Clinicians and staff are motivated to address obesity in primary care but often encounter significant systematic barriers.

The ins and outs of providing obesity services in primary care settings: The Making Obesity Services and Treatments work (MOST) study.

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CONTEXT
- Obesity remains as a prevalence and challenging public health issue.
- Primary care (PC) providers and staff are recommended to screen patients for obesity and offer intensive, multicomponent behavioral therapy.1
- In 2011, The Centers for Medicaid and Medicare Services approved the use of a new code for providing Intensive Behavioral Therapy (IBT) services for patients with obesity.2
- However, this benefit is significantly underutilized—less than 1% of eligible Medicare beneficiaries have participated in IBT.

OBJECTIVE
- Understand the experience and provision of obesity services among primary care providers and staff, including use of IBT.

SETTING & PARTICIPANTS
- PC practices in 14 states selected regionally that submitted claims >10 Medicare beneficiaries per year between 2012-2016 and random sampling that did not submit claims at this level
- Practice-Based Research Networks and Professional Organizations

DESIGN & METHODS
- Descriptive, qualitative study
- Written Survey of practice characteristics (N = 291)
- Individual semi-structured interviews (N = 85)
- Qualitative thematic analysis (data triangulation and constant comparative technique)

KEY RESULTS & QUOTES

“Treating obesity is an essential part of primary care.”

- Almost all providers expressed a strong passion to providing obesity care and great joy in helping patients:
  - “The primary care physician has an incredible opportunity and influence to help with weight control. We’re the front line.”
  - “You get to celebrate stuff with them ... and that gives you some of your job satisfaction back.”

“So for those patients, I got all rejections back which was really discouraging for me. It didn’t work.”

- High frustration with low reimbursement rates and those experienced with IBT Medicare billing found it difficult and burdensome:
  - “As a nurse practitioner, she takes a bit away from Medicare already on reimbursement. I think that part’s a little bit frustrating... we’re not doing it because we want to make money, but we certainly want to be profitable.”

- RDs experienced great frustration with billing under the “incident to” criteria for IBT:
  - “The fact that the dietitian had to do it incident to rather than using their own number was an issue. Well there were a lot of issues.”

- Providers that specialize in obesity medicine added or revered to self-pay in addition to using various insurance billing codes.
  - “That’s my other gripe. They are self-pay as soon as their BMI’s falls below 30.”
  - “So we actually give a 40% discount if they have to self-pay.” (If patients move to self-pay and get MNT codes)

“Successful” Approaches to Obesity Management

- Practices self-described as “successful” have established protocols for obesity services, including multidisciplinary staff (MD/DG, APP, RD, BHP) and have a specified plan and approach for weight loss:
  - “We really focus on the five pillars, which is diet, exercise, sleep, relaxation, and brain activity. And all those modules have lots and lots of things underneath it that we work with them on to make it work, and we’re basically teachin’ ’em how to eat better, be active, and get their sleep in.”
  - “So we really like to think of ourselves as providing comprehensive care... I’ll start off with a nutritional inventory, and we actually view the nutritional part to be the biggest piece that we really want to have a firm foundation with, so sometimes, we do offer a medical meal replacement program”

DISCUSSION

- PC Providers have strong inherent value and belief to prevent and treat obesity.
- Many hassles with IBT for obesity benefit have caused many have to stop using it.
- Providers experienced varied emotions to obesity treatment:
  - Very satisfying to help patients but the emotional toll of managing obese patients in a challenging and complex treatment system is stressful.
  - Some practices have a successful process and protocol to obesity management, which requires dissemination to other practices to help reduce overall burden and prevalence of obesity.

<table>
<thead>
<tr>
<th>Table 1. Practice Characteristics (N = 291)</th>
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<tbody>
<tr>
<td>Practitioners who provide obesity services</td>
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<tr>
<td>Physicians</td>
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<tr>
<td>NP/APP</td>
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<tr>
<td>Registered dietitians</td>
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<tr>
<td>Physician assistants</td>
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<tr>
<td>Other</td>
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<tr>
<td>Registered nurses</td>
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<td>Resident physicians</td>
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<td>Social workers</td>
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Types of regular obesity services

- Brief advice during regular encounter visit 225 (77.3%)
- Patient education materials on weight loss 209 (71.8%)
- Brief advice during obesity specific encounter 183 (62.9%)
- Referral to bariatric surgery 164 (56.4%)
- Weight loss medication 154 (52.9%)
- IBT counseling for obesity 118 (40.5%)
- Referrals to weight loss programs and services 113 (38.8%)
- Medical supervision of meal replacement programs 59 (20.3%)
- Other 47 (16.2%)
- Education materials on insurance coverage of obesity 45 (15.5%)
- On site group weight loss 40 (13.7%)

Submitted claims for obesity treatment

- Private Insurance 141 (48.5%)
- Medicare 133 (45.7%)
- Medicaid 55 (18.9%)
- Not Submitting Claims 51 (17.5%)
- Not Sure 45 (15.5%)

Submit claims under the Medicare IBT code G0447

- Yes 97 (33.3%)
- No, never used 87 (29.9%)
- Not sure 55 (18.9%)
- Missing 33 (11.3%)
- No, have used 19 (6.5%)

References
2. DHHS for CMS, Intensive Behavioral Therapy (IBT) for obesity, 2014

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