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**TOOLS IN THE TRENCHES: WHAT CLINICIANS CAN DO ABOUT POOR FITNESS, OBESITY,
AND CHRONIC DISEASE**

The twin epidemics of obesity and diabetes have clinicians asking, "What can I do to help my patients?"

The primary causes of these epidemics are social and environmental. Many small changes have made it more difficult for us to be physically active and eat in a healthy way. The ubiquity of high-calorie snacks within easy reach, and new communities designed so that it's necessary to drive rather than walk are important contributors.

Although this is a social problem, experience addressing other health hazards, such as tobacco, has demonstrated that health care providers are opinion leaders in the policy arena. You have credibility because of your education and because you see the effects of obesity every day in your practice. You have a great deal to contribute to local coalitions working to address these issues; but when you see individual patients you can also play a role.

Until recently, the evidence supporting health systems-based weight management has been sparse. In this issue of the *CD Summary*, we review what's out there, examine data on Oregonians' physical activity and nutrition patterns, and provide a resource healthcare providers can use in an office setting.*

THE EVIDENCE

1) Weight assessment is a key first step. The U.S. Preventive Services Task Force (USPSTF)¹ recommends that clinicians screen all adult patients for obesity by calculating a body mass index (BMI = weight in kilograms/

height in meters²) and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (those with a BMI over 30).

2) Intense, multi-disciplinary interventions work. The recommendation above was adopted by the USPSTF in light of evidence from multiple studies that intensive counseling (defined as contact more than once a month during the first 3 months of treatment) is of benefit when combined with regular physical activity and caloric restriction. Counseling without this other support was not as effective. Many of the successful programs were multi-disciplinary and involved nutritionists and other ancillary staff, rather than requiring the clinician to "do it all". These programs resulted in sustained weight loss of 3-5kg after one year, significantly more than that seen in controls.^{2,3} To help an obese patient lose weight and keep it off, periodic contact and reinforcement with behavioral therapy have been associated with sustained weight loss after follow-up of up to 60 months.³ Examples of behavioral therapy approaches include coaching on portion size to limit caloric intake, and developing strategies to integrate physical activity into one's daily routine.

3) Promote regular physical activity. The Institute of Medicine recommends at least one hour of moderate to vigorous activity each day to promote weight control.⁴ In addition, resistance training increases muscle mass; and, pound for pound, muscle takes more calories to maintain than

fat. Of course, you can tailor your recommendations based on the needs of your patient. For someone with a BMI well below 25kg/m², even 30 minutes of moderate activity (such as walking) 5 times a week or 20 minutes of vigorous activity 3 or more times a week can lessen the risk of hypertension and cardiovascular disease.⁵ Smaller or less frequent amounts of physical activity are, no doubt, salubrious as well, we just don't have the evidence to confirm their benefit.

4) Limit caloric intake. Physical activity is tremendously important. Still, you'd have to run 10 miles to work off the 1,100 calories you'd get from a half-pound cheeseburger and a large order of fries. In the words of the 2005 Dietary Guidelines Advisory Committee,⁶ an expert panel appointed by the Secretaries of Agriculture and Health and Human Services, "When it comes to weight control, calories *do* count – not the proportions of carbohydrate, fat, and protein in the diet." Caloric restriction in association with a physical activity program and behavioral therapy promoted weight loss, regardless of whether the diet was low fat or low carbohydrate.² However, a low-fat diet, (<30% of calories from fat, <300mg cholesterol) is recommended due to potential beneficial effects on lipids.⁷

HOW ARE OREGONIANS DOING CURRENTLY?

In a phrase, we're quite heavy, across the age span. Among Oregon adults in 2005, 60% reported a BMI that would classify them as either overweight (36%) or obese

* Many thanks to a group of clinicians that has been meeting with us over the past two years to review the literature and develop evidence-based strategies for weight management in the clinical setting. Please see references for sources consulted.



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(24%). Among Oregon teens, 25% of 8th graders reported a BMI that would classify them as overweight or at risk of overweight, as did 25% of 11th graders[†]. Almost one third (32%) of Oregon children 2-5 years of age receiving services from the Women's Infant and Child (WIC) nutrition program were overweight or at risk for it, higher than the national average of 30%.**

Given current patterns of physi-

cal activity and nutrition in Oregon, the prevalence of obesity isn't surprising. Just 26% of adult Oregonians in 2005 ate five or more servings of fruits or vegetables daily. Only 56% of adult Oregonians met the relatively minimal CDC recommendations for physical activity (≥ 30 min. of moderate exercise at least five days a week, or ≥ 20 minutes of vigorous exercise at least three days a week).

Among adolescents and younger kids, the recommendation from the 2005 *Dietary Guidelines for Americans* is for 60 minutes of physical activity most days of the week (preferably daily). In Oregon, only 58% of 8th graders and 49% of 11th graders meet these minimum recommendations. On the food side only 18% of 11th graders report eating five or more servings of fruits or vegetables a day. Further, only 17% of 11th graders drank 3 or more glasses of milk a day, while 28% report drinking seven or more soft drinks per week.

A RESOURCE FOR WEIGHT MANAGEMENT

The *Guide to prevention and treatment of overweight and obesity in adult primary care* was developed by Kaiser Permanente. It includes practical suggestions outlining how to start conversations about weight management with patients who might benefit, as well as a straight-

forward, evidence-based algorithm for identifying weight-management issues, recognizing important co-morbidities, assessing patient readiness for weight-management interventions, and initiating appropriate treatment. It is available at http://xnet.kp.org/communitybenefit/chil/tools/docs/other_resources/KP%20Community%20Weight%20Management%20Guide.pdf. Printed copies can be obtained from Keith.H.Bachman@kp.org.

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Dietary Pointers from the 2005 Dietary Guidelines for Americans⁴

- * Encourage patients to "choose fats wisely". By recognizing and limiting foods high in saturated fat and trans fat. The ideal is to keep saturated fat below 10% of calories and trans fat below 1%. If patients don't feel up to label reading, suggest that they limit saturated fat by decreasing intake of animal fats. For trans fats, they can limit products with partially hydrogenated vegetable oils.
- * Help patients "choose carbohydrates wisely". You might recommend avoiding empty calories like sugared soft drinks, and replacing refined carbohydrates with whole grain products.
- * Encourage intake of fruits and vegetables. Eating 5-13 servings (2 ½ - 6 ½ cups) of fruits and vegetables per day is associated with reduced risk of cardiovascular disease, diabetes (vegetables more than fruit) and can be a useful component of programs designed to achieve and sustain weight loss.

[†] In youngsters under 18 years of age, "overweight" is defined by a BMI for age and sex above the 95th percentile; "at risk of overweight" is defined by a BMI between the 85th and 95th percentiles.

** These data for young children are based on actual measurements of height and weight, rather than self-report, which is used for teens and adults. Self-reported BMI is generally an underestimate of true BMI.