyloris-preserving duodenoileostomy and ileoileostomy (biliopancreatic diversion with duodenal switch)	43845
Gastric restrictive procedure, with gastric bypass for morbid obesity; with short Limb (150 cm or less) Roux-en-Y gastroenterostomy	43846
with small intestine reconstruction to limit absorption	43847
Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric band	43848
Gastric restrictive procedure, open; revision of subcutaneous port component only	43886
Removal of subcutaneous port component only	43887
Removal and replacement of subcutaneous port component only	43888

HCPCS Level II – Procedure, Counseling and Supply Codes

HCPCS Level II codes were developed to fill in the CPT-4 procedure code gaps. While they are reported in the same way as a CPT-4 code, they consist of one alphabetic character (A-V) followed by four digits. The following codes are used for weight management related education and counseling services:

Education and Counseling Codes

Procedure or Supply	HCPCS Code
Patient Education; non-physician provider, individual, per session	S9445
Patient Education; non-physician provider, group, per session	S9446
Weight management class; non-physician provider, per session	S9449
Exercise class; non-physician provider, per session	S9451
Nutrition class; non-physician provider, per session	S9452
Stress management class; non-physician provider, per session	S9454
Diabetic management program; group session	S9455
Diabetic management program; nurse visit	S9460
Diabetic management program; dietitian visit	S9465
Nutritional counseling; dietitian visit	S9470

Insurance Coverage for MNT[111]

Medical Nutrition Therapy is covered by a variety of insurance plans. Because coverage for and access to MNT services varies by health insurance program or carrier, please consult with your health insurance Evidence of Coverage booklet or call your health plan regarding coverage for MNT services.

Medicare Part B (Medical Insurance) covers nutritional assessment, one-on-one counseling, and therapy through an interactive telecommunications system provided by a registered dietitian or Medicare-approved nutrition professional.

Who's eligible?

- People with Medicare who have kidney disease (but who aren't on dialysis)
- People with Medicare who've had a kidney transplant
- People with Medicare who have diabetes

Physicians must prescribe MNT services to Medicare recipients and renew the referral annually as necessary

9 Community/Environmental Advocacy

- Healthcare Professionals are Natural Advocates
- Understanding Advocacy
- Linking Community Advocacy with Clinical Practice
- Matching the Advocacy Activity to the Time Available
- California Medical Association Foundation's (CMA Foundation) Healthcare Professionals for Healthy Communities Initiative
- California Medical Association Foundation's (CMA Foundation) Walk with a Doc Program
- CMAF Healthcare Professionals for Healthy Communities Initiative

Healthcare Professionals Are Natural Advocates[112]

As a Healthcare Professional, you are a natural and powerful advocate on behalf of patient's health. You have a voice that resonates with others on a profound level and speaks to your first-hand experiences with patients. Consider the following reasons why you are uniquely suited for advocacy:

You Put a Human Face to the Statistics: You care for patients every day who are affected by the environments in which we live and work. When you tell your story, you make the issue of obesity tangible to people in a way that fact sheets or statistics alone cannot.

You Have Credibility: By the nature of your profession, education, and training, people in your community respect and trust you. When you speak out on an issue, you bring credibility and relevance to that issue.

You Have Influence: Because you instill trust in others and add credibility to your cause, your investment in the community can inspire others to do likewise. Moreover, your voice is listened to when other voices are not—a survey revealed that patients wanted physicians to be their primary source of information about nutrition, physical activity and other health issues associated with obesity.

Your Patients are Depending on You: You have the power to not only advocate for patients, but to consolidate the message of their families into a cohesive advocacy voice. Through advocacy, you can help ensure that decision makers are not simply recognizing patient health and well being as an important issue, but that they are actively working to improve their health and their lives.

You Have Passion: Advocacy allows you to dig deeper into your interests and touches on why you originally became a Healthcare Professional. Through advocacy, you can channel your passion for health and well being into meaningful and lasting change. Advocacy allows you to help improve the lives of patients while simultaneously strengthening the role of your profession within the community.

You Have Well-Suited Skills: Healthcare Professionals already have the skill set of an advocate. The same skills you use every day to establish trust, develop relationships, and provide solutions to your patients can be applied in your community advocacy work.

Research is on Your Side: The issues you care about are backed by research. Through advocacy, you can convey both the personal and factual importance of the environmental factors that influence obesity.

You Are Not Alone: Through advocacy, you can join other Healthcare Professionals, school personnel, youth organizers, agricultural groups and others, who, through their efforts, and community partnerships, are making patient's health a priority and working to eradicate obesity. There is strength in numbers!

Understanding Advocacy

Advocacy simply means speaking out on your patients' and clients behalf. Advocacy brings about changes to benefit the health of children in your community. Now more than ever, advocacy is crucial in shaping local policy change. Today's local issues often become tomorrow's state or national legislation.

Advocacy: Advocacy means speaking on behalf of a group of people within the public sphere around a particular issue.

Linking Community Advocacy with Clinical Practice

Factors that influence a person's ability to achieve and maintain a healthy weight come from a number of sources. The Dahlgren and Whitehead (1991) model maps the layers of influence on health.

Individuals are at the centre with a set of fixed genes. Surrounding them are influences on health that can be modified. The first layer is personal behavior and ways of living that can promote or damage health (e.g. choice to smoke or not). Individuals are affected by friendship patterns and the norms of their community. The next layer is social and community influences, which provide mutual support for members of the community in unfavorable conditions. But they can also provide no support or have a negative effect. The third layer includes structural factors: housing, working conditions, access to services and provision of essential facilities.

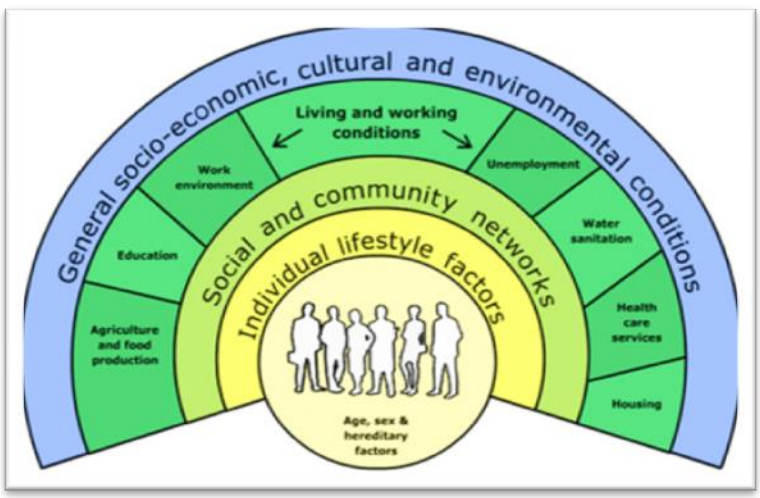
It is therefore essential to identify community based approaches with the payoff being to reverse this epidemic among our nation. The following avenues can be used to implement programs and policies that improve health.[113]

Community Settings—Policies that take into account the way a community is designed—in terms of physical space, walkability, access to healthy food grocers, and other factors—affect child and family health, as do policies that mitigate the socioeconomic factors that harm a child's ability to lead a healthy life. State efforts to promote a culture of wellness in communities have centered on strategies like transit-oriented development, complete streets, grocery store access, and local food procurement, even as states have worked to increase access to farmers' markets. Voluntary initiatives and public-private partnerships also promise to give kids healthier food and beverage options and more opportunities to be active.

Healthcare Settings—the healthcare setting presents an important opportunity to prevent obesity by better integrating prevention policies into Medicaid and other public health programs that engage millions of people.

The AAP created its Prevention of Obesity Policy Opportunities Tool for those healthcare professionals who have not been exposed to these community policy initiatives, and may not readily see the link between what they encounter with patients and clients each day and these policy approaches. (Located in the *"Online Resources"* section of this chapter).

When you make this connection, you become empowered to share powerful stories describing the negative impacts of policy inaction on your patients, and become a strong partner to address policy change to reverse the obesity epidemic.



Matching the Advocacy Activity to the Time Available[114]

Advocacy is achievable and it doesn't require a lot of time. The table below provides an overview of the types of community advocacy activities physicians and other healthcare professionals can engage in based on their time availability. We need your involvement. Change is difficult. It is in the aggregate that we can make significant changes, changes that will make a difference.

Effective advocacy can, and should be scaled to the time you have available to maximize the likelihood that you will continue your efforts.

Activity	< 1 Hour a Month	1 Hour a Month	>1 Hour a Month
Vote	X	X	X
Call, email or write a letter to a decision maker addressing your advocacy issue.	X	X	X
Contribute to a nonprofit advocacy organization that focuses on your advocacy issue.	X	X	X
Sign up for 1 or 2 email lists that are related to your advocacy issue.	X	X	X
Patronize businesses that donate a percentage of their profits to health issues related to preventing overweight and obesity in children.	X	X	X
Cultivate long-term relationships with a public official or other decision maker in your community who can impact your advocacy issue.		X	X
Write a letter to the editor of your local newspaper about your advocacy issue.		X	X
Talk to other healthcare professionals and parents that you come into contact with about the advocacy issue you care about. Encourage them to get involved.		X	X
Submit an article on your advocacy issue to your professional association's newsletter or website.		X	X
Attend community forums and events sponsored by decision makers who may have a say on your advocacy issue.		X	X
Testify before the state legislature or participate in community forums about your advocacy issue.			X
Apply for community advocacy grants.			X
Set up a booth in your professional setting that explains the issue you are working on that provides information to and resources for getting involved.			X
Serve as a spokesperson for a local issue or community based organization that is also addressing your advocacy issue.			X
Volunteer as a board member of a health organization working that is supportive of your advocacy issue.			X

California Medical Association Foundation's (CMA Foundation) Healthcare Professionals for Healthy Communities Initiative

Please join the California Medical Association Foundation's Obesity Prevention Project: *Healthcare Professionals for Healthy Communities Initiative* to promote important policy and environmental changes in schools and neighborhoods to counteract the obesity epidemic and support improved access to healthy food and opportunities to be physically active. The Initiative provides Healthcare Professionals with training on community collaboration, nutrition messages, and advocacy techniques to promote healthy eating and active living throughout California.

For more information, please see the following one pager or visit CMAF online at **http://thecmafoundation.org/.** To join the *Healthcare Professionals for Healthy Communities Initiative*, please fill out and submit the subsequent form.

Healthcare Professionals for Healthy Communities

An Initiative of the California Medical Association Foundation

90% of Californians surveyed stated that they wanted physicians to be their primary source of information about nutrition, physical activity and other health issues associated with obesity.

- Field Research Poll conducted by The California Endowment (2004)

The CMA Foundation is working to prevent obesity related diseases by turning healthcare professionals into community educators and advocates for healthy eating, physical activity and policy change in the battle against obesity. Through diverse partnerships with businesses, government, health plans and community organizations, the CMA Foundation will utilize healthcare professionals' expertise and credibility to maximize their impact on the obesity epidemic.

CMA Foundation Healthcare Professional Champions will receive:

- Provider, Community Outreach, and Advocacy toolkits
- Connections with school boards, city councils and many other organizations to spread the message of healthy living
- Assistance from CMA Foundation staff
- Access to online resources

Available Resources

- Guide for Health Care Professionals to Partner with Community Based Organization

- Community Based Organization and Health Care Professional Partnership Guide

Guides include strategies and tips to partner with health care professionals and community based organizations. Available online at: **www.thecmafoundation.org**.

"Engaged communities and engaged physicians are vital to the health of Californians. Please consider joining the CMA Foundation's efforts to turn the tide on the obesity epidemic in California."

-Frank Staggers, MD
Past Chair, CMA Foundation Board of Directors

CMA FOUNDATION

For more information about the *Healthcare Professionals for Healthy Communities* Initiative, please contact Vanessa Saetern, Obesity Prevention Project Coordinator, at (916) 779-6631 or **vsaetern@thecmafoundation.org**, or visit **http://www.thecmafoundation.org/projects/obesityProject.aspx**.

Healthcare Professionals for Healthy Communities
Are you ready to help *your* community become healthy and active?
Become a part of the Speaker's Bureau!

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Phone: (_____) _____ **Fax**: (_____) _____

Preferences:
County/City for Presentation: _____

_____

Time of Day and Week: _____

_____

Age Group: Children Adolescents Adults Families

Setting (school, community group, church, etc.):
_____

_____

Do you have any established contacts with groups you'd like to work with? (If yes, please detail):
_____

_____

_____

Advance notice required (number of days, weeks, etc.):_____

Please fill out and submit to Vanessa Saetern, Project Coordinator at vsaetern@thecmafoundation.org, FAX 916.779.6658, or 3840 Rosin Court Suite 200, Sacramento, CA 95834

California Medical Association Foundation's (CMA Foundation) Walk with a Doc Program

Please join the California Medical Association Foundation's Obesity Prevention Project: *Walk with a Doc Program* to encourage people to get out and walk with a physician. The *Walk with a Doc Program* provides general health information and moderate physical exercise in a supportive group environment. It's a free walk program open to the public, lead by local physicians and volunteers. The walks are held on Saturday mornings, lasting about an hour each and starts with a physician giving a quick 5-10 minute informational health talk. The program strives to encourage healthy physical activity in people of all ages, and reverse the consequences of a sedentary lifestyle in order to improve the health and well-being of the country.

More than half of all California adults age 18 and over are either overweight or obese, which can contribute to a number of chronic diseases. Research shows one of the most effective ways to address obesity is through exercise and physical activity and that walking for as little as 30 minutes a day can have significant benefits.

Physicians play a key role in reversing the obesity epidemic. Nearly 90 percent of Californians surveyed in a 2004 Field Research Poll indicated that they wanted to hear from their physicians about issues related to overweight and obesity. Lifestyle, environmental, and policy interventions that promote healthy eating and increased physical activity can significantly impact obesity and the risk for chronic disease. The CMA Foundation's Walk with a Doc program utilizes physicians' expertise and credibility to enact lifestyle changes.

Physician walk leaders and program volunteers are needed. Physician walk leaders and program volunteers must be energetic, enjoy meeting and motivating people and most importantly, include:

1. Working with the program team to plan the date and locations of the regular short, safe and friendly walks;
2. Helping promote the "Walk with a Doc" program to local people and communities and;
3. Supporting your fellow volunteers and any new Walk leaders.

To volunteer, please contact Vanessa Saetern at vsaetern@thecmafoundation.org or 916-779-6631. For more information on the CMA Foundation's "Walk with a Doc" program, please see the following one pager or visit our website at http://www.thecmafoundation.org/projects/wwaad.aspx.

"Walking offers countless health benefits and of course helps reduce a person's risk factors for heart disease…we started this program because it was an opportunity for us to connect with patients and hopefully, for walkers to have the motivation to come out and join us for 30-60 minutes. Learning about healthy lifestyle options and connecting with other walkers is an easy and fun way to get or stay fit."

-David A. Sabgir MD, FACC
Founding CEO, Walk with a Doc, www.walkwithadoc.org
Medical Director, Cardiac Rehabilitation, Mount Carmel Health System
Partner, Clinical Cardiovascular Specialists

VOLUNTEER TO BECOME A WALK LEADER

justwalk
a WALK WITH a DOC PROGRAM

Walk with a Doc was created to encourage healthy physical activity in people of all ages. It's a fun way to participate in your community and show your **passion for health and wellness!**

We need physician volunteers to lead walks in local parks on Saturday mornings. The walks last about an hour and begin with a physician providing a brief 10 minute talk about healthy living and the benefits of exercise.

To volunteer, contact Vanessa Saetern at (916) 779-6631, vsaetern@thecmafoundation.orgor visit our website http://thecmafoundation.org/projects/WWAAD.aspx for more information.

Your participation will **lead by example** and show our community that there are **fun steps** that can be taken to stay healthy.

What 1 Hour of your time each week can do:

- Dramatically alter your patients' lives by replacing a sedentary behavior with a healthy, active one.
- A 3-5 minute informational talk can educate your patients on exercise, nutrition and health.
- Immediately become recognized as a community leader and impact your community in a positive, life-changing way.

Funding provided by:

CMA FOUNDATION

Anthem BlueCross

Anthem Blue Cross Foundation

Online Resources

Fact Sheets	Obesity Fact Sheets	NICHQ's Obesity Factsheets provide the most recent national, state, and county-based data regarding childhood overweight and obesity prevalence and the environmental and behavioral factors that influence health. There are two kinds of Factsheets available: State Factsheets and County Factsheets (categorized by state). www.nichq.org/advocacy/obesity_resources/obesity_rates_map.html
Resource Guide	Resource Guide for Healthcare Professionals Interested in Advocating for Children's Health	The Advocacy Resource Guide (PDF) and Advocacy Toolbox (PDF) are designed to assist healthcare professionals to take a stand in their communities and workplaces to advocate for healthy eating and active living for children and their families. Whatever your level of time commitment, know that every effort you make is improving the health and wellbeing of children and families in your local area. www.nichq.org/advocacy/obesity_resources/toolkit.html
Training Curriculum	*Be Our Voice* Advocacy Training Curriculum	Hold a training to get other healthcare professionals involved in advocating for community change to impact the reversal of childhood obesity. By training others and building a coalition, your voice to advocate for children can be strengthened. www.nichq.org/advocacy/advocate_training/hostatraining.html
Webinars	*Be Our Voice* Self Study Resources and webinars	Self-study resources and webinars were developed through the BOV technical assistance calls from the sites. Choose the resources that best fit the needs in your community. www.nichq.org/advocacy/advocate_training/selfstudy.html
Monograph	Inspiring Change in our Communities: Physician Champions Making a Difference Monograph	The CMA Foundation's Obesity Prevention Project, "Inspiring Change in our Communities: Physician Champions Making a Difference" Monograph provides a snapshot of the innovative programs implemented by Physician Champions throughout California. Each of these physicians was inspired by a patient, an incident, or a movement. Some have dedicated months and years while others could only spare a few hours; and each has changed behavior to break the cycle of childhood obesity by empowering patients to take control of their health. http://thecmafoundation.org/projects/ObesityGeneralPDFs/final%20Obesity%20Monograph%207-23.pdf
Initiative	CMAF's Obesity Prevention Project: *Healthcare Professionals for Healthy Communities Initiative*	The *Healthcare Professionals for Healthy Communities Initiative* provides training on community collaboration, nutrition messages, and advocacy techniques to promote healthy eating and active living throughout California. The Initiative promotes important policy and environmental changes in schools and neighborhoods to counteract the obesity epidemic and support improved access to healthy food and opportunities to be physically active. www.thecmafoundation.org/projects/phyChampion.aspx
GIS Map	Network for a Healthy California - GIS Map Viewer	The Network for a Healthy California mapping application is an interactive, internet-based Geographic Information System (GIS) that allows users to view and query mapped nutrition data. The application contains a rich set of nutrition and other health related data, including: • Nutrition and school health programs • WIC grocery stores and other local nutrition resources • Demographics (race and spoken language) of general and at-risk populations • Various California Department of Public Health regions • Political (senate and assembly) districts www.cnngis.org

End Notes

[1]Flegal KM, Carroll MD, Ogden CL, et al. Prevalence and Trends in Obesity among U.S. Adults, 1999-2008. Journal of the American Medical Association, 303 (3):235-41, 2012.

[2] Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Obesity in the United States, 2009–2010. NCHS data brief, no 82. Hyattsville, MD: National Center for Health Statistics. 2012.

[3] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. The Evidence Report. National Heart, Lung and Blood Institute. September 1998. NIH publication no. 98-4083

[4] Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Obesity and Trends in the Distribution of Body Mass Index Among US Adults, 1999-2010. *JAMA*. 2012;307(5):491-497. doi:10.1001/jama.2012.39.

[5] U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001]. Available from: US GPO, Washington.

[6] Wolf AM, Colditz GA. Current estimates of the economic cost of obesity in the United States. *Obesity Research*.1998;6(2):97–106.

[7] Wolf, A. What is the economic case for treating obesity? *Obesity Research*. 1998;6(suppl)2S□S

[8] Finkelstein, EA, Trogdon, JG, Cohen, JW, and Dietz, W. Annual medical spending attributable to obesity: Payer- and service-specific estimates. *Health Affairs* 2009; 28(5): w822-w831.

[9] California Center for Public Health Advocacy (CCPHA). The Economic Costs of Overweight, Obesity and Physical Inactivity Among California Adults – 2006. Retrieved from http://www.publichealthadvocacy.org/costofobesity.html

[10] Roadmaps for Clinical Practice: Booklet 1 Introduction and Clinical Considerations. American Medical Association. Retrieved from www.ama-assn.org.

[11] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. Evidence Report. National Heart, Lung and Blood Institute. September 1998.

[12] The Surgeon General's Call to Action to Prevent and Decease Overweight and Obesity. US Department of Health and Human Services. Office of the Surgeon General, 2001. Retrieved from www.surgeongeneral.gov.

[13]Vainio H, Bianchini F. IARC handbooks of cancer prevention. Volume 6: Weight control and physical activity. Lyon, France: IARC Press, 2002.

[14] The United States of Diabetes: Challenges and opportunities in the decade ahead. Working Paper 5 November 2010. UnitedHealth Center for Health Reform & Modernization. http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper5.pdf

[15] Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

[16] Centers for Disease Control. Retrieved from
http://www.cdc.gov/diabetes/pubs/pdf/DiabetesReportCard.pdf
[17] Metabolic Syndrome. American Heart Association. Retrieved from http://www.americanheart.org/presenter.jhtml?identifier=4756.

[18] Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), Final Report, National Heart Lung, and Blood Institute. September 2002. Retrieved from www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf.

[19] Romero-Corral A, Caples SM, Lopez-Jiminez F, et al. Interactions between obesity and obstructive sleep apnea: implications for treatment. Chest. 2010;137:711–719.

[20] Yu JC, Berger P 3rd. Sleep apnea and obesity. S D Med. 2011;Spec No:28-34. http://www.ncbi.nlm.nih.gov/pubmed/21717814

[21] National Digestive Diseases Information Clearinghouse (NDDIC). Nonalcoholic Steatohepatitis. NIH Publication No. 07–4921. November 2006. Updated April 30, 2012. http://digestive.niddk.nih.gov/ddiseases/pubs/nash/
[22] NICHQ. "Creating a Healthy Pediatric/Family Practice Office Environment."

[23] California Medical Association & California Medical Association Foundation. Electronic Health Records Desk Reference.

[24] Industry Collaboration Effort – Better Communication, Better Care: Provider Tools to Care for Diverse Populations

[25]. Medicare Health & Drug Plan Quality and Performance Ratings. 2013 Part C & Part D Technical Notes, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/2013-Part-C-and-D-Preview-2-Technical-Notes-v100212-.pdf.

[26]. CQC's MedicareStarQuest Change Package: http://www.calquality.org/programs/clinicalcare/pastprogs/documents/starquest/Change_Package-Clinical_Metrics.pdf.

[3]. CQC Medicare StarQuest conference program resources: http://www.calquality.org/programs/clinicalcare/pastprogs/starquest.html.

[27] Primer: CMS Star Ratings for Medicare Advantage Plans at www.calquality.org/programs/clinicalcare/.../4_StarsPrimerforGroups.pptx.

[28] Reid, Rachel O., Deb, Partha, Howell, Benjamin L., and Shrank, William H., Association Between Medicare Advantage Plan Star Ratings and Enrollment. JAMA, January 16, 2013 – Vol. 309, Nov 3. (p 267-274).

[29] Medicare Stars Measures, Differences Between the 2011 Plan Ratings and 2012 Plan...For Assigning Part C and D Measure Star Ratings; Aug 4, 2011. www.calquality.org/documents/Technical_Notes_2012.pdf.

[30] Presenting CMS Stars to Practicing PCP's at http://www.calquality.org/programs/clinicalcare/resources/documents/Presenting_CMS_Stars_to_Practicing_PCPs.pdf.The Health Outcomes Survey® (HOS) is administered by CMS annually to obtain data for the first four measures in the table. The results are based on patient recall for each topic. Ratings for the last two measures are derived from responses to questions administered bi-annually to the same cohort of members. Functional status results from the baseline survey are compared to responses on the follow-up survey to assess decline in functional status. Functional status questions are based on patient perception of physical and mental health status.

[31] The Consumer Assessment of Healthcare Providers & Systems® (CAHPS) is administered annually by certified survey vendors hired by health plans. The first two questions in the table rely on patient recall of flu and pneumonia vaccines rather than administrative (claim/encounter) or medical record review data.

[32] This information is submitted by the plans to CMS.

[34] California Academy of Family Physicians Foundation. "Addressing Language and Culture a Practice Assessment for Health Care Professionals." (2007).

[35]http://www.census.gov/popest/data/state/totals/2012/tables/NST-EST2012-02.xls
http://www.census.gov/hhes/socdemo/language/data/acs/ACS-12.pdf

[36] Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.

[37] Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.

[38] Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.

[39] Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.

[40] Addressing Language and Culture: A Practice Assessment for Health Care Professionals. Sponsored by the California Academy of Family Physicians Foundation.

[41] Harvinder Sareen, PhD, Diane Vicensio, RN, MPH, Shirley Russ, MB, ChB, MPH, Neal Halfon, M.D., MPH. The Role of State Early Childhood Comprehensive Systems in Promoting Cultural Competence and Effective Cross-Cultural Communication. National Center for Infant and Early Childhood Health Policy. No. 8. July 2005.

[42] Culturally Competent Health Care. Oliver Goldsmith, MD. The Permanente Journal. Winter 2000/Vol. 4, No. 1.

[43] ACOG Statement: Cultural Sensitivity Allows Quality Care. Laurie Barclay, MD. May 2, 2001

[44] National Center for Cultural Competence. Referenced in Educating Physicians to Provide Culturally Competent, Patient-Centered Care. Robert C. Like, MD, MS; Theresa J. Barrett, MS; Jeffrey Moon. Summer 2008

[45] Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. *A Provider's Handbook on Culturally Competent Care Asian and Pacific Islander Population 2nd edition* (2003).

[46]Berlin EA, Fowkes WC. A Teaching Framework for Cross-cultural Health care – Application in Family Practice. *West J Med.* 1983; 139(6): 934-8.

[47]Kobyarz FA, Heath JM, Like RC. The ETHNIC(S) mnemonic: a clinical tool for ethnogeriatric education. *J Am Geriatr Soc.* 2002; 50(9): 1582-9.

[48]Betancourt JR, Carrillo JE, Green AR. Hypertension in multicultural and minority populations: linking communication to compliance. *CurrHyptens Rep*. 1999; 1(6): 482-8.

[49]Adapted from Kaiser Permanente's Culturally Competent Care Card

[50]The Provider's Guide to Quality & Culture. Non-verbal Communication, Management Sciences for Health. http://erc.msh.org/

[51] American College of Preventive Medicine. Coaching and Counseling Time Tool. Retrieved from http://www.acpm.org/?CoachingClinRef_Clin#MotivationalInterviewing.

[52]Otten, JJ; Jones, KE; Littenberg, B; Harvey-Berino, J.*Arch Intern Med.* 2009;169(22):2109-2115.

[53] The Practical Guide – Identification, Evaluation and Treatment of Overweight and Obesity in Adults. NLHBI Obesity Education Initiative. National Institutes of Health. October 2000.

[54] Roadmaps for Clinical Practice: Booklet 1 Introduction and Clinical Considerations. American Medical Association. Retrieved from www.ama-assn.org.

[55]Flegal et al, JAMA, April 2005, Vol.293, No.15.

[56]Mokdad et al, JAMA, March 10, 2004, Vol.291, No. 10.

[57] The Practical Guide – Identification, Evaluation and Treatment of Overweight and Obesity in Adults. NLHBI Obesity Education Initiative. National Institutes of Health. October 2000.

[58] BMI and Waist Circumference Classifications and Disease Risk. AACE/ACE Position Statement on the Prevention, Diagnosis, and Treatment of Obesity, AACE/ACE Obesity Task Force; Endocrine Practice, Vol. 4, No.5, 1998.

[59] U.S. Preventive Services Task Force; Screening for Obesity in Adults: Recommendations and Rational, American Family Physician; Vol.69, No.8.2004.

[60] Bray G. Office Management of Obesity. U.S.: Elsiver Inc. 2004.

[61] About BMI for Adults. Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI

[62] Body Mass Index. Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/nccdphp/dnpa/bmi/index.htm.

[63] Roadmaps for Clinical Practice: Booklet 2 Assessment and Management of Adult Obesity. American Medical Association. Retrieved from www.ama-assn.org.

[64] Kline S. et al. Waist circumference and cardiometabolic risk: a consensus statement from Shaping American's Health: Association for Weight Management and Obesity Prevention; NAASO, The Obesity Society; the American Society for Nutrition; and the American Diabetes Association. Am J ClinNutr 2007; 85: 1197-202.

[65] Kushner RF. Roadmaps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion—Assessment and Management of Adult Obesity: A Primer for Physicians. Chicago, Ill: American Medical Association; 2003.

[66]http://www.mayoclinic.com/health/cholesterol-levels/CL00001

[67] U.S. Department of Health and Human Services - National Institutes of Health. Urine Albumin-to-Creatinine Ratio (UACR). NIH Publication No. 10-6286 March 2010. Accessed December 2012. http://www.nkdep.nih.gov/resources/quick-reference-uacr-gfr-508.pdf

[68] PubMed Health. A.D.A.M. Medical Encyclopedia. Total protein. Last reviewed: May 30, 2011. Accessed December 2012.http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0003954/

[69] PubMed Health. A.D.A.M. Medical Encyclopedia. ALP. Last reviewed: May 30, 2011. Accessed December 2012. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0003941/

[70] PubMed Health. A.D.A.M. Medical Encyclopedia. AST. Last reviewed: February 20, 2011. Accessed December 2012. http://www.nlm.nih.gov/medlineplus/ency/article/003472.htm

[71] PubMed Health. A.D.A.M. Medical Encyclopedia. Bilirubin - blood. Last reviewed: February 20, 2011. Accessed December 2012. http://www.nlm.nih.gov/medlineplus/ency/article/003479.htm

[72]Seagle HM, Strain GW, Makris A, Reeves RS; American Dietetic Association. Position of the American Dietetic Association: weight management. J Am Diet Assoc. 2009 Feb;109(2):330-46.

[73] Wu, T., Gao, X., Chen, M. and Van Dam, R. M. (2009), Long-term effectiveness of diet-plus-exercise interventions vs. diet-only interventions for weight loss: a meta-analysis. Obesity Reviews, 10: 313–323. doi: 10.1111/j.1467-789X.2008.00547.x

[74]Seagle HM, Strain GW, Makris A, Reeves RS; American Dietetic Association. Position of the American Dietetic Association: weight management. J Am Diet Assoc. 2009 Feb;109(2):330-46.

[75]167. http://www.ahrq.gov/clinic/uspstf/uspsobes.htm.

[76] 169. http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm.

[77] The Practical Guide – Identification, Evaluation and Treatment of Overweight and Obesity in Adults. NLHBI Obesity Education Initiative. National Institutes of Health. October 2000.

[78] Internal Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). National Center for Health Statistics. Retrieved from www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm.

[79] NHLBI Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Obesity in Adults (US). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. Bethesda (MD): National Heart, Lung, and Blood Institute; 1998 Sep. Chapter 4, Treatment Guidelines. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2004/

[80] What a Registered Dietitian Can Do for You. American Dietetic Association. www.eatright.org.

[81] Medical Nutrition Therapy. American Dietetic Association. www.eatright.org.

[82] RDs and Medical Nutrition Therapy Services. American Dietetic Association. www.eatright.org.

[83] Nutrition therapy services (medical). Centers for Medicare & Medicaid Services. http://www.medicare.gov/coverage/nutrition-therapy-services.html

[84]Seagle HM, Strain GW, Makris A, Reeves RS; American Dietetic Association. Position of the American Dietetic Association: weight management. J Am Diet Assoc. 2009 Feb;109(2):330-46.

[85] Choose MyPlate. United States Department of Agriculture. http://www.choosemyplate.gov/.

[86] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. National Institutes of Health. National Heart, Lung, and Blood Institute. Your Guide to Lowering Your Blood Pressure with DASH. NIH Publication No. 06-4082. Originally Printed 1998. Revised April 2006. http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf

[87]Healthwise Staff. Low-calorie diet. WebMD. http://www.webmd.com/diet/low-calorie-diet.

[88] What is a Very Low-Calorie diet? Weight Control Information Network. US Department of Health and Human Services. Retrieved from http://win.niddk.nih.gov/publications/low_calorie.htm#whatis.

[89] WebMD. High Protein, Low Carb Diets. Retrieved from http://www.webmd.com/diet/high-protein-low-carbohydrate-diets.

[90] Just Enough For You: About Food Portions. Weight-control Information Network. U.S. Department of Health and Human Services National Institutes of Health. www.win.niddk.nih.gov. January 2003. Updated August 2006.

[91] Just Enough For You: About Food Portions. Weight-control Information Network. U.S. Department of Health and Human Services National Institutes of Health. www.win.niddk.nih.gov. January 2003. Updated August 2006.

[92] How much physical activity do adults need? Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. December 1, 2011. http://www.cdc.gov/physicalactivity/everyone/guidelines/adults.html.

[93]Physical Activity and Health. Centers for Disease Control and Prevention. http://www.cdc.gov/physicalactivity/everyone/health/index.html.

[94] Target Heart Rate and Estimated Maximum Heart Rate. Centers for Disease Control and Prevention. Last updated: March 30, 2011. http://www.cdc.gov/physicalactivity/everyone/measuring/heartrate.html

[95] Losing Weight - Physical Activity and Calories. American Heart Association. http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/LosingWeight/Losing-Weight_UCM_307904_Article.jsp

[96] NHLBI Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Obesity in Adults (US). Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. Bethesda (MD): National Heart, Lung, and Blood Institute; 1998 Sep. Chapter 4, Treatment Guidelines. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2004/

[97] Miller RW, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York, NY: The Guilford Press; 1991.

[98]Rogers CR. Client-centered therapy. Its current practice, implications and theory. Boston, MA: Houghton Mifflin Co; 1951.

[99] The Practical Guide – Identification, Evaluation and Treatment of Overweight and Obesity in Adults. NLHBI Obesity Education Initiative. National Institutes of Health. October 2000.

[100] How Are Overweight and Obesity Treated? National Heart, Lung, and Blood Institute. July 13, 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/obe/treatment.html#.

[101] Prescription Weight Loss Drugs: What Are the Options? Drugs.com. http://www.drugs.com/article/prescription-weight-loss-drugs.html

[102] How Are Overweight and Obesity Treated? National Heart, Lung, and Blood Institute. July 13, 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/obe/treatment.html#.

[103] How Are Overweight and Obesity Treated? National Heart, Lung, and Blood Institute. July 13, 2012. http://www.nhlbi.nih.gov/health/health-topics/topics/obe/treatment.html#.

[104] Position of the American Dietetic Association: Integration of Medical Nutrition Therapy and Pharmacotherapy. American Dietetic Association. J Am Diet Assoc. 2010;110:950-956.

[105] Bariatric Surgery for Severe Obesity. WIN. Weight-control Information Network. U.S. Department of Health and Human Services. NATIONAL INSTITUTES OF HEALTH. NIH Publication No. 08– 4006 March 2009. Updated June 2011.

[106] Consumer Health Information in Many Languages Resources. National Network of Libraries of Medicine. http://nnlm.gov/outreach/consumer/multi.html

[107] Internal Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). National Center for Health Statistics. Retrieved from www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm.

[108] ICD9-CM Official Guidelines of Coding and Reporting. Center for Medicare and Medicaid Services. Retrieved from www.cms.gov.

[109] The new ICD-9 codes that every internist should know. American College of Physicians. Retrieved from http://www.acponline.org/clinical_information/journals_publications/acp_internist/sep05/coding.htm.

[110] HCPCS Background Information. US Department of Health and Human Services. Retrieved from www.cms.hhs/gov/medhcpsgeninfo.

[111] Nutrition therapy services (medical). Centers for Medicare & Medicaid Services. http://www.medicare.gov/coverage/nutrition-therapy-services.html

[112]American Academy of Pediatrics (AAP). *AAP Advocacy Guide: Pointing you in the right direction to become an effective advocate*. 2009. Pg. 24

[113]Mulheron, Joyal, and Vonasek, Kara. NGA Center for Best Practices - Health Division. September 2009. Shaping a Healthier Generation: Successful State Strategies to Prevent Childhood Obesity.

[114]American Academy of Pediatrics (AAP). AAP Advocacy Guide: Pointing you in the right direction to become an effective advocate. 2009 pp19-21, 25. Available at: www.aap.org/moc/advocacyguide.


CMA
FOUNDATION


California
Association
of Health Plans