WEIGH FORWARD: ACHIEVING HEALTHY WEIGHT GOALS IN UNDERSERVED COMMUNITIES

Site: Jackson-Hinds Comprehensive Health Center
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BACKGROUND

The American Medical Association (AMA) made headlines this past June when it announced that in an effort to better address epidemic obesity throughout the country it would reclassify the condition—now shared by a third of all Americans—as a disease.¹ Not simply the result of genetic misfortune or the sum of improper diet and fitness habits, we should consider obesity as a pathophysiological disorder like pneumonia, malaria, osteoporosis and cancer, which may entail more serious health consequences or even death. I believe the intention behind this controversial motion was for (at least) the greater medical community to reimagine obesity beyond the bounds of an individual problem that requires only individual treatment—in somuch as this view fails to recognize the cultural, socioeconomic, and political factors, which have become part and parcel of weight gain and maintenance in our modern society. Such a ruling suggests that the solutions to our national weight problem must be thought of non-traditionally and increasingly outside of the individual and medical context—and further, that any serious effort to address America’s ballooning waistlines will necessarily involve transforming our culture and society, not simply modifying diet and exercises behaviors. In short, we must rethink the cause of the problem in order to solve the problem. We must understand how the seeds of obesity have been sewn into the very foundation of our nation, and then began the long, arduous task of reinventing ourselves.

Internationally, obesity rates scale with GDP. That is, more wealthy countries tend to have higher obesity rates than middle and low-income countries.² ³ Nationally this process is reversed, wherein regions of lowest earning per capita tend to achieve the highest scores of body mass index.² Moreover, low income and other disenfranchised populations are at significantly higher risk for overweight status and obesity.⁴ Obesity is well known as a preventable risk factor for many chronic diseases. In accordance with the aforementioned new classification, such diseases may be understood as symptomatic of the more sinister and more ubiquitous disease process that is obesity. Historically in the U.S., southern states have topped the lists of weightiest states. Yet, Mississippi has
claimed the title for the “most obese state” more times than any other. Mississippi also champions a number of other unflattering titles, not the least of which is ranking as the poorest state in the union. Thus, obesity and poverty are correlative measures, trending positively in southern regions, especially in states like Mississippi, wherein the mutual, reinforcing nature of these afflictions is practically palpable. Many researchers cite poor access to fresh food in poverty-dense areas, labeling them as “food deserts” due to the utter scarcity of high quality, nutritious consumables. Yet, after only a brief residence in Jackson, Mississippi, it has become clear to me that the problem is substantially more complex than this assertion suggest.

**INTRODUCTION**

Jackson-Hinds Comprehensive Health Center (JHCHC) is the largest provider of primary health care services to the uninsured and underserved in Central Mississippi. Therefore, the organization is uniquely positioned to make a significant impact on the nation’s highest recorded obesity rates. 2010 data revealed that approximately 67.9% of adult Mississippians were overweight, with a Body Mass Index (BMI) greater than 25; and approximately 34% were obese, with a BMI greater than 30. In this same population only 22.9% of adults reported having consumed fruits at the recommended level of at least two times per day; and only 21.6% reported having consumed vegetables at least 3 times per day. 2010 physical activity statistics were seen to support these dietary behaviors, wherein only 35.6% of adults achieved at least 300 minutes a week of moderate-intensity aerobic activity or 150 minutes a week of vigorous-intensity aerobic activity. Moreover, at the time of survey, about a third of adult Mississippians reported they had not participated in any physical activity in the past month. Such figures suggest the critical factors that underlie Mississippi’s weight problems and points of interests for refocusing solution efforts.

My first days in the city of Jackson, Mississippi were comprised of attempts to understand the current endeavors being made by clinicians of JHCHC to target obesity. It was clear early on that the patient community of Jackson-Hinds was no stranger to the earlier mentioned statistics. Over a week’s time I observed droves of obese adults arrive to see providers who themselves were quite overweight, and then leave with little more
than a printed handout on healthy eating habits. Thus, I hypothesized that poor provider recognition of patient overweight status, failure to prevent further weight gain, and ineffective treatment of obesity were all contributing factors to sustained average high BMIs. Given the time and resources at my disposal, I could not test the full breadth of these hypotheses. However, at least some of my basic assumptions warranted further investigation and could be tested in the given six week timeframe.

The healthy weight project sought to better understand the problem of obesity in the Jackson-Hinds patient community through assessments of JHCHC providers and patients, as well as propose a feasible and effective alternative or supplement to its present weight loss interventions. Research into other community health center efforts to tackle weight challenges revealed a variety of specialty programs designed for such a feat. That JHCHC does not have such a program, I believe evidences a significant unmet need. Furthermore, to my knowledge, JHCHC does not track outcomes data for its patients, a measure which forms the basis of this project. Nor has it developed an earnest strategy for obesity prevention and treatment, despite its well-known risks and prevalence in the Jackson-Hinds patient community. Thus, to some extent, this project also constituted a feasibility study for a survey-based feedback system, a way of recording patient outcomes in the apart from electronic medical records, which would enable Jackson-Hinds to optimize standard-of-care practices.

METHODS & MATERIALS

PHASE I

The first phase of the project employed two surveys of 10 questions each. Survey I, *The Provider Survey on Patient Weight & Obesity* (See Appendix), was distributed to 50 providers at all 15 Jackson-Hinds Comprehensive Health Center sites. Survey I questions were generally designed to determine provider sentiment and treatment protocols regarding patient obesity, in addition to retrieving department specific information on patient weight profiles. Survey I was distributed via the internal messaging capability of “eClinicalWorks” medical systems software, a new electronic
medical record application which all providers are required to access and use. This survey was open for provider completion for 10 days.

Survey II, *The Patient Weight Survey* (See Appendix), was distributed to four JHCHC sites determined by proximity to the Main Clinic (the Dr. James Anderson Health Facility) and the number of patients seen per day. Those sites were: (1) the Main Clinic, (2) the South Jackson Clinic, (3) the Medical Mall, and (4) Woodrow Wilson Clinic. In total 125 surveys were distributed to the Adult Medicine departments of each clinic, 50 to the Main Clinic, and 25 to all others. Patients received the surveys as part of the standard intake paperwork given and collected by front desk personnel. Survey II was designed to determine patient sentiments on current weight status and generally consisted of questions pertaining to interactions with JHCHC providers on weight-related issues. This survey was distributed directly to patients and collected over a 7-day period.

**Phase II**

The second phase of the project involved conducting an informative, interactive learning session entitled “*The Healthy Weight Workshop*” (See Appendix). The workshop was administered to 13 adults (clinicians and patients) and ran approximately 90 minutes. It was conceived to provide a forum for attendees to speak out about their struggles with weight and weight loss, while also providing important instruction on how to eat and exercise appropriately to achieve healthy weight goals. The “*Healthy Weight Workshop Evaluation*” (See Appendix) consisted of 5 diet questions and 5 exercise questions. Evaluations on diet and exercise were administered before and after the workshop to test its effectiveness. Subsequently, before and after results were tabulated and compared.

The free web-based application “Survey Monkey” was used to produce, disseminate, and analyze all surveys and evaluations. Microsoft Excel was also employed to facilitate data processing.

**Results**

**General Information**

Of the 50 copies of Survey I disseminated to providers, 35 copies were returned in total. 2 surveys were discounted due to provider respondents completing them more than
once, and 3 were inadmissible due to partial completion. Therefore, 30 Survey I copies were used to generate the following data.

Of the 125 copies of Survey II disseminated to patients, 91 copies were returned in total. 7 surveys were discounted due to patients improperly completing the survey, and 4 were inadmissible due to partial completion. Therefore 80 Survey II copies were used to generate the following data.

Of the 13 attendees of the Healthy Weight Workshop, 11 completed before workshop evaluations (BW); all of which were valid. 9 attendees completed after workshop evaluations (AW), all of which were valid. Therefore only 9 copies of the Healthy Weight Workshop Evaluation were used to generate the following data.

**Survey I.**

**Figure I: JHCHC Patient Weight Profile**

- **JHCHC Patient weight Profile (Figure I)**
  As shown in Figure I, 46% of provider respondents ranked “overweight” as the 2\textsuperscript{nd} most common body type seen in their department, while 33% of provider respondents ranked “overweight” as the most common body type. 29\% of respondents ranked “obese” as the 2\textsuperscript{nd} most common body type seen in their department, while 33\% ranked “obese” as the most common body type seen. 21\% of respondents ranked “normal weight” as the most commonly seen weight
profile in their department. Therefore, about 75% of respondents felt that the patients they see most often are above normal-weight, being either overweight or obese.

- In response to the survey question “when do you feel like it's appropriate to discuss an overweight patient's weight with him or her?”, 54% of provider respondent reported: “when the patient is being seen for a weight-related health issue” and “when the patient expresses concern about his or her weight with you”; while 38% reported it was appropriate “regardless of whether the patient’s feelings would be hurt by the discussion”. 0% of provider respondents reported that it was appropriate “only when you feel like you can safely discuss weight without hurting the patient's feelings”. Moreover, 75% of respondents said that “anytime is a good time” to discuss a patients overweight status.

**Figure II: JHCHC Weight-Related Health Conditions**

- **JHCHC Weight-Related Health Conditions (Figure II)**
  The survey reflected that about a third (33%) of provider respondents reported that 50-75% of patients visiting adult medicine departments have a “weight-related health condition”. One-quarter of respondents reported that 0-25% of patients have a weight-related condition. One-fifth of respondents reported that either 25%-50 or 75%-100% of patients had a weight-related health condition. Thus, most responders felt that the majority of patients (54%) seen in their depts.
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have a weight-related illness or condition (e.g. obesity, diabetes, high cholesterol, heart disease, etc.).

- In response to the survey question “if you are seeing a patient who is overweight, how often do you express your concern to the patient regarding his or her weight status?”, 48% of providers reported they do so “frequently”, while 22% reported they do so either “always” or “sometimes”. Only 9% of respondents stated they expressed concerns to patients “rarely” with respect to their overweight status.

Figure III: Causes of Overweight Status

- **Causes of Overweight Status**
  Of the 8 possible choices for causes of patient overweight status, the top three reported were (1) “poor perception of overweight status” with a third of provider respondents ranking it first, (2) “lack of resources that enable healthy diet and exercise”, with 25% of providers ranking it first, and (3) “cultural cuisine and
exercise”, also with 25% of providers ranking it first among all possible causes. Least among the choices were “genetics, illness, or other health condition”, with 0% of provider respondents ranking it first; and “lack of information regarding how to eat and exercise healthily” and “personal responsibilities that jeopardize healthy diet and exercise” ranking at approximately 4%.

- Findings for the survey question, “what method(s) do you use most often to address patient concerns and/or conditions relating to his or her overweight status?” were as follows: 87% “counsel patient on how to eat healthy”; 83% of respondents surveyed reported that they “give the patient pamphlets or printed information on eating healthy” and also “discuss risks of being overweight/obese with patient”. All other possible responses were reported by at least 50% of provider respondents with one exception; less than half of provider respondents reported that they “develop a diet and/or exercise plan with patient for weight reduction”.

SURVEY II.

Figure IV: Patient Weight-Loss Strategies
• **Patient Weight-Loss Strategies**

Of the survey choices for patient weight-loss strategies, almost half (47%) of patient respondents ranked “watching portion sizes” as the number one strategy. The second most commonly reported strategy was “doing more cardio exercise”, and “dieting on my own” was the third most common. About 21% of patient respondents reported they were “not currently doing anything”. 0% of respondents reported that they were “dieting with a plan”. Lastly, about 16% of patient respondents reported “other” as their current strategy, but responses were variable or unlisted among them.

• 59% of patient respondents reported they saw themselves as “overweight”. However, 31% and 10% of respondents surveyed that they view themselves as “normal weight” and “obese” respectively. 0% answered “underweight” in response to the question “how do you view your current weight?”

**Figure V: JHCHC Patient Body Mass Index**

• **JHCHC Patient Body Mass Index**

BMI was calculated for all patient respondents based on survey responses of height and weight. 56% of patients were found to be “obese” based on these calculations. As well, 20% of patients were found to be of both “normal weight” and “overweight”. Less than 3% of patient respondents were “underweight”.

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• 62% of patient respondents answered “yes” to the question “has a health care provider ever told you that you were underweight, overweight, or obese?”, while 56% answered “yes” to the question “has health care provider ever expressed concern for your health because of your weight?” 84% of respondents answered “yes” they do wish to get into better shape. The complement of each these questions answered “no”. Finally, over half of patients completing the survey (54%) stated they would be interested in a class or workshop offered by Jackson-Hinds to help learn about how to lose weight and exercise.

Figure VI: Weight Loss Detractors

• Weight Loss Detractors

46% of patient respondents agreed that “stress” and “my busy schedule” were the primary detractors preventing them from losing weight. These detractors were closely followed by “lack of energy” at 44%. “Money” was reported by 33% of patients as a detractor, while “food and fitness is too confusing” and “none of the above” were reported at 13% and 5% respectively.
Healthy Weight Workshop Evaluation

Evaluations “before workshop” (BW) and “after workshop” (AW) were administered. Patient attendees scored 69% on the 5 diet questions administered before the workshop, and 76% on the 5 exercise questions. Patient attendees scored 89% on the 5 diet questions administered after the workshop and 91% on the 5 exercise questions.

**DISCUSSION**

**SURVEY ANALYSIS**

Overall, the provider surveys represented a provider population that was both recognizing and treating patient obesity. Determining the actual effectiveness of that treatment was beyond the scope of this project. However, the majority of provider respondents said that they were counseling patients, giving patients educational information and discussing the benefits of weight loss with them. Importantly, it was found that less than half of respondents (44%) were helping patients to develop diet and exercise plans. This may be problematic, in that patients are less likely to commit to weight-loss interventions that are not structured and goal directed. Clinical studies comparing counseling alone against counseling and/or weight-loss programs are sparse,
but the data available suggests that these latter interventions are indeed more effective at achieving weight loss.10

The data demonstrated that both providers and patients believe there is a problem with excessive weight. However, there was a disagreement in both the cause and degree. The most common answers among providers as to the cause of patient overweight status was perception of weight problem and lack of resources. That most overweight patients believe that weight gain or inability to lose weight is caused or stifled primarily by a “busy schedule” and “stress” represents a significant contrast in opinion between the two groups. Furthermore, substantially less patients viewed themselves as obese (10%) than was found from survey calculations (56%). Furthermore, a third of providers agreed that the most common weight status in their department was obese. These findings lend credence to the idea of a perceptual distortion in the patients’ self-view, and support provider assertions that overweight and obesity status in Jackson may first be an image problem. Despite this reasoning, it is reasonable to assume that patients have a markedly different definition of obesity than providers, and that responses differed greatly due to lack of knowledge about what actually constitutes obesity.

Finally, the perceptual disparity may represent shame on behalf of the patients. That is, patients may blame themselves for their current overweight or obese status, not realizing that there are greater socio-structural forces at work, facilitating the process of weight gain and maintenance. This notion is supported by the fact that over half the providers at least “frequently” speak to overweight patients about their concerns, while most overweight or obese patients voice their concerns to providers only “sometimes”. Moreover, it seems that an effective address of obesity in the Jackson-Hinds patient community is complicated by (1) the poor perception by patients of their actual weight status, and when excessive weight is perceived, (2) the failure to seek help due to shame and the erroneous belief that it can and should be dealt with privately.

**WORKSHOP ANALYSIS**

Reduction in portion sizes was the primary method reported for weight loss. I suspect this was by means of food abstinence (i.e. caloric restriction). Patients may be unsure or uniformed as to how to change their diets; despite the fact that the majority of provider respondents stated they were actively informing patients of healthy dietary
habits. Additionally, it was found from Survey I that little was being covered with respect to exercise. These data collectively suggest that there is a significant, unmet need within the Jackson-Hinds patient community with respect to weight management education. Both provider and patient surveys tell a story of a patient population, which is majority overweight or obese, in need of more intensive, long-term interventions. The Healthy Weight Workshop sought to rectify this deficit in provider quality care practices. Data from the workshop evaluations showed that such an instrument could effectively educate patients on appropriate methods of diet and exercise, as well as provide a forum for discussion and support, enabling a much needed sense of community. I found the small group format to be ideal, allowing for enough patients to be efficient, but not too many as to be ineffective. Future workshops may be adapted to shorter durations, rather than the 90-minute timeframe; this would permit pertinent information to be distributed over a workshop series, rather than concentrated into a single session.

**Sources of Error**

The number of provider respondents was not sufficient to be representative of the entire provider population. As well, the number of patient respondents was not sufficient to be representative of the entire patient population. Thus, it is difficult to generalize the findings or resultant interpretations produced from the surveys.

Multiple data points were taking only for the workshop, so any interpretation of data with respect to the effectiveness of current provider approaches is erroneous. Finally, the data collected is primarily qualitative and sentiment-based, ascribing significant bias to the results. Moreover, it’s impossible to divorce the survey findings from the subjectivity inherent in them.

**Conclusion & Recommendations**

The Healthy Weight Project was a needs assessment, characterizing the current weight profile of patients in the JHCHC patient community, and an effort to determine the feasibility and effectiveness of a workshop style intervention. It will hopefully serve as a starting point for future endeavors of this accord. Data collected from patient and provider surveys as well as the Healthy Weight Workshop demonstrated that Jackson-
Hinds patients are in need of greater, more intensive interventions to facilitate weight reduction. Both JHCHC patients and staff are poised to accept such interventions.

The importance of longitudinal data cannot be understated. This project demonstrates the ability of the survey to collect patient information, feed back outcomes data, and incite changes in JHCHC best practices. I feel that my project was able to very rapidly test the provider/patient population to assess current weight statuses and treatments. However, with the exception of the Healthy Weight Workshop Evaluation, my surveys represent only a single data point, which says nothing about change or effectiveness of current practices. At least two data sets would be required for that. What’s more, the statistical significance of the project survey findings is dubious. Nevertheless, based on project findings and my own observations, it is my recommendation that the Jackson-Hinds organization implement an intensive workshop and/or weight-loss program, as well as an outcomes-based feedback system for the better health of their patients.

In my research, I discovered that other community health centers have already instituted workshops and weight-loss programs in analogous communities that have been very successful. Government and third-party organizational resources are available online that can assist in implementing such weight management interventions. Overall, I believe these interventions to be superior to the current methods in use by JHCHC, not simply because they are more intensive, but because they move people beyond a place of guilt and self-blame for their weight struggles, to a place of hope and productivity. I believe this is the essence of the aforementioned AMA motion to consider obesity as a disease. Fortunately, clinicians endeared to the compassionate, quality care of their patients staff Jackson-Hinds Community Health Center. Now, these clinicians need only take the next step to help patients achieve their healthy weight, and to help Mississippi achieve a lighter, brighter future.
REFERENCES


GE-NMF PRIMARY CARE LEADERSHIP PROGRAM

APPENDIX

I. Survey I
II. Survey II
III. Healthy Weight Workshop Presentation
IV. Healthy Weight Workshop Evaluation
I. **Survey I**

Provider Survey on Patient Weight & Obesity

1. Please select the clinic where you currently work. If you work at multiple locations, please select the site where you spend the most time. You will use this location as a reference for completing the rest of the survey.

   Other (please specify)

2. Please select your current department.

   Adult Medicine
   Pediatrics
   Women's Health
   WIC
   Optometry
   Dentistry
   Social Services

   Other (please specify)

3. Please select your current job title.

   Physician
   Nurse Practitioner
   Nurse
   Medical Assistant

   Other (please specify)

4. In your opinion, what is the current weight profile of patients seen in your department? Please rank the weight conditions below with '1' being the most frequently seen, and '5' being the least frequently seen.
5. What percent of patients do you see in your department that have a weight-related illness or condition (e.g. obesity, diabetes, high cholesterol, heart disease, etc.)?

- 0%-25%
- 25%-50%
- 50%-75%
- 75%-100%
- Other (please specify)

6. What do you believe are the most important determinants of overweight status and obesity in the Jackson-Hinds patient community? Please rank the following responses with ‘1’ being the MOST important contributor and ‘8’ being the LEAST important contributor.

- Lack of information regarding how to eat and exercise healthily.
- Lack of resources that enable healthy diet and exercise (e.g. healthy restaurants and food stores, gyms, safe areas, etc.).
- Personal responsibilities that jeopardize healthy diet and exercise (e.g. children, employment, other time commitments, etc.).
- Poor perception of overweight status or obesity as a health problem.
- Poverty or other financial complication.
7. When do you feel like it's appropriate to discuss an overweight patient's weight with him or her? Please mark all that apply.
   - When the patient is being seen for a weight-related health issue.
   - When the patient is being seen for a non-weight-related health issue.
   - When the patient expresses concern about his or her weight with you.
   - Only when you feel like you can safely discuss weight without hurting the patient's feelings.
   - Regardless of whether the patient's feelings will be hurt by the discussion.
   - Anytime is a good time.
   - Not Applicable (please Specify)

8. If you are seeing a patient who is overweight, how often do you express your concern to the patient regarding his or her weight status?
   - Never
   - Rarely
   - Sometimes
   - Frequently
   - Always
   - Other (please specify)

9. How often do patients express concerns to you about being overweight?
   - Never
   - Rarely
   - Sometimes
10. What method(s) do you use most often to address patient concerns and/or conditions relating to his or her overweight status? Please mark all that apply.

- Counsel patient on how to eat healthy (e.g., portion sizes, food choices, nutrition, etc.).
- Give the patient pamphlets or printed information on eating healthy.
- Counsel patient on how to exercise (e.g., time, frequency, type, etc.).
- Give the patient pamphlets or printed information on exercising.
- Develop a diet and/or exercise plan with patient for weight reduction.
- Discuss risks of being overweight/obese with patient.
- Discuss benefits of losing weight with patient.

Other (please specify)
II. SURVEY II

Patient Weight Survey

1. Clinic where you are currently being seen?

2. How long have you been a patient of Jackson-Hinds Comprehensive Health Center or an affiliated clinic?
   - Less than 1 year
   - 1-5 years
   - 5-10 years
   - Over 10 years

3. How do you view your current weight?
   - Underweight
   - Normal weight
   - Overweight
   - Obese

4. Has a health care provider ever told you that you were underweight, overweight, or obese?
   - Yes (please specify which):________
   - No

5. Has a health care provider ever expressed concern for your health because of your weight (e.g. told you your weight was unhealthy)?
   - Yes
   - No

6. Do you want to get in better shape?
   - Yes
7. Are you currently doing anything to improve your health or lose weight? Check all that apply.

- Watching portion sizes
- Doing more cardio exercise (like running, walking, biking, dancing, etc.)
- Doing more strength and toning exercise (like push-ups, weights, crunches, etc.)
- Dieting on my own
- Dieting with a plan (e.g. Atkin's diet, Weight Watchers, or Jenny Craig)
- No, I'm not currently doing anything
- Other (please specify) ____________________________________________

8. If you do want to get healthier and in better shape, what, if anything, do you feel is holding you back? Check all that apply.

- Stress
- Lack of energy
- My busy schedule
- Lack of support from friends
- Money
- Food and fitness is too confusing
- None of the above. (I'm in good shape or don't want to be in better shape.)
- Other (please specify): ____________________________

9. Would you be interested in a class or workshop offered by Jackson-Hinds to help learn about how to lose weight and exercise?

- Yes (please specify): ____________________________
- No

10. Weight class per BMI?

- Underweight
- Normal Weight
III. **Healthy Weight Workshop Presentation**

**Breakdown**

- Share-Out
- Risks & Effects
- Gain & Maintain
G
E
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N
M
F
P
RIMARY
C
A
R
E
L
EADERSHIP
P
RGRAM

25

Share-Out

Risks & Effects

-type II diabetes, high blood pressure high cholesterol, high triglycerides, coronary heart disease, stroke, sleep apnea, respiratory problems, gallstones, osteoarthritis, breast cancer, colon cancer, uterine cancer, cervical cancer, ovarian cancer, metabolic syndrome, depression, cardiovascular disease, excessive sweating, fatigue, back pain, Alzheimer's disease, infertility, irregular periods, erectile dysfunction, liver disease, skin problems, social isolation, shame, disability…

mortality
Gain & Maintain

- Unhealthy eating and exercise habits
  - Perception of weight status
    - Lack of energy
  - Food and fitness is confusing
  - Availability of food/fitness resources
    - Climate is not conducive
      - Money
      - Cultural cuisine
    - Other responsibilities
      - Stress
Build-up

• Weight-loss Basics
• Lose & Maintain
  • Myths & Tips
• Things to Remember

Weight-loss Basics

“CALORIE IN = CALORIE OUT?”
Weight-Loss Basics

- The energy cost to metabolize fat, carbs and protein is different.
  - Calorie restriction slows metabolism
  - Protein reduces appetite
  - Fiber reduces calorie absorption
  - Timing of eating affects calorie processing

Weight-Loss Basics: Exercise

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<td>Procrastination</td>
<td>Take it easy</td>
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<td>Inactivity</td>
<td>Workout alone</td>
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<tr>
<td>Smoking</td>
<td>Spare sleep</td>
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<td>Making excuses</td>
<td>Food intake</td>
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<td>Duration (&gt;20)</td>
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<td>Running</td>
<td>Dynamic exercise</td>
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<td>Swimming</td>
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Weight-loss Basics: Diet

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<td>‘Dieting’</td>
<td>‘Seconds’</td>
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<td>High sugar</td>
<td>Fluid sizes (except H2O)</td>
<td>Desserts</td>
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<td>Starches</td>
<td>Salt</td>
<td>Take-out</td>
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<td><strong>Increase</strong></td>
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<td>Fruit &amp; Veggies</td>
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<td>Fiber</td>
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Lose & Maintain

- Unhealthy eating and exercise habits
  - Perception of weight status
    - Lack of energy
  - Food and fitness is confusing
  - Availability of food/fitness resources
    - Climate is not conducive
      - Money
      - Cultural cuisine
    - Other responsibilities
      - Stress
Myths & Tips

1. Don’t eat after xx-o’clock because it will make you fat.
2. Eating small frequent meals boost your metabolism.
3. Going on a diet is the best way to lose weight.
4. Eating fat makes you fat.
5. You need to buy diet foods in order to lose weight.

Things to Remember

• It’s not easy
• Be goal-driven
• You will not see changes right away
  • Be hard on yourself
  • Don’t be so hard on yourself!
• Activation starts in the mind
  • Stay motivated
  • Teamwork
Questions

http://www.youtube.com/watch?v=y8doH7rZg9E
IV. Healthy Weight Workshop Evaluation

Healthy Weight Quiz

1. Genetic factors are the main contributor to a person’s weight status.
   True
   False

2. The most important environmental contributors to weight gain are poor eating and exercise habits.
   True
   False

3. The amount of calories you take-in and burn is unaffected by food source. That is to say, a calorie is a calorie, whether it comes from sugar, protein, or fat.
   True
   False

4. Dieting (i.e. calorie restriction) is the best way to lose weight and maintain the loss.
   True
   False

5. Fiber has no affect on how full you feel because it is not digested by the body.
   True
   False

6. Eating small frequent meals helps to maintain your blood sugar throughout the day.
   True
   False

7. Eating fat will make you fat.
   True
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8. Eating fat will make you fat.
   True
   False

9. You must workout for greater than 20 minutes at a time to see any positive cardiovascular health affects.
   True
   False

10. Exercising alone is the best way to achieve your personal goals.
    True
    False