

EDITORIAL



Obesity Treatment in Primary Care — Are We There Yet?

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The U.S. Preventive Services Task Force recommends that clinicians arrange for their obese patients to receive intensive, multicomponent behavioral weight-loss counseling.¹ However, less than 50% of primary care physicians (PCPs) report that they consistently provide diet and weight-control advice to their adult patients with weight-related disease, and less than 25% regularly refer patients for further management or track their weight-control behaviors over time.²

Recognizing the need for effective weight-management treatments that can be implemented in the primary care setting, the National Heart, Lung, and Blood Institute funded the Practice-based Opportunities for Weight Reduction consortium,³ a group of independent but coordinated comparative-effectiveness trials of weight-loss interventions delivered in primary care settings to obese patients with cardiovascular risk factors. The primary outcome was weight change at 2 years. In this issue of the *Journal*, the results of two of these studies^{4,5} are presented.

In the study by Wadden et al.,⁴ usual care (counseling provided at quarterly PCP office visits) was compared with the addition of brief lifestyle counseling (monthly, 15-minute, in-person counseling visits by trained medical assistants) and with enhanced lifestyle counseling (brief lifestyle counseling plus a toolbox that included meal replacements and weight-loss medications). Although weight loss in the brief-lifestyle-counseling group (2.9 kg) and the usual-care group (1.7 kg) did not differ significantly at 2 years, participants in the enhanced-lifestyle-counseling group lost significantly more weight (4.6 kg) than did those in either of the other two groups and were more likely to lose at least 5% of their initial body

weight (35% in the enhanced-lifestyle-counseling group, vs. 26% in the brief-lifestyle-counseling group and 22% in the usual-care group).

In the study by Appel et al.,⁵ participants from six primary care practices were randomly assigned to a self-directed weight-loss program (control group); to in-person individual sessions plus group sessions, along with electronic and telephone contacts delivered by office-based lifestyle coaches (in-person support); or to a commercial call center–directed group in which coaches delivered all lifestyle interventions by telephone, Internet, and e-mail (remote support). Physicians supported the delivery of the interventions, reviewed participants' weight status, and at routine medical visits encouraged participants to be engaged with the weight-loss treatment. Weight loss at 2 years was similar in the groups that received in-person support (5.1 kg) and remote support (4.5 kg) and was significantly greater than the weight loss in the control group (0.8 kg). Participants assigned to either the in-person or the remote lifestyle intervention were twice as likely as those assigned to the control group to have lost 5% or more of their initial body weight at 2 years (41% for the in-person group and 38% for the remote group, vs. 19% for the control group).

A well-recognized issue that affects the sustainability of behavioral interventions is that attendance at face-to-face counseling sessions decreases substantially over time. In the study by Wadden et al., participants in both the brief-lifestyle-counseling and the enhanced-lifestyle-counseling groups attended fewer than half the scheduled counseling visits during year 2. Similarly, in the study by Appel et al., those assigned

to the in-person group participated in only 2 of 24 recommended face-to-face individual and group sessions between month 7 and the end of the trial. In contrast, those assigned to the remote group participated in a median of 16 of 18 recommended telephone contacts during that time. Given that remotely delivered coaching resulted in weight-loss outcomes similar to those of in-person visits, the use of mobile technologies to deliver behavioral weight-loss treatment in primary care appears to be promising. Such interventions may present fewer barriers to adherence than interventions delivered in person, since they allow for greater scheduling flexibility, decreased travel time, and lower transportation costs. In addition, a telephone-based coaching program has the potential for widespread implementation in multiple practice settings, including geographically isolated areas.

Both these studies provide evidence that PCPs can deliver safe and effective weight-loss interventions in primary care settings. However, there are important caveats. Although described as “effectiveness” rather than “efficacy” studies, both studies provided treatments (including lifestyle coaching, counseling, and, in the case of the Wadden study, meal replacements and medications) at no cost to the participants. Whether patients would be willing to pay for these therapies, or insurers would be willing to reimburse for them, is not known. Determining the costs and cost-effectiveness of these and other treatments in primary care settings is crucial. In addition, these two studies were not powered to detect differences in cardiovascular risk reduction, and there were no consistent between-group differences with respect to lipid levels, glucose levels, or blood pressure at 2 years. Particularly when one is augmenting behavioral treatments

with medication, it is critical to assess the impact of such interventions on obesity-related co-existing conditions.

Finally, although more than one third of patients may respond to lifestyle counseling with weight loss of at least 5% of their baseline weight, many obese persons do not successfully achieve or maintain weight losses sufficient to improve their health by means of lifestyle changes alone. Some patients will require additional treatments (e.g., medications or bariatric surgery) as an adjunct to, but not a replacement for, lifestyle interventions. Continued research on ways to enhance patients’ adherence to long-term lifestyle changes should improve the reach and effectiveness of behavioral treatments for obesity in primary care settings.

The opinions expressed herein are those of the author and do not necessarily reflect the views of the National Institutes of Health or the Department of Health and Human Services.

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