

# Efforts Toward Prevention in Hawaii: Resources for Providers to Counsel Patients About Healthy Lifestyles

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#### Abstract

*As part of the Healthy Hawaii Initiative professional education campaign, 14 focus groups were conducted across the state with primary care providers, staff and community leaders to determine what messages about healthy lifestyles work with patients in health care settings. Focus group members indicated that culturally sensitive and personalized messages, positive reinforcement, and teamwork are most effective in counseling patients.*

#### Introduction

In the US, tobacco use, poor diet and physical inactivity account for over 30% of all mortality. In their analysis of 2000 mortality data Mokdad and colleagues found that tobacco accounted for 435,000 deaths or 18.1% of total deaths, and poor diet and physical inactivity accounted for 365,000 deaths or 15.2% of total deaths.<sup>1</sup> According to the January 2004 Progress Review of the nutrition and overweight objectives of the Healthy People 2010 Project, the prevalence of obesity is increasing across all racial and age segments of the U.S. Additionally, there has been no appreciable increase in the intake of fruits, vegetables, and whole grains, or diminution of the intake of high fat foods. Among the many barriers to decreasing obesity and poor nutrition, the report identified "[L]ack of acceptance of obesity as a disease by a large part of the public, healthcare providers, and third-party payers."<sup>2</sup> While tobacco continues to lead as the underlying cause of death, the prevalence of smoking among adults has declined from 25% in 1990 to 22.5% in 2002.<sup>3</sup> As the campaign against tobacco matures, the Healthy People 2010 Progress Review recommends customizing antismoking messages to reach occupational and ethnic groups that continue to show relatively high prevalence of cigarette use, as well as collaboration between public and private entities.<sup>4</sup>

To address these behaviors, the State of Hawaii is utilizing a portion of its share of the tobacco master settlement funds for a program titled "Start Living Healthy," the goal of which is to improve lifestyle choices by promoting simple and consistent lifestyle modification messages to all of the people of Hawaii<sup>5</sup>. The messages of the mass media social marketing

campaign are (1) Eating Better, (2) Getting Active, and (3) Living Tobacco Free. The State of Hawaii Department of Health also supports activities to promote these messages in schools and in communities. In order to achieve synergy among the social marketing campaign, community activities, and the health care system, the Hawaii Department of Health has collaborated with the University of Hawaii John A. Burns School of Medicine Area Health Education Center to develop and deliver an educational campaign known as Provider Training for Changing Habits (PiTCH).

Because of their credibility and authority regarding health issues and long-term relationships with their patients, health care providers play a central role in motivating patients to adopt positive lifestyle behaviors. However, in the U.S., during the 1990s, in clinical encounters with patients with obesity, diabetes, hyperlipidemia, or heart disease, fewer than 45% of patients received counseling regarding diet, and fewer than 30% of patients received counseling regarding physical activity.<sup>6</sup> Fewer than a quarter of physicians assess and counsel patients about tobacco use<sup>7</sup>, and only 42% of obese adults in the U.S. report that health care professionals advised them to lose weight<sup>8</sup>. Failure to perform such preventive counseling has been attributed to time constraints, lack of reimbursement for counseling services, and limited knowledge about nutrition and nutritional counseling among physicians<sup>9</sup>. However, in order to prevent the morbidity and mortality that arise from tobacco use, poor diet, and physical inactivity, the adoption of healthy lifestyles must be encouraged at every possible opportunity.

To this end, a task force including representatives of academia, physicians, nurses, nutritionists, the public health community, local legislative members and the private sector met regularly during 2003 to review and adapt national guidelines for local needs. In order to assess the needs of the unique population of Hawaii, this group organized 14 focus groups of health care providers across the state to examine the role of lifestyle education in clinical practice in Hawaii. Participants were asked about barriers to and facilitators of providing patient education, and techniques those local providers have found to be useful. This article

describes the results of these focus groups and how they served as the basis for the development of a curriculum to equip providers with simple and easy-to-remember messages regarding smoking cessation, diet, and exercise.

## Methods

The task force developed a structured focus group discussion outline and contracted with a private research firm to hold focus groups across the state. Institutional review board exemption was obtained from the University of Hawaii Committee on Human Subjects. Participants were selected by convenience sampling. One-hundred sixteen participants (34 primary care physicians, 34 non-physician healthcare providers, 40 medical office staff, and 8 community leaders) were divided into fourteen focus groups according to occupation and practice location. The focus group discussions were conducted from June 2003 to August 2003 on Oahu (8 focus groups), the Big Island of Hawaii (2 focus groups), Maui (2 focus groups), Kaua'i (1 focus group), and Moloka'i (1 focus group). Providers' length of practice, experience, and ethnic background varied. The setting they practiced in included hospitals, community health centers, private practices, and group organizations.

The groups were led by an experienced focus group moderator who utilized the focus group discussion outline developed by the PiTCH Task Force. She encouraged individuals to share their opinions in an open discussion format. Topics covered in the focus groups included: current health issues, current health practices, barriers to healthy lifestyles and behavioral change, solutions to health issues, physical activity, nutrition, smoking, health education, and partnerships between organizations and health care professionals. Each focus group meeting was two hours in duration. Task force members observed the groups from behind a one-way mirror or the back of the room as dictated by the location. The focus groups were audio tape-recorded, and transcribed. Summary and transcripts were provided by the research firm, and the task force applied a hermeneutic method of interpretation, moving from part to whole and back, to extract the most significant meanings from the focus groups. Disagreements in interpretation or emphasis among the authors were resolved through discussion.

## Results

### Barriers to Patients Adopting Healthy Lifestyles

Health care providers agree that the general population of the State of Hawaii - including adults, adolescents, and children - have unhealthy lifestyles such as poor diet, physical inactivity, and lack of preventative care that contribute to chronic health problems such as heart disease, diabetes, hypertension, hypercholesterolemia, asthma, and gout. Participants believe that "the lack of understanding of what a healthy meal is and what actually is meant by regular exercise" poses a barrier for patients and that "we have to do screening and educate [the public] for prevention."

Fear of gaining weight, peer pressure, and increased stress were noted as obstacles to patients stopping smoking. Passive entertainment, busy lifestyles, and ease of obtaining fast food were identified as barriers to healthy lifestyles. The availability of food of poor nutritional value in the schools was identified as particularly problematic. "These kids from elementary through high school

- if they're being ingrained to eat junk foods in school, and they're already eating junk food on the outside, especially on weekends - how are we going to train these people to change that diet when they become adults?"

Most of the participant health care providers reported asking their patients about smoking history. However, fewer asked about diet or exercise unless patients presented with medical problems such as diabetes, hypercholesterolemia, or obesity. Due to time constraints, providers tend to discuss one aspect of prevention at a time. "In a situation where you know this patient is going to come back again and again and again you'll have opportunities to address this one and that one in their turn. So it's not like you forget the others because you only have an opportunity today to address one."

A commonly expressed opinion was that patients generally do not present for care unless they have some sort of problem. "Unfortunately we don't see too many people that just come unless they have a pain or something." Newly diagnosed medical conditions are seen as opportunities and motivators for behavior change. "If we identify a problem like diabetes or elevated cholesterol or blood pressure, often I go with the approach [lifestyle changes] because they don't want to start on medication right away so the usual first treatment is exercise, eating healthy".

Physicians uniformly agreed that they had little time to counsel patients, but were receptive to learning simple approaches to encouraging healthy lifestyles. Most participants did not recognize the "5A's" for smoking cessation (ask, advise, assess, assist, arrange)<sup>10</sup> when queried about it, let alone name them. When told what the 5A's stood for, however, many declared that they perform all the suggested tasks - that they just don't think of them as the "5A's."

Many participants cited the lack of reimbursement for counseling regarding lifestyles as a barrier to performing such counseling during medical encounters. There were many complaints that obesity has not been a reimbursable diagnosis. A related problem identified by the participants was that nutrition counseling was not reimbursed for patients who are simply obese, while, in contrast, it is reimbursed for patients with diabetes. A number of clinicians found it ironic that they had to wait for overweight patients to develop diabetes before being able to refer them for nutrition counseling. A number of participants expressed dismay that pharmacologic aids for smoking cessation, nicotine replacement products and bupropion, are not covered by insurance. "Three years ago a woman came in who had just spent 10 days on a ventilator in our hospital. She had chronic respiratory disease and smoked and couldn't get off of cigarettes. She showed me the QUEST [Medicaid] bill where they paid for close to \$60,000 for her ICU care, and she said, 'They won't give me a \$100 for the damn patches.'"

### Useful techniques

Many focus group participants described the need for a variety of methods to reach patients and described different approaches for members of different genders, cultures or ethnic groups that they had found successful.

*If I have a male, I'll challenge them and say, "You know, I bet you can't do this." And you know what? Men lose weight ... because they're going to prove to you that they can do it. You can't do the same thing to a woman so I use a different approach. I can kind of talk around it. "Let's talk about this as a problem." With my males*

*I'll have them come back, and they've lost 20 pounds, and their blood pressure is great.*

*Sometimes I have a special technique especially effective for middle-aged Japanese male patients. "Okay, I'm going to have you promise that by the time that you come in to see me the next time you will be down to such and such a weight." Sometimes it works.*

*"You have to respect the culture number one. You have to see what their support system is and where that support is going to come from...it's not just the patient but who are they going to have their support from. " "...for some cultures Western medicine is sort of like a last resort..."*

*"...the cultural part, food is love...you visit four people that day, you ate four times in one day."*

Many providers emphasized building trust.

*"There are techniques, if you will, in creating an atmosphere of trust. . . . Absolutely it takes time, but it also takes a certain amount of skill. I know that if I make myself vulnerable and . . . if I reveal the story of my youth and early adulthood and so on, it sets a standard for what you can reveal in the exam room. So if I've done it then they can too. That's my style. . . . In any event I think building trust is appropriate and understanding how you create a trusting environment wherein you can take risks and reveal things and discuss them that would be a really important part of any behavior change curriculum I would think."*

Positive reinforcement and lack of a judgmental attitude were described frequently. "I think they (providers) needs to look at the person...in a holistic way...you're not just going to say you need to lose weight but what is it you enjoy?" "...if the patient just lost a little bit of weight I'd say 'Wow, you're really firming up here and you lost a couple of pounds and you really look good.'" "...I would encourage them with positive reinforcement." "Give them kudos."

Most providers emphasized a team approach whereby the work could be distributed and patients contacted by many members of the medical office. Many non-physician providers and office staff don't feel it is appropriate to counsel patients unless directed to do so by the physician. Therefore, patients will benefit maximally if the lead health care provider initiates a collaborative program and, expresses enthusiasm, and provides ongoing support for the program or system introduced.

### Useful resources

The focus groups emphasized the need for teamwork in the office and in the community to disseminate the Start Living Healthy message. Interdisciplinary teamwork - collaboration among providers, local hospitals, the medical school, the health department, and the community - were seen as having a positive impact upon encouraging healthy lifestyles. Solutions discussed included early education, team managers and team efforts initiated by the physicians and implemented by other health professionals in the office setting.

Tools cited by providers as helpful include posters, brochures, health walks, pedometers, health fairs, literature and videos available for distribution to individuals and groups. Insurance reimbursement for counseling, for necessary medications, for gym membership were all described as desirable. Start Living Healthy media spots on television and at the movie theaters were cited as positive influences on the lives of their patients, though the participants reflected

on their own, rather than on their patients' reactions to these spots. Specific visual aids that participants viewed as effective included the poster depicting a baby smoking inside his mother's uterus and a poster of a tobacco diseased lung, as well as body mass index (BMI) charts.

*I also have a BMI chart in all my rooms, and actually I don't think 90% of the time I bring it up. I think because I have it there, and I'm always late to see my patients, they have time to look at the wall and figure this out. And by the time I walk in, they're like, "Hey what is this thing, and how come I'm in this red section instead of this green section over here?" So that's almost like a stop light. Some people can't even get on the chart and that's not very good. So then we bring it up, so I'd say maybe about 70% of the time.*

Finally, dancing, such as hula, ballroom and line dancing, was an activity recommended by many providers.

Rural areas were perceived to have fewer resources than urban areas, especially where physical activity was concerned. Rural community members have less access to fresh foods, are less aware of healthy messages, and have less educational materials available to them. Rural providers identified preventive services, health screenings, and health classes as unmet needs in rural areas. Also patients in lower socioeconomic classes had less access to fitness equipment. On the other hand, whereas middle class individuals have access, they lack the time to use it.

The above ideas were then reviewed by the PiTCH Task Force, together with the latest guidelines and research findings and incorporated into a brief curriculum for providers across the state. Brochures, posters, and pedometers have been delivered during in-office visits by the PiTCH staff and at large group meetings of providers in Hawaii.

### Discussion

As a public health intervention, the Start Living Healthy campaign is directed toward the entire populace, with the intent of improving the health status of all the people of Hawaii. In contrast, physicians see their patients one at a time, and therefore think in terms of disease states and risk factors for morbidity and mortality. Many physicians noted that they are not comfortable discussing prevention on a first visit, but primary care providers who have a longitudinal relationship with their patients utilize this relationship to promote the adoption of healthy lifestyles. Of necessity, primary care providers personalize the messages that they give to their patients, and find that positive reinforcement and cultural adaptation of the message increase their perceived success. In the office setting, teamwork was described as necessary to succeed in prevention counseling, because of the longstanding time demands of medical care and the lack of financial incentives to counsel patients. However it was noted by office staff, that the initiative must be taken by the health care provider, at which time staff feel empowered to participate.

Limitations of this study include the lack of a method to ensure that the focus group participants are statistically representative of the population of providers in Hawaii. This is, however, a qualitative study; its results can form the basis for subsequent quantitative studies on counseling of patients by providers.

### Gender and Cultural Influences

That middle-aged Japanese men are identified as being more amenable than others to directive instructions by their providers implies that different strategies might be of varying efficacy with different populations. Further study should explore the possibility that different strategies work better with men vs. women or with different ethnic groups.

### Need for provider reimbursement

It was apparent that the providers wanted to help their patients adopt healthy lifestyles. However, they did not have the time to provide all of the counseling they could. Enhanced collaboration among members of the healthcare team and better reimbursement from third-party payers would facilitate such efforts directed at health promotion and disease prevention. That obesity is increasingly recognized as a reimbursable condition is a great advance.

### Conclusions

Examined in terms of actual causes of death, tobacco, poor diet, and physical inactivity continue to be the major determinants of preventable death in the U.S. The obesity epidemic continues to worsen, as does world-wide consumption of nicotine. We can have no hope of reversing these trends without a concerted effort that involves society as a whole. Messages that patients receive in the consulting room, the waiting room and from the office staff must be consistent with those that they receive from their families, friends, neighbors, and those that they receive from the mass media. These messages must be personal, culturally sensitive, appropriate and delivered with positive reinforcement. In an effort to develop simple but useful

lifestyle modification messages that they can deliver to patients, we asked health providers what they need to know. Our task force has drawn on the focus group results reported here to develop the PiTCH curriculum. The task now is to disseminate the message that Hawaii's health care providers can encourage their patients to adopt healthy lifestyles.

### Acknowledgements

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