#### Lehigh Valley Health Network

#### **LVHN Scholarly Works**

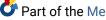
**USF-LVHN SELECT** 

### Implementing Guidelines for IBT in Conjunction with CMS Regulations

Robin Schroeder MD Lehigh Valley Health Network, robin.schroeder@lvhn.org

Jeanette Qablawi MS2 USF MCOM- LVHN Campus

Follow this and additional works at: https://scholarlyworks.lvhn.org/select-program



Part of the Medical Education Commons

#### Let us know how access to this document benefits you

#### Published In/Presented At

Schroder, R., Qablawi, J. (2015, July 16). Implementing Guidelines for IBT in Conjunction with CMS Regulations. Poster presented at The Prologue II Presentation Day University of South Florida, Tampa FL.

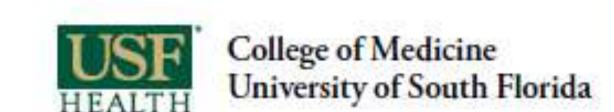
This Poster is brought to you for free and open access by LVHN Scholarly Works. It has been accepted for inclusion in LVHN Scholarly Works by an authorized administrator. For more information, please contact LibraryServices@lvhn.org.

# Implementing Guidelines for IBT in conjunction with CMS



Experiences for a lifetime. A network for life.™

# Regulations





## Robin Schroder M.D. Jeanette Qablawi

# Lehigh Valley Weight Management Center 1234 S. Cedar Crest Blvd. Suite 2200 Allentown, PA 18103

Introduction: The AMA house delegates announced obesity as a disease and stated it required a range of medical interventions to advance its treatment and prevention. Along with this, the CDC has reported that obesity rates have increased dramatically in the U.S and it is now considered an epidemic. In the Medicare population alone, over 30% of people are obese. Efforts have been made to increase preventative measures on obesity since the Affordable Care Act listed it as 1 of the top 10 essential health benefits. IBT or intensive behavioral therapy is one of the new services now being offered to Medicare patients. As of November 29, 2011 Medicare now covers IBT for obesity, defined as a BMI of 30kg/m<sup>2</sup> or greater for the prevention or early detection of illnesses and disabilities. IBT consist of the following:

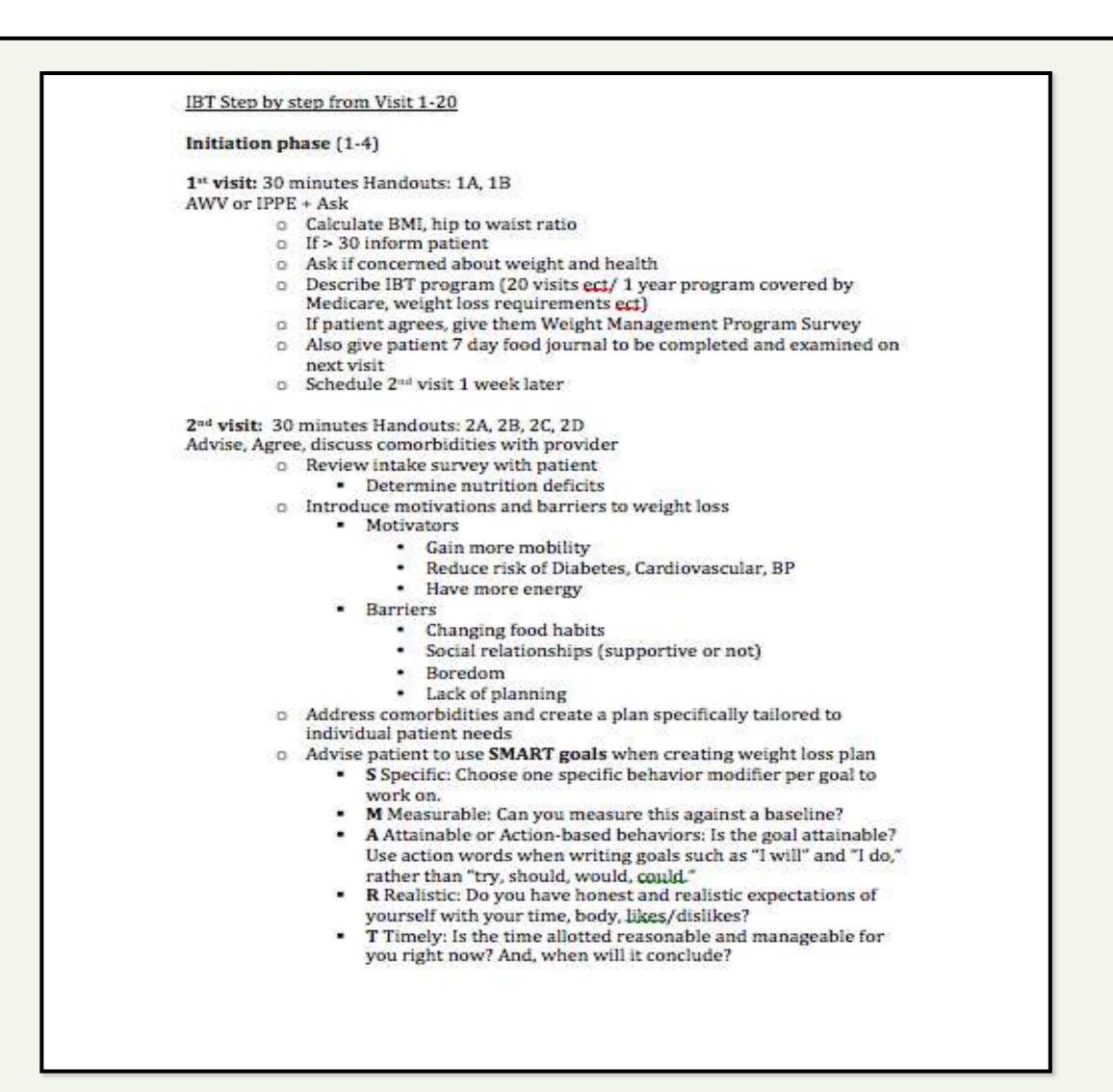
- Screening for obesity in adults using measurements for BMI
- Dietary (nutritional) assessment
- Intense behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.
- •IBT is based off the 5 A's approach adopted by the United Preventative Services Task Force and Centers for Medicaid and Medicare Services for obesity counseling. Primary care physicians will preform it.

**Plan:** IBT is a year long program, its schedule consist of Face to Face weekly visits for the 1<sup>st</sup> m month. It then moves to face to face visits every other week for months 2-6, and for months 7-12 visits are once a month. This constitutes a total of 20 visits in the year. In order for the patient to continue with the IBT program, they must lose a total of 6.6lbs in the first 6 months. Although a complete time line has been developed, there are no uniform guidelines or resources on how a primary care physician should conduct IBT and what exactly should be targeted at each visit.

## 3 Year Timeline

- •1st year- Create Universal guidelines for IBT and assemble tools/handouts to use during each IBT session
- •2<sup>nd</sup> year- Partner with Primary Care Physician and run a pilot study using Universal IBT Guidelines and tools/ handouts
- •3<sup>rd</sup> year- Collect data and analyze, implement into capstone project

## Table 1.. The 5 As Approach Adopted by the USPSTF and CMS in Obesity Counseling<sup>8,9</sup> Ask about and assess behavioral health risk (s) and factors affecting choice of behavior change goals and Give clear, specific, and personalized behavior change advice including information about personal health harms Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change behavior Using behavior change techniques (self-help or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social and environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate Schedule follow-up appointments (in person or by telephone) to provide ongoing assistance and support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment. CMS Centers for Medicaid & Medicare Services; USPSTF United States Preventative Services Task Force



### Literature cited:

MA. Accessed June 22, 2015.

Hamirudin A, Charlton K, Dalley A, et al. Feasibility of implementing routine nutritional screening for older adults in Australian general practices: a mixed-methods study. BMC Family Practice [serial online]. 2014; Available from: Academic OneFile, Ipswich, MA. Accessed June 22, 2015.

Kolasa K. Developments and challenges in family practice nutrition education for residents and practicing physicians: an overview of the North American experience. European Journal Of Clinical Nutrition [serial online]. 1999; Available from: AGRIS, Ipswich, MA. Accessed June 22, 2015.

Kolasa K, Rickett K. Barriers to Providing Nutrition Counseling Cited by Physicians: A Survey of

from: Science Citation Index, Ipswich, MA. Accessed June 22, 2015. Sharma A, Kushner R. A proposed clinical staging system for obesity. International Journal Of Obesity

<del>serial online]. March 2009,33(3).289-295. Available from. Academic Search Premier, Ipswich,</del>

Primary Care Practitioners. Nutrition In Clinical Practice [serial online]. n.d.;25(5):502-509. Available

management and bariatric surgery. Bariatric Nursing and Surgical Patient Care [serial online]. 2011:25. Available from: Academic OneFile, Ipswich, MA. Accessed June 22, 2015. Yao A. Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force

Idzik S, Davenport J. Implementing an educational program for primary care providers on obesity

Recommendation Statement: A Policy Review. Annals Of Medicine And Surgery [serial online]. January 1, 2013;2:18-21. Available from: ScienceDirect, Ipswich, MA. Accessed June 22, 2015.

## Acknowledgments

We would like to acknowledge the following for their support in our project:

- Lehigh Valley Health Network
- •Gerald Rodriquez behavioral therapist

Act / Conclusions: A completed guideline to conducting IBT was created along with labeled and organized tools/handouts sheet. The tools/handout sheet contains the list of resources to be used during each IBT session. Included in the handout is quality of life survey specifically QOL SP36. This is to be given to patients at the 1<sup>st</sup> visit, 14<sup>th</sup> visit, and the 20<sup>th</sup> visit. This will be scored and used to determine if their quality of life has improved as a result of the IBT pilot study. This data will then be analyzed to determine if the guidelines have a significant impact on weight loss for the patient as well as improve their quality of life. Obesity has become a serious health issues and it is imperative that the healthcare system create sustainable improvements to combating this issue.

Ways to improve: After extensive research some concerns and challenges have been identified with the Medicare obesity benefit.

- Weight loss intervention differs in older and younger adults, yet the benefit of IBT relies predominately on data collected from interventional studies on younger people.
- •BMI is not the most accurate measure to identify obesity.

## Proposals to overcome shortcomings:

- Obesity treatment should focus on improving quality of life, physical function, and mitigating muscle and bone loss rather than focusing solely on weight loss.
- Weight circumference or waist-hip ratio should be considered as additional anthropometric measures in ascertaining obesity.