Weight management for patients in general practice tailored to health literacy

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Policy context

Obesity rates have increased in Australia and present a significant health challenge, particularly for people from low socio-economic communities and people with low health literacy. General practices have an important role to play in helping obese patients manage their weight. The National Health and Medical Research Council (NHMRC) provide guidelines for the management of overweight and obesity in Australia. These guidelines are based on the 5As of the chronic disease model approach: Assess, Advise, Agree, Assist and Arrange. However, evidence suggests poor implementation in general practice across the 5As, especially in the provision of Advice, Assist (referral) and Arrange (follow-up). This is due to barriers that operate at the patient, practitioner, practice and system levels. The complexity of information involved in weight management and patients’ lack of health literacy are key obstacles, especially for patients from vulnerable and disadvantaged groups.

A program of work was conducted to evaluate the feasibility and impact of a primary health care approach to weight management for obese patients tailored to their level of health literacy. A literature review and a pilot study were used to develop a weight management intervention called “Better Management of Weight in General Practice” (BMWGP), which aimed to improve the management of obesity in patients with low health literacy attending general practices in low socio-economic areas. Providers (general practitioners (GPs) and PNs) were trained in the implementation of the 5As for obesity management and ways of identifying and communicating with patients with low health literacy.

The BMWGP trial was a pragmatic cluster randomised trial of the intervention in 20 general practices in Sydney and Adelaide. Patients with a BMI ≥ 30 kg/m², aged 40–70 years and fulfilling other inclusion criteria were recruited. Control practices received training on a different topic (cardiovascular disease (CVD) risk) and continued to provide usual care. Data collection was conducted at baseline, 6 months and 12 months after the intervention. Data included audits of clinical records and interviews with patients and providers. Patients’ BMI and other risk factors were assessed by the PNs.

Policy options

Australia’s federal and state governments have implemented a variety of strategies to prevent and manage chronic diseases and their risk factors. A new framework is currently being developed that recognises the importance of risk factors, such as obesity, which is common to many long-term conditions, and the need to specifically prioritise actions that address risk factors in disadvantaged communities.
population groups. The second draft framework identifies the need for strategies to ensure that people with varying levels of health literacy receive health advice tailored to their needs and are able to comprehend health information to meet their health needs. This study provides evidence to inform the implementation of these strategies.

At the federal and state government levels, there is a need to develop:

> Patient education materials on obesity management that are appropriate for patients with low health literacy and different language groups and made readily accessible through practice software as well as via the internet and social media. Many currently available materials are not independent or evidence-based and do not meet standards for readability or health literacy.

> A funding model that will support general practices to be more proactive in the identification and support of obese patients with low health literacy. PNs can be effective in tailoring advice and education for obese patients with low health literacy and providing them with navigation support to attend referral programs. However, they need training and they need to be adequately remunerated for their time.

At the local or regional level,

> Primary Health Networks (PHNs) need to train PNs and GPs and provide practice support visits to improve the identification and support of obese patients with low health literacy to manage their weight across the 5As. This training and practice support needs to address the following areas:

  o Identification of obese patients with low health literacy and differentiation of low health literacy from low motivation

  o Tailoring advice and education to patient health literacy while mitigating the stigma associated with obesity

  o Providing patient navigation to evidence-based local or telephone/online referral programs using information that is up-to-date and readily available at the point of care on what to expect about costs, availability, location, format, content and other participants.

> PHNs need to work with state and local governments, non-government and community organisations, and private providers to develop referral options and pathways for the weight management of obese patients. These options and pathways need to be appropriate for low health literacy patients, who are non-English speaking and who are part of disadvantaged groups. They should take a variety of forms, including telephone, online and face-to-face (individual and group) programs, for patients and their providers to choose from. The performance of these referral pathways needs to be monitored, especially the levels of referral and attendance, cost, availability and feedback mechanisms to general practice.
Key findings

Literature review
The review found evidence for the effectiveness of interventions that focussed on improving knowledge and skills (health literacy) for weight loss.

The pilot
> It was feasible to screen patients for low health literacy in general practice
> The intervention had an impact on recording of preventive care in patients’ notes but did not alter the way that providers delivered patient education or arranged patient referrals.

BMWGP - baseline patient data
> 10-20% of patients were identified as having low health literacy using a short screening questionnaire. However, while those identified by screening were confirmed to have low health literacy, it is probable that some patients were missed.
> Low health literacy was associated with smoking, higher BMI, and poor mental and physical health status.
> Four in 5 patients were trying to lose weight. One-third of patients had experienced weight-related stigma in the previous week. The quality of life was higher in those who were employed, had lower BMI, did more physical activity and had higher health literacy.

Baseline data on GP and PN behaviour
> The attitudes of most GPs and PNs were positive towards the treatment of obesity and considered managing it as part of their role. However, only 15% reported being successful helping obese patients manage their weight.
> Low levels of implementation of 5As related to assessment, advice and referral.
> GPs and PNs self-reported rarely assessing health literacy and about half reported they tailored advice to patients’ health literacy, but only one-third reported using ‘teach-back method’ or assisting access to referral.
> PNs were more likely than GPs to report uncertainty in how to manage health literacy, suggesting a possible need for training in this area.

Changes in practitioner behaviour at 12 months
> PNs and GPs in intervention practices demonstrated greater improvement in self-reported behaviour and confidence in assessing obese patients with low health literacy and providing advice and referral to them for weight loss compared with the control group. improvements included tailoring advice, using specific communication techniques, such as teach-back and encouraging questioning, assisting access to referral and following up on referral.

Changes in patient receipt of preventive care and health literacy skills 6 months after the intervention
> intervention group patients were more likely than the control group to report having received assessment, advice and referral for weight loss.
> intervention group patients reported a greater increase in health literacy skills in three of the nine domains of the Health Literacy Questionnaire than did the control group.