

AIM-HI Practice Manual



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Table of Contents

Introduction	2	Foundations For Fitness	21
Integrating Fitness Into Your Practice	3	Physical Activity And Health	21
Assess Practice Environment	3	Overview And Assessment	21
Get Started With The AIM-HI Tools	4	Prescribing Physical Activity	21
Adjust Office Processes and Procedures	4	Strategies For Increasing Physical Activity . . .	22
Establish A Referral System	6	Increasing The Likelihood Of Success	
Maximize Reimbursement	7	For Patients	22
Working With Patients	9	Healthy Eating.	22
The Patient-centered Conversation.	9	A Non-diet Approach To Health Living	23
The Teachable Moment	11	The Eating Cycle	23
The AIM-HI Fitness Inventory.	12	Small Changes, Big Results	23
Using The AIM-HI Fitness Inventory Results .	12	Emotional Well-being	26
Fitness Prescription	13	Physical Activity And Emotional Health	26
Using The AIM-HI Fitness Prescription	13	Nutrition And Emotional Health	26
Writing The AIM-HI Fitness Prescription	14	Sleep And Emotional Health	26
Food & Activity Journal.	15	Helping Patients Improve Their	
Using The Food & Activity Journal	15	Emotional Health	27
Following-up With Patients	15	Coping With Stress	27
How And When?	15	Improving Sleep.	28
Contact Methods	15	Appendices A – R	20
Addressing Relapse	15	Bibliography	29
Being Sensitive To Obese Patients' Needs	16		
Cultural Considerations For Addressing Fitness . .	16		
Health Literacy	20		
Pharmacotherapy	20		



Introduction

Family physicians and clinicians play a vital role in encouraging patients to lead healthy lives through physical activity, healthy eating, and emotional well-being — that is, through **fitness**. Your practice has taken a major step toward improving your patients' fitness by participating in AIM-HI. The AIM-HI approach focuses on facilitating a conversation between you and your patients. Our goal is not to provide you with just a stack of handouts and patient educational materials; rather, we hope to improve your ability to engage in a patient-centered conversation about fitness.

Fitness includes three interconnected domains: physical activity, healthy eating and emotional well-being.

Throughout the AIM-HI materials, you will see that we intentionally present fitness in a central role as “the treatment of choice” for general prevention and management of chronic conditions. AIM-HI was developed by family physicians for family physicians and the family medicine office environment. In part, this approach was adapted from Am I Hungry?, a multidimensional program developed by AAFP family physician, Michelle May, M.D. AIM-HI will help you integrate a fitness focus in your practice through implementation of the following critical steps:

- STEP 1** Raise awareness among clinicians and office staff regarding their own personal physical activity, nutrition, and emotional well-being; and encourage everyone to make changes for the better. This is covered in **“Fostering a Healthy Office.”**
- STEP 2** Create an office environment that is conducive to including AIM-HI concepts in everyday office routines. This is covered in **“Integrating Fitness into Your Practice.”**
- STEP 3** Use AIM-HI tools and resources to help your patients improve their fitness. This is covered in **“Working with Patients.”**
- STEP 4** Improve clinician and staff knowledge of the central role of physical activity, nutrition, and emotional well-being in health. This is covered in **“Foundations For Fitness.”**

The AIM-HI approach relies on three critical tools that all practices are encouraged to adopt:

1. **AIM-HI Fitness Inventory** — a brief survey for patients to complete that assesses their attitudes, interest, readiness to change behavior(s), and behaviors or patterns regarding physical activity, nutrition, and well-being; done annually at check-in.
2. **Fitness Prescription** — a contract between the patient and clinician that uses simple, measurable, mutually “agreed upon” goals that are assessed periodically.
3. **Food & Activity Journal** — a week-long journal that patients can use to track their physical activity and nutrition to be assessed at the next visit.

These tools and “how to use them” are described in this manual. Additionally, you will find a number of supplementary educational tools and handouts that you can use to stimulate dialogue within your practice and with patients and the appendices. Feel free to expand on the AIM-HI concepts and materials to suit your practice and patient populations.

AIM-HI material should be considered a progressive guide. Begin using these materials sequentially, as presented in this manual. The goal is to maximize awareness and integration of AIM-HI steps at the practice level before you adopt these strategies at the patient level.

The term “clinician” refers to physicians, nurse practitioners, residents and medical students — those that assess and treat patients.

Integrating Fitness into Your Practice

Your practice may already be great at talking to most patients about fitness (physical activity, healthy eating, and emotional well-being), or you may need some help figuring out how to integrate fitness discussions into patient visits. This part of the AIM-HI manual will help you think about how your office works and how you can make small changes to encourage clinicians and staff to use AIM-HI tools with patients.

Integrating Fitness into Your Practice

1. Assess the Environment
2. Get Started with the Tools
3. Adjust Processes and Procedures
4. Establish a Referral System
5. Maximize Reimbursement

1. Assess Your Practice's Environment

Your practice can demonstrate a commitment to fitness and facilitate patient-centered conversations about fitness by proactively setting up the physical environment to support fitness. Take a look at the way you do things now and consider making changes to better support fitness. Conducting a brief, informal assessment of your practice will help you examine where your practice is-in terms of promoting fitness.

To assess how your practice does or does not support fitness, you may need to examine its policies, procedures, equipment, etc. You can accomplish this by using the following Practice Assessment Questions.

Practice Assessment Questions

1. What approaches does your practice use to encourage patients to engage in a behavior change for:

- Physical activity?
- Healthy eating?
- Emotional well-being?

Examples may include distributing educational materials, referring patients to behavior change classes, and involving support from behavior change specialists such as health educators and dietitians.

2. How does your practice environment currently promote fitness?
3. Imagine that your practice is successfully doing everything that it can do to promote fitness. How might that look?
4. What are some of the challenges to promoting fitness in your current practice routine?
5. What has worked in terms of promoting fitness in your practice? What hasn't?
6. What policies, procedures, and systems do you have in place for promoting fitness?
7. What roles and responsibilities do staff have in promoting fitness?
8. What community resources are available for patients?
9. How do you link patients to community resources?
10. What fitness promotion services and activities (with patients) does your practice document?
11. What areas would you like your practice to improve as it relates to promoting fitness?

Once you have assessed attitudes and policies related to fitness, you should look at the physical environment of the practice, to see if certain aspects facilitate or hinder patient interactions about fitness. Use the Checklist for Office Environment to see if your practice is ready to take on fitness.

Integrating Fitness into Your Practice

Checklist for Office Environment

Does the waiting room have the following culturally appropriate materials?

- Fitness health guides or educational materials
- Fitness posters
- Fitness magazines
- Audio/video displays (optional)

Do exam rooms or adjacent areas to exam rooms have the following?

- Tape measure (for waist circumference measurements)
- Scales with a capacity of more than 300 pounds
- Scales located in private area
- Sturdy exam tables and chairs to accommodate large patients
- Gowns for people of different sizes
- Body mass index measuring tools
 - Adult BMI Chart
 - BMI-for-Age Instruction Guide
 - Growth and BMI Charts for Children and Teens Ages 2 to 20
- Fitness posters
- List of local resources

Do you have established procedures (protocols) for:

- Following the Adult Obesity Clinical Guidelines
- Distributing patient education materials
- Starting the conversation about fitness
- Documenting fitness promotion
- Following-up with patients
- Evaluating fitness promotion activities

2. Get Started with the AIM-HI Tools

After you have evaluated your practice's current physical environment and resources and considered how you might make changes to better support AIM-HI and fitness in your practice, you are ready to begin using the AIM-HI tools with patients. We recommend developing a plan for how you will implement the AIM-HI program in your office.

1. Ensure all staff and clinicians know about AIM-HI and their role in sharing the tools with patients. Holding an in-service training session will motivate staff, promote teamwork, and help formalize the protocol for delivering AIM-HI. For example, you can
 - Share information that you gathered during your practice assessment.

- Discuss the main goals of AIM-HI, how AIM-HI promotes fitness, and potential benefits to patients, staff, and the practice.
- Present and explain each of the AIM-HI tools.
- Discuss staff roles and responsibilities in implementing the intervention (see next section for more detail).

2. Decide how each tool (AIM-HI Fitness Inventory, Fitness Prescription and Journals) will be delivered to and used with patients.
3. Strategically locate AIM-HI materials (i.e., AIM-HI Fitness Inventory, Fitness Prescription pads, and Food & Activity Journals) throughout your office and make them visible to everyone. Identify ways to ensure that patients, staff, and clinicians are exposed to multiple messages about AIM-HI at different times while at the office (waiting areas and exam rooms).

Patient Scenarios

AIM-HI developed a number of instructional patient scenarios about fitness your practice can use to build skills for clinicians and staff. These scenarios provide examples of what the patient-centered conversation looks like. Use these patient-based scenario cards to orient staff to the opportunities to discuss fitness with patients and to provide an opportunity to develop and practice new skills before trying this new approach with patients. These scenarios are included in your AIM-HI Materials, separate from this practice manual.

3. Adjust Office Processes and Procedures

Consider how you might modify your current office processes to integrate AIM-HI into routine clinical procedures. Successful integration of AIM-HI into your practice routines will promote sustainability of the program, help staff think about fitness issues as a part of clinical care (not just an educational add-on), and create an environment that supports fitness. Examples of process modifications at the patient level include

- incorporating the AIM-HI Fitness Inventory into periodic screening activities,
- adding BMI and waist circumference to routine vital sign measurements,
- adding system prompts/reminders for clinicians to address fitness with patients,

- providing information to help with reimbursement, billing and coding during the visit,
- providing continuing education opportunities related to fitness for staff,
- providing regular updates and feedback to staff, and
- establishing a feedback mechanism with health clubs or weight management programs to track patients that have been referred by your office.

Next, take a moment to examine how patients flow through your office while considering each of the AIM-HI tools. See the sample Patient Flow Chart on page 9. This will help you identify opportunities where you can incorporate aspects of AIM-HI to ensure that patients are exposed to fitness promotion messages and receive adequate support from staff. Questions that you may want to consider include:

- What happens when patients enter the clinic?
- Who do patients see before seeing the clinician?
- What happens to patients when vital signs are measured?
- What information is exchanged with patients before the patient/clinician encounter?
- What happens when patients see the clinician?
- How do clinicians support fitness during the encounter?
- What services are documented, and how?
- What reminder systems and prompts are in place for clinicians to alert them of opportunities to discuss fitness?
- What happens when patients exit the clinic?

Determine specific points where you can modify your operating procedures to create opportunities to deliver AIM-HI to patients. You need teamwork to successfully integrate the AIM-HI program. Make sure each clinician and staff member understands his or her role and responsibilities for promoting fitness (see patient visit flow chart on page 9). Remember, the impact of AIM-HI tools is greatly increased by clinicians and staff reinforcing fitness promotion messages at the right moment.

- What process modifications can help staff implement AIM-HI?
- How might a patient “slip through the cracks” and miss an opportunity to discuss fitness?
- How might staff support each other?

Incorporate **systematic prompts/cues** and operating procedures to support dialogue about fitness with patients at every visit. Consider how your clinic will incorporate systematic triggers throughout the normal day-to-day practice routine that may encourage and support specific patients, clinicians, and staff to fitness discussions of.

- Prompts can include placing reminder sheets or flags in charts, identifying patients prior to their visit, getting automated alerts, and handing all patients an AIM-HI brochure at check-in.
- Weight management or lifestyle DVD’s played in the waiting room may encourage patients to talk to staff or at least ask questions signaling interest.
- Challenge patients to walk 10,000 steps with you
- Wear pedometer and use it as a prompt for discussing fitness with patients

Determine staff performance goals/expectations for implementing AIM-HI. For example, you may decide to record BMI for every patient whose height and weight are measured at your site. Identify staff responsible. (see flow chart, page 9, for example).

Incorporate systematic prompts/cues and operating procedures to support dialogue about fitness with patients during most visits. A systems and team approach will help make fitness a routine part of patient visits. Prompts can include placing reminder sheets or flags in charts, placing fitness promotion items next to stairs, etc.

Integrating Fitness into Your Practice

Patient Visit Flow Chart

Front Office Staff:

- Hand patient AIM-HI Fitness Inventory

Patient Checks in

Nurses or Medical Assistants:

- Calculate BMI
- Measure waist circumference
- Explain why these (BMI, waist circumference) are done
- Review AIM-HI Fitness Inventory and screen issues for clinician to address
- Introduce or remind patients about AIM-HI tools

Vital signs checked

Patient meets with clinician

Clinicians:

- Refer to the Adult Obesity Clinical Guidelines
- Ask if patient is willing to discuss lifestyle changes today
- Use AIM-HI Fitness Inventory
- Discuss BMI, waist circumference
- Stay alert for opportunities to discuss fitness (e.g., when talking about chronic conditions)
- Use Fitness Prescription to help patient set goals
- Plan follow up intervals
- Ask patient to complete Fitness & Activity Journal
- Document appropriate information in charts

Patient leaves

Front Office Staff:

- Remain available to answer fitness questions or provide fitness resources
- Schedule referrals and follow up appointments

Nurses or Medical Assistants:

- Remain available to answer fitness questions

4. Establish a Referral System

Just as you have a referral system for getting patients into subspecialty care, you need a strong referral system related to fitness. For example, for patients who would benefit from additional one-on-one support, you may refer them to registered dietitians, health educators, local physical activity centers, personal trainers, walking groups, and wellness centers.

If a patient's main goal is to improve emotional well-being, you will need to focus on resources that provide access to these opportunities within your community. Remember, not all referrals will be weight-based.

Treating patients in an effective and cost-efficient manner requires a strong relationship with allied healthcare professionals. The clinician and registered dietitian should be at the core of any treatment team where improved fitness is a goal. While both members of the team understand the pathophysiology of obesity, the dietitian often sees the patient on a more regular basis throughout all stages of the obesity treatment.

The clinician assesses, diagnoses, and monitors the overall medical progress of the patient. Clinicians are usually more involved in the acute or weight change stage of obesity. **It is important to note that Centers for Disease Control and Prevention data indicate that patients are three times more likely to undertake a weight loss program if a clinician suggests that they do so.**

Dietitians assume more team responsibility during the patient's chronic or weight maintenance stage. The dietitian has primary responsibility for assessment and recommendations related to food behavior. Because of the interrelationship of physical activity to energy expenditure, the dietitian may also be involved in assessment and recommendation of activity, provided the patient is cleared for physical activity by the clinician. Additionally, the dietitian may be asked to interpret the results from the initial assessment and make appropriate, patient-matched treatment recommendations. The dietitian plays a major role in helping the patient formulate reasonable goals, which can be met using the 2005 *Dietary Guidelines for Americans*.

Healthcare professionals should work as motivators and reinforce what the other team member suggests. Most research indicates that behavior therapy and regular physical activity are necessary for long-term success. Generally, the dietitian is better positioned to conduct this follow up. Continued patient contact further ensures successful weight maintenance for the patient.

While clinicians and staff may not have all the answers or all the resources a patient needs, there is help available to support both you and your patients.

Find out what resources are available within your local community to encourage patients to explore these services. Develop your own local “Fitness A to Z” list that includes resources such as local YMCAs, fitness centers, registered dietitians, and groups such as the early morning mall walkers. Keep a copy of this list in patient rooms for reference. Below are two resources developed in cooperation with the AAFP.

Age-Friendly Fitness Locator (<http://www.icaa.cc/facilitylocator.htm>) — The International Council on Active Aging (ICAA) created a special section of its Web site as part of its relationship with the AAFP to quickly assess locations in your area for patients interested in a structured facility approach to physical activity.

Family Physician Nutrition Resource Center (<http://www.nationaldairycouncil.org/NationalDairyCouncil/FamPhyResCen/index.asp>) — This National Dairy Council resource center includes a nutrition professional locator service, supported by the American Dietetic Association and reproducible patient education tools. You can also access the American Dietetic Association (www.eatright.org) to locate a Registered Dietician by typing in your zip code.

Note that out-of-pocket costs may be a barrier for some referrals.

5. Maximize Reimbursement

As most clinicians know, Medicare and most private payers do not consider services related to obesity or weight management covered under benefit plans. Because of this, clinicians must link services to covered diagnoses such as diabetes, hyperlipidemia, metabolic syndrome or hypertension.

Likewise, clinician services aimed at helping patients to manage their health conditions through behavioral health counseling are not separately reportable and payable beyond counseling included in an evaluation and management service for a covered condition. Codes for services such as health and behavior

assessment/intervention are limited for use by non-clinician healthcare professionals. However, this does not mean that there is no reimbursement for clinician services.

When clinicians spend more than half of the face-to-face time with a patient in counseling and coordination of care activities, the level of evaluation and management service provided may be chosen based on time. Counseling is defined in CPT as discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results and/or recommended diagnostic studies,
- Prognosis,
- Risks and benefits of management (treatment) options,
- Instructions for management (treatment) and/or follow up,
- Importance of compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

Thus, time spent discussing the potential benefits of lifestyle changes with patients, that have been identified as lessening the risks associated with or as helpful in managing their diagnosed condition, would be considered counseling.

Assume that you see a hypertensive, obese patient in follow up who has no new complaint and requires only an expanded problem-focused history and examination. Even if you documented medical decision making of moderate complexity, this would probably be reported with code 99213 based on the key components. However, if you have spent 25 minutes of face-to-face time with this patient and at least 13 minutes of that time was spent in counseling, the service may be reported as a 99214 based on time. The significance is indicated by the average Medicare allowable amounts for codes 99213 and 99214. While the national average allowable for a 99213 is \$59.50, the national average allowable for a 99214 is \$90.20. Billing based on time would result in over \$30.00 more in payment for the service than billing based on key components. Likewise, a 15 to 20 minute visit with 50% counseling will be a 99213 and a 40 minute visit (multiple problems) as a timed visit will be a 99215.

In order to report services based on time, documentation should include the approximate amount of time spent

Integrating Fitness into Your Practice

face-to-face with the patient, approximate amount of time spent counseling, and details of the discussion between the patient and clinician.

Example of documentation language:

"Discussed the risks associated with hypertension and obesity with patient, patient feels he does not eat excessively but has always been big boned, asked the patient to keep a diary of his diet for one week, physical activity - 2 flights of stairs twice per day and bowling once a week, patient agrees to use pedometer and record steps daily until next visit, time spent 25 min. w/counseling 15 min."

To learn more about billing based on time, see **"Time is of the Essence; Coding Based on Time for Physician Services,"** *Family Practice Management*, June 2003.

Note also that patients may be seen in follow up to clinician services by staff, incident to the clinician, for services such as recheck of blood pressure measurement. Under Medicare, incident to guidelines, these services may be reported with code 99211 as long as they are medically necessary. Such visits represent another opportunity to evaluate the patient's progress and provide educational materials to assist the patient. The national average allowed amount for code 99211 is \$20.09.

When in the course of a preventive service visit, the clinician addresses problems that require significant work beyond that of the preventive service, the work of diagnosing and managing the problem may be separately reported. The problem-focused E & M service is reported with the appropriate level of office or other outpatient services code appended with modifier 25. Separate documentation of the chief complaint, history of present illness, problem focused review of systems and examination, and plan of care may allow for easier determination of the appropriate level of service and is useful in indicating to payers the additional work of the service.

Note that counseling, anticipatory guidance and risk factor reduction are included in the preventive service. When a "significant problem" focused E & M service is provided on the same date as a preventive service, only counseling specific to the management of the problem would contribute to the level of that service. Medicare requires that the clinician deduct the amount paid for the problem-oriented service from the cost of the preventive service provided on the same date. Many private payers, but not all, pay the clinician for both services.

Group visits. You may have success scheduling group visits with patients who are working on improving fitness. In group visits, the patients teach each other and share successful strategies. Your patients may find that group visits provide emotional support and reduce any stigma they may feel. Two types of group visits are coordinated health care clinics (CHCCs) and drop-in group medical appointments (DIGMAs). See <http://www.aafp.org/fpm/20030500/66grou.html> for more detail on how to conduct group visits.

List of codes:

- 277.7** Dysmetabolic Syndrome (need diagnosis, need 3 of 5 for diagnosis)
- 278.00** Obesity, unspecified
- 278.01** Morbid Obesity (BMI 30-39.9)
- 278.02** Overweight (BMI 25-29.9)
- 414.01** Coronary Artery Disease, native coronary artery
 - 401.1** Hypertension, benign
 - 401.9** Hypertension, unspecified
 - 796.2** Elevated Blood Pressure, w/o diagnosed hypertension
 - 272.0** Pure Hypercholesterolemia
 - 272.4** Other and Unspecified Hypercholesterolemia

Example Note for Level IV (Time-based) Follow-up Visit for patient with Hypertension

CC: Hypertension F/U

HPI: Doing well on his HCTZ and lisinopril, no noted side effects, no chest pain, SOB, DOE, PND, impotence or edema noted has not increased activity trying to watch diet but still eats fast food 4 - 5 times per week

Exam: BMI 32, Weight 224, BP 138/88 P 76 T 98.4

Lungs clear to A and P

RRR without murmur – distant heart sounds

No edema

A/P: HTN – controlled on meds but drifting upward, weight up 2 more pounds, may be developing metabolic syndrome, counseling provided re: effect of physical activity on weight, blood pressure and cardiovascular risk- will begin to wear pedometer and find ways to add 2000 steps per day- hand out given

Return in 3-4 weeks fasting for cholesterol

Total visit 25 minutes – 15 counseling

Working with Patients

This section of the AIM-HI manual covers how you can use the AIM-HI tools and philosophy to help patients improve their fitness. First, we start by discussing how to work with patients in a patient-centered way, different characteristics of the Stages of Change, how to take advantage of teachable moments, and how to be sensitive to cultural considerations and issues of health literacy. Next we move into step-by-step instructions for using the AIM-HI tools — the Health Inventory, the Fitness Prescription, and the Food & Activity Journal. Finally we describe how to set (and keep) follow up appointments with patients, how to encourage progress and maintenance of behavior changes, and how to prescribe pharmacotherapy, when indicated.

The Patient-Centered Conversation

A major component to any conversation is assessing patients' attitudes and readiness to change. "Patient-centeredness" is a communication style in which clinicians actively seek patients' views of their illness and/or health and encourage patients to express expectations, thoughts, feelings, and other aspects of their individual experience during the patient-clinician encounter. There's emerging evidence that "patient-centered" care is associated with greater patient satisfaction and better medical outcomes than more traditional approaches that have been described as more disease or doctor-centered.

The AIM-HI Fitness Inventory promotes patient-centered conversations between patients and clinicians by helping clinicians to assess and consider patients' attitudes and readiness to discuss changes in lifestyle choices, rather than simply telling patients what to do. As clinicians capture "teachable moments" with patients to discuss fitness, they should actively engage patients in the conversation to uncover their readiness to change, identify areas where they would like to focus, how they would like to proceed, and what their personal goals may be.

Behavioral counseling techniques such as the Five A's or motivational interviewing also promote "patient-centered" communication. Both approaches were developed and have been found effective to help address behavior change.

The Five A's approach (Ask, Advise, Assess, Assist, Arrange) involves a process of steps to structure interventions in a concise and effective manner to address many health behaviors.

- Visit <http://www.ahrq.gov/clinic/3rduspstf/behavior/behavintr.pdf> for more information about the Five A's behavioral counseling construct.
- Visit www.motivationalinterviewing.org for information about Motivational Interviewing.

Motivational interviewing is another effective counseling technique for behavior change. It is "a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence." Motivational interviewing is based on:

- using nondirective counseling skills through reflective listening,
- centering the conversation on the patient, and
- using reflective listening statements, directive questions and strategies to bring out the patient's internal motivation or desire to change.

While time may be too limited in the average patient encounter to thoroughly apply such principles, it is possible to apply the basics of these effective behavioral counseling techniques to all your conversations with patients. It is also critical to communicate your ongoing support and motivate your patients toward sustained behavior change. Tailor your approach to enable patients to open up and discuss their health.

The Stages of Change Theory divides people into categories based on their thoughts and actions about change. People move from uninterested, unaware or unwilling to make a change ("precontemplation"), to considering a change ("contemplation"), to deciding and preparing to make a change ("preparation"), to modifying behavior ("action"), to avoiding a relapse ("maintenance"). The following table shows how you can use a patient's readiness for change to have a patient-centered discussion about fitness.

Working with Patients

Patient Characteristics	Stage of Change	Discussion Topics	Example Questions	Potential Handouts
Not currently interested or considering change; "ignorance is bliss"	Pre-contemplation	Come at the problem/issue with a "benefits based" approach. Discuss the potential benefits of lifestyle changes and indicate that you are available if and when they are ready to discuss it further.	<ul style="list-style-type: none"> • How do you feel about your health these days? • Would you consider me a resource if you are interested in making changes in the future? 	Appendix A
Open to making changes for better health at this time; "sitting on the fence"	Contemplation	Discuss some of the changes they could make and help them determine an achievable goal (e.g., to eat more fruits and vegetables, to make time for exercise, OR to gain more "me" time for hobbies, etc.).	<ul style="list-style-type: none"> • Are you willing to make some changes to improve your cholesterol levels? • What would you like to do to try to simplify your life? • Would you be open to exploring a couple of ways to be more active every day? • What are some things you could see yourself doing to relax? 	Appendix B, D, E, H and P
Ready to commit to changes; "testing the waters"	Preparation	Let patients decide what their goal is. The emphasis should be on the patient's goal and how he or she can make small changes in daily life for meaningful, lifelong results.	<ul style="list-style-type: none"> • What would you like to see come out of trying to eat better? • What do you want out of this? 	Appendix B, C, E, F, G, L, M, N and O
Already doing something to improve their health; "Charge!"	Action	Offer support, referrals and tools. Anticipate challenges and set-backs and discuss ways to handle them.	<ul style="list-style-type: none"> • You seem healthier today since our last visit. Have you been doing anything different? • You look really fit today. Tell me what you have been doing since I saw you last time. • You seem to be in a good mood today; tell me what you've been up to. 	Appendix B, C, G, J, K, N and Q

Adapted from C.O.R.E., Centers for Obesity Research and Education.

Key Reminders:

1. Keep in mind that patients will be at different stages of change. Therefore, each conversation must be individualized.
2. The goal is to facilitate discussion and then enable patients to determine their own solutions for improved health.
3. Allow patients to share reasons for or against change and how their current lifestyle choices may support or conflict with their health goals.

4. State that you are willing to provide ongoing support and encouragement.
5. Refer patients to community resources to help them build on the efforts they make toward better health, as needed.

As you enable patients to take charge of their own health and make healthy decisions, you may offer some additional resources to let them further explore what healthy changes they can make after leaving the visit. See the handouts in the appendices for specific patient materials.

The Teachable Moment

The AIM-HI approach focuses heavily on recognizing, creating, and capitalizing on the “teachable moment.” The “teachable moment” is that point in the patient visit where you are able to reshape the conversation from advice-giving to shared decision-making. This opportunity often presents itself when patients are presented with information that requires them to attend to or process new information. We encourage you to capitalize on “teachable moments” in every possible patient encounter to discuss healthy lifestyle choices. Some key opportunities you could use include new patient visits, annual physicals, women’s wellness exams, well-child exams, group visits, and problem-oriented office visits for the many diseases influenced by lifestyle choices. Once you decide to engage your patient in this conversation, it is important to open and discuss the topic effectively.

A teachable moment also presents itself when clinicians provide patients with a set of issues concerning their overall health. This moment allows clinicians the opportunity to re-evaluate assumptions, create an opportunity to deepen learning, and empower the patient to act.

Rarely does a patient present with the stated need to “help me improve my nutrition.” Rather a patient presents with a specific acute or chronic condition. The current treatment approach includes addressing the acute or chronic problem; however, visits such as these are also opportunities to address other areas. You may note a change in vital signs or hear patients casually mention issues that provide a segue into a conversation about fitness. Remember, too, that the majority of chronic diseases can be improved through increased activity and improved nutritional status.

Helping patients understand the opportunities for improved fitness and how it is interrelated with their chronic problems is very important but challenging. Use an open-ended, non-threatening question/answer patient-centered conversation to discuss these concepts in a way that does not make the patient resistant.

As you notice “teachable moments” to discuss fitness with patients, actively engage them in a conversation to uncover their readiness to change, what areas they would like to focus on, how they would like to start and what their personal goals are.

We believe that by modifying routine patient care to incorporate six simple steps with each and every patient, practices can:

- build a dialogue that is patient-centered and focused on the total patient,
- bring about a desire for behavior change and eliminate resistance when dealing with lifestyle and personal change,
- approach change through realistic, yet measurable, goal setting,
- improve continuity of care
- develop a plan together that ultimately places the patient in the position of power, not the clinician.

AIM-HI encourages the use of these six steps (and tools) with patients.

1. Have patients complete the **AIM-HI Fitness Inventory** and review their interests and readiness to make changes (Appendix A)
2. Using the AIM-HI Fitness Inventory, establish a patient-centered dialogue and ask questions
3. Agree on goals and write a **Fitness Prescription** (Appendix B)
4. Commit to each other by signing the Prescription
5. Provide a **Food & Activity Journal** (Appendix C)
6. Set up a plan for follow up and referral if needed

Working with Patients

The AIM-HI Fitness Inventory (Appendix A)

The AIM-HI Fitness Inventory is intended to capture the patients' interest, willingness, and confidence about their personal fitness. It also provides a snapshot of their readiness to change and desire for help. Using the AIM-HI Fitness Inventory, you'll find that some patients may already be in a process of change and sustained behavior change (requiring your support, encouragement and credible guidance) while others will be in the pre-contemplative stage.

The AIM-HI Fitness Inventory has two parts and purposes. First, it assesses the patient's interest and readiness by asking if the patient is currently engaging in specific fitness activities and if not, asks whether or not he or she would be willing to start. It also gives the option to decline support. This is an important element of the AIM-HI Fitness Inventory. If patients are not ready or willing to address their fitness concerns (pre-contemplation), your facilitation of the conversation will be different than for that of a patient in contemplation or maintenance.

Second, the AIM-HI Fitness Inventory asks brief questions pertaining to current activity in each fitness domain. This element is also important because to establish a productive dialogue, you can ask patients about their progress and build upon what they are currently doing.

The AIM-HI Fitness Inventory provides the clinician and staff with a springboard for discussion, education, and counseling to discuss fitness and a healthy lifestyle in a proactive and positive way. It will aid in the development of a shared plan.

We suggest the **front office staff administer the AIM-HI Fitness Inventory at check-in**. Once completed, it should be handed to the intake nurse or medical assistant. It is then reviewed, used to guide initial discussions, and made available for clinicians. Prior to entering the exam room, the clinician will review the AIM-HI Fitness Inventory. During the patient encounter, the clinician will highlight items of particular relevance and ask questions, in addition to addressing the reason for the visit. Patients' responses on the AIM-HI Fitness Inventory will be related to their interest, willingness, confidence and readiness towards fitness and ultimately will lead the

patient and the clinician to establish specific, realistic and actionable goals and more importantly a shared plan.

The AIM-HI Fitness Inventory should be integrated into the office routine and reassessed annually for all patients. This activity should be considered just as important as gathering insurance information each year. The AIM-HI Fitness Inventory should also be provided to all new patients upon entering your practice.

Using the AIM-HI Fitness Inventory Results

You can use the AIM-HI Fitness Inventory to work with the patient to **establish goals that are realistic, specific and actionable**. For example, a patient indicates on the AIM-HI Fitness Inventory that she has an active lifestyle, does not participate in a formal walking or exercise program, and is not interested in making a change. However, she is interested in improving her diet and indicates that she is not eating five fruits or vegetables a day and has a diet high in saturated fat. She has no concerns about her emotional well-being at this time.

Using the **Fitness Prescription**, the clinician would work with her to set concrete goals for change. For example, she might first choose to set a goal to increase her fruits and vegetables by taking fruit to work for a snack and having a salad with dinner. At the next follow up visit she says she succeeded in improving her fruit and vegetable consumption, so with your encouragement, she might next decide to decrease her saturated fat intake by buying leaner cuts of meat and substituting beans or fish several times a week.

As patients experience **small successes, their self-efficacy improves** and they become **motivated** to make additional lifestyle changes. Setbacks can be framed as "learning experiences or opportunities."

Fitness Prescription (Appendix B)

Whether a patient is underweight, overweight, suffers from a chronic disease, or even appears to be healthy, he or she should be encouraged to consider choices that will lead to a healthier lifestyle for primary prevention and weight management or weight maintenance. The AIM-HI Fitness Prescription is a tool that helps you and the patient create a plan for the future. Although there are more physically oriented “exercise prescriptions” the AIM-HI Fitness Prescription is a broader approach using a 4x3 approach. The three domains of fitness (physical activity, healthy eating, and emotional well-being) are interrelated with the four areas of personal interest and commitment.

- **Opportunity** — “What do I want to do or what am I willing to do?” (walk after dinner, use stairs, ride a stationary bike, park further away, get off the bus a block early and walk)
- **Goal** — “My Target, My Reason” (to keep up with my kids, feel better about myself, lose weight, reduce the cost of my medications)
- **Dose** — “How much, how often?” (I think I can only do three times a week to start, I will start with 15 minutes each day except for weekends)
- **Benefit** — “What’s in it for me?” (better fitting clothes, less money out for medications, breathe easier, feel stronger, fit in my old jeans, kids will be proud, enjoy playing again, feeling less stressed)

The AIM-HI fitness prescription is a broad approach that considers all three fitness domains as interconnected. This approach will minimize the burden on the clinician and provide a useful, simple, easy to understand framework for the patient. All four areas can be addressed in follow up visits and adjusted as needed.

The fitness prescription was developed to be a comprehensive, coordinated tool to suggest an interconnectedness; however, for some it may be overwhelming. For those patients and staff, setting one goal, such as physical activity, first, may be best. If the patient does well with this, another fitness domain, such as healthy eating, may be added during consecutive visits.

The most important/effective prescription you can write for patients is a personalized prescription based on their specific interests and needs, encouraging them to be physically active, eat healthier and take care of their emotional well-being.

Using the AIM-HI Fitness Prescription

Using the patient’s completed AIM-HI Fitness Inventory as your guide, ask open-ended questions and discuss potential goals. Refer back to the AIM-HI Fitness Inventory to identify the changes the patient is open to making. Work together with the patient to identify small changes that are both realistic and sustainable for the patient. **Keep in mind that this prescription may be just the first step toward supporting ongoing behavior changes.**

It is totally appropriate to agree to just one goal in one fitness domain or goals in all three fitness domains. **The outcome to this dialogue** will be to create a personalized fitness prescription with the **patient deciding on choices and committing to what he or she feels is realistic.**

One technique to ensure patients are invested in the goal setting process is to ask or allow them to, in their own hand-writing, using their words, fill in the goals for each of the three domains.

It is important to determine what the patient would like to explore and then focus on those benefits. This can be done simply by asking questions such as:

- What types of things do you enjoy doing?
- What makes you feel good about yourself?
- What kinds of things could you see yourself doing between now and our next visit to improve your overall health?

The personalized prescription also indicates that follow up conversations will be needed to share successes and challenges at the next visit. Once the personalized fitness prescription is provided to the patient, make sure to reference what was discussed and the outcome in the patient’s record. Make a note to follow up at the next visit you have with the patient to assess his/her progress, successes, challenges and insight.

Working with Patients

Signing the prescription signifies a contract between you and your patient. This has been proven to be an effective strategy for behavior change. Encourage patients to keep this prescription posted on their refrigerator or in a prominent place in the home and bring it with them for each visit.

How to Use the Fitness Prescription

1. Review the AIM-HI Fitness Inventory with the patient.
2. Using the AIM-HI Fitness Inventory as a guide, ask open ended questions such as “What are you interested in focusing on at this time?” to assess the patient’s readiness to change.
3. Based on the responses, work with the patient to identify one or two small changes that he or she is willing to make and that are realistic, actionable and sustainable.
4. Create the personalized fitness prescription with the patient, setting specific and measurable goals.
5. Allow the patient to write the goal in his or her own words to internalize it and ensure that the goal is properly communicated or represented.
6. Sign and have the patient sign the fitness prescription as a statement of your mutual commitment to work together.
7. Record what was discussed and what was written on the Fitness Prescription including the plan for follow up in the patient’s record.

Writing the AIM-HI Fitness Prescription

Just like any other prescription, individuals should know what is being prescribed, why, how to take it and any side effects or warnings. With this in mind, consider the following:

Opening Opportunity: Using the AIM-HI Fitness Inventory, note which opportunities in any or all of the fitness domains the patient is open to exploring.

Example One: A patient suggests she likes the nice weather and would like to be outdoors more.

Discuss activities she may be interested in doing outdoors to be more active, such as going for a walk or riding a bike. Encourage the use of a pedometer (step counter) to help motivate and create awareness of daily activity.

Goal: Once you have noted which opportunities will be considered, allow her to make note of specific goals for any or all areas of fitness.

Ask her to consider how often she feels she can be successful at this goal — if once, twice or more each week. Help her set a realistic goal.

Benefits: Ask her to verbalize what she will get out of this opportunity and encourage her to think about the benefit each time she is engaging in activity.



Food & Activity Journal (Appendix C)

Encouraging the patient to keep a Food and Activity Journal will help him or her become more aware of current behavior, patterns and the choices made each day related to eating and physical activity. Awareness is an important part of making lasting changes for healthy living. The **Food and Activity Journal** is a practical tool that patients can use to record their observations about their choices, including when, what and how much they eat, the situations (feelings) that may have affected their decisions and the types of activity and movement in their day.

Using the Food & Activity Journal

Ask the patient to complete this journal and bring it back to the next appointment. Emphasize that the purpose is awareness not judgment.

This is an opportunity to make a referral to a registered dietitian or exercise professional, if appropriate. Suggest the journal be taken to the dietitian for discussion with the dietitian.

Reinforce that using a journal is one of few very successful tools for changing behavior and successful weight loss. If the patient is receptive, encourage the “Search the Shelf” activity. (Appendix N) This is also a fun activity for kids. Another interesting activity that shows how adjusting serving bowls for one month can decrease overall calories consumed can be found in Appendix M.

Following-up with Patients

Most people change behavior gradually. Patients cycle forward and backward through stages ranging from uninterested, unaware or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation), to modifying behavior (action), to avoiding a relapse (maintenance). You can expect that relapses of some sort are almost inevitable. An adequate, individualized plan for **support and follow up** will help the patient with his or her change efforts, preferably leading to the “maintenance” phase of a healthier lifestyle.

You and the patient will establish a plan for adequate follow up — this plan should be tailored to the patients’ needs and health concerns. Part of the shared decision-making process includes a plan to evaluate progress or renegotiate goals — that is, to follow up. When formulating this plan, consider the appropriate intervals and the contact method that will work for both clinician and patient.

How and When?

The more frequently you have contact with the patient, the better the outcome. Schedule the first follow up visit within three weeks of issuing the fitness prescription.

Contact Methods

Frequency of contact for treatment is a major determinant of success, but the contact need not be limited to direct, in-person visits with the provider. Use whatever means exist to maintain frequent contact with patients, including contact with clinicians, dietitians, nurses, and health educators.

Telephone follow up. You can arrange to have patients call their clinician or a staff member to discuss how they are doing. If you have a staff member who can dedicate some time to this effort, have that person call patients. Determine what is best for your practice.

E-mail follow up. Using techniques similar telephone follow up, you can contact patients by e-mail.

Addressing Relapse

Relapse is part of the process of working toward life-long change. When you are working with patients who have relapsed, try not to view it as a failure — **patients may think this way**, so you might want to **explain that some relapse is to be expected**. For patients, experiencing relapse as failure, especially when it happens repeatedly, may cause them to give up. Similarly, try to **avoid thinking of patients who relapse as “noncompliant,” “nonadherent,” or “unmotivated.”** These labels focus on the patient’s character and do not account for the complex nature of the behavior change process.

When counseling a patient who has relapsed, begin by normalizing the situation and focusing on the positive. Explain to the patient that even though a relapse has occurred, the patient has learned something new about him- or herself and about the process of changing behavior.

Ask WHAT got in the way. The goal here is to have the patient identify obstacles. Note that the question isn’t a *why* question — again, if you assume that relapse is normal and expected, the why is already answered. For example, patients who travel frequently may find that they have trouble maintaining their physical activity goals while on business trips. Help the patient focus in on the details of the obstacles, which will later facilitate problem-solving. Some situations (such as business travel) aren’t

Working with Patients

necessarily changeable, so the patient will have to discover strategies that help overcome (rather than simply avoid) these challenges.

Ask HOW the patient would deal with the same situation in the future. This conversation will help the patient shift the focus from failure to problem-solving. Here is another opportunity for a very patient-centered conversation: patients will be more vested in solutions if they come up with them than if you prescribe them. As part of this discussion, you can have patients identify what worked previously.

Acknowledge the difficulty of the behavior change and provide encouragement. The goal of this exchange is to support patients and help them re-engage in the change process.

Have patients make a new plan or simply modify the current one using the Fitness Prescription, and shorten the interval between repeat visits required for success. Consider using phone calls for patients having difficulty reaching their goals. Ask patients if they need a new plan, need to modify their goals, or need a shorter timeframe to gage their success. Patients should finish this discussion with a sense that they have realistic, actionable and sustainable goals and that they can get back on track.

Being Sensitive to Obese Patients' Needs

Clinicians and staff in your practice may want to spend some time becoming aware of their own biases, developing empathy, and working to address the needs and concerns of overweight and obese patients. Some specific strategies recommended by North American Association for the Study of Obesity www.naaso.org are outlined below:

1. Consider that patients have probably had negative experiences with other health care professionals regarding their weight, and approach patients with sensitivity.
2. Recognize the complex etiology of obesity and communicate this to colleagues and patients to avoid stereotypes that obesity is attributable to personal willpower.
3. Explore all causes of presenting problems, not just weight.
4. Recognize that many patients have repeatedly tried to lose weight.
5. Emphasize behavior changes rather than just the number on the scale.

6. Negotiate concrete changes (e.g., start to add movement by walking for 30 minutes, eat at home three or more times a week), rather than simply saying, "You need to lose weight."
7. Acknowledge the difficulty of lifestyle changes.
8. Recognize that small weight losses can result in significant health gains.
9. Create a supportive health care environment with large, armless chairs in waiting rooms, appropriately-sized medical equipment and patient gowns, and friendly patient reading material.

You also may want to examine your own biases about weight. Ask yourself the following questions:

1. Do I make assumptions regarding a person's character, intelligence, professional success, health status, or lifestyle behaviors based only on the person's weight?
2. Am I comfortable working with people of all shapes and sizes?
3. Do I give appropriate feedback to encourage healthful behavior change?
4. Am I sensitive to the needs and concerns of obese individuals?
5. Do I treat the individual or only the condition?

Recognizing and reducing stigma about weight in your own practice will improve not only your interactions with patients, but will make your office a more patient-centered practice.

Cultural Considerations for Addressing Fitness

We know that you work with people from cultures other than your own, and you may have a lot of experience counseling patients from varied cultural backgrounds about fitness. Even so, it is helpful every now and then to think about how to improve communication between health care professionals and patients. Be aware that **every clinical encounter is cross-cultural**. This awareness is essential and will greatly help you with your interactions with patients from a variety of cultural backgrounds.

In the tables that follow (pages 20 – 22), we present some cultural generalizations as starting points, where one begins with an assumption about a group but then seeks further information about whether the assumption fits that individual. **Clinical care should remain individualized.**

African American communities	
<p><i>Challenges:</i></p> <ul style="list-style-type: none"> • General perception that “eating healthy” can be seen as giving up part of their cultural heritage and trying to conform to the dominant culture; fear ridicule for “acting white.” • Usually, family and friends are not supportive of dietary changes. • There may be no sense of urgency. • Barriers include the poor taste (or perceived poor taste) and expense of “healthy” foods. • These communities may lack information about or access to healthier choices. • Those living in low income neighborhoods, may have fewer well-equipped playgrounds, parks and recreational facilities, pedestrian and bike-friendly streets, and other safe and affordable places to exercise, play and be active. • Physical activity for women is perceived to result in undesirable outcomes, including appearing too masculine. • For people without a private vehicle, public transportation may be the only option, and can be an impractical, time consuming and costly means of accessing a supermarket that is not within walking distance. • The belief that obesity is to be anticipated and accepted as part of ones’ heritage may influence patients’ beliefs in the efficacy of exercise and the autonomy of their personal struggle with weight control. • Body weight and physical activity are generally viewed as independent. • People may perceive that one could be both fit and heavy. As a result, women may believe the physical and mental health benefits of physical activity should be emphasized over weight-related outcomes in physical activity interventions. • View time as relative to the situation, which allows for a feeling of punctuality even when 15-20 minutes late. 	<p><i>Helpful Hints:</i></p> <p>The following cultural generalizations may assist clinicians in interacting with patients from these cultures. Remember that diversity exists within groups as well as between them and it is important not to over generalize; clinical care should remain individualized.</p> <ul style="list-style-type: none"> • Apply the term “healthy” to the community environment as a whole, not simply to individuals. • Help patients focus on the future — what they can “become.” • Acknowledge the importance of social and cultural symbolism of certain foods. • Address patients by their formal names, not by their first names, especially for elderly patients. • Make direct eye contact. • Explain reason for obtaining information, since there may be reluctance to engage in personal disclosure. • Be aware of historic and basic distrust of health professionals by some African Americans, and how it might impact your discussions regarding fitness.

Asian American communities	
<p><i>Challenges:</i></p> <ul style="list-style-type: none"> • Some Asian cultural traditions emphasize self-humility in social interactions, which may lead to feeling uncomfortable about giving and receiving compliments. • For many Asian American groups, physical contact such as a handshake or a hug between a woman and a man may be interpreted as a sexual advance or overture. • Fear of shame and stigma reinforce denial rather than open admission of problems. • High noncompliance with western prescription medications among the Asian American populations is of concern. 	<p><i>Helpful Hints:</i></p> <ul style="list-style-type: none"> • Be aware that the idea of a visit to a health care professional for a checkup without getting prescriptions for medications does not live up to the expectations of many Chinese Americans. • Some Southeast Asians may respond “yes” to a question as a way of being polite and avoiding conflict, even when they do not understand the question being asked; when developing a fitness plan, ask for the patient to repeat the plan back to you in their own words. • Do not expect some Asian elders to look straight into your eyes, as some Asians may equate this with disrespect. • Try to ascertain the patient’s use of Chinese healing arts, which may include nutrition and dietary therapy, exercise, meditation, acupuncture, and herbal remedies, and incorporate aspects of Chinese healing arts into the patient’s fitness plan.

Working with Patients

Muslim communities	
<p><i>Challenges:</i></p> <ul style="list-style-type: none"> • For many Muslims, disease may be seen as the will of God, a test of faith, or as a punishment for sins committed. • It is important to respect the cultural diversity of Muslims in the US. While Muslims have many similarities, they are from a variety of countries and have many different food and cultural traditions. • Muslim patients may tend to demonstrate passivity in the presence of an authority figure. 	<p><i>Helpful Hints:</i></p> <ul style="list-style-type: none"> • Be aware of the Muslim tradition of fasting during Ramadan. • In scheduling appointments, make accommodations for daily prayers by Muslims. • For Muslims, gelatin is prohibited if originating from pigs. • Respect the modesty of your female Muslim patients when weighing, discussing or demonstrating physical activities, etc. • Try to provide patients with a healthcare professional of the same sex. • Explain the need for requesting patients to disclose personal information. Muslim patients may be reluctant to share such content/information with others. • Consider sharing some bit of personal information to gain the patient's trust, such as personal difficulties in maintaining a regular exercise routine. • Ensure that the "family leader" considered the "spokesperson" is involved in the decision making process and all conversations or communication with the patient.

Native American/American Indian communities	
<p><i>Challenges:</i></p> <ul style="list-style-type: none"> • Health care professional's approach to physical activity, healthy eating, and emotional well-being must respect traditional healing practices that aim to restore balance and harmony to the mind, body, spirit and community. • Many Native American/American Indian individuals relate through kinship. They may have long memories and significant experience with each other. This serves both to facilitate and to hamper change. • The non-Indian concepts of personal insight, individual awareness, and self-actualization are seen as agents of separation between traditional Native Americans and their world; approaching fitness in these terms may not be helpful. 	<p><i>Helpful Hints:</i></p> <ul style="list-style-type: none"> • Recognize that you are part of an entire traditional healing process that has an established history, practice, credibility, and acceptance; understanding the roles and services of each healer in the circle may prove advantageous in discussing fitness. • Be aware that the pace when working with Native American/American Indian patients may be different than your cultural norm. Waiting and patience are words often used. • For best result, the interaction between healer (you) and client should involve family, tribal, and community members who may also benefit from the exchange between the individual, the group, and the sociocultural environment. • Be aware that lactose intolerance is common among Native Americans.

Cultural suggestions adapted from The Provider's Guide to Culture and Quality, available at <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

<p>Latino/Hispanic communities</p>	
<p><i>Challenges:</i></p> <ul style="list-style-type: none"> • Weight gain eventually affects many Latino immigrants who, for the most part, eat healthier and get more exercise before coming to the U.S. • Immigration, acculturation, and conditions in countries of origin are factors relevant to Latino obesity. • Cultural beliefs like <i>fatalismo</i>, the idea that whatever happens, happens: “I’m going to get diabetes like my parents and my grandparents.” • Maternal nutrition knowledge of recent immigrants and feeding practices may be factors in obesity. • For those living in low income neighborhoods, they may have fewer well-equipped playgrounds, parks and recreational facilities, pedestrian and bike-friendly streets, and other safe and affordable places to exercise, play and be active. • Traditional foods, such as flour tortillas and use of lard, may not be what you consider “healthy.” • Due to economic constraints, many Latinos settle in low-income neighborhoods that have limited access to affordable healthy food options available in produce markets, well-stocked discount supermarkets, and other outlets that offer healthy ready-to-eat foods. • Fast food restaurants, taco wagons, and street vendors tend to cluster in areas where people have fewer options to obtain healthy food. • For people without a private vehicle, public transportation may be the only option, and can be an impractical, time consuming and costly means of accessing a supermarket that is not within walking distance. • View time as relative to the situation, which allows for a feeling of punctuality even when 15-20 minutes late. 	<p><i>Helpful Hints:</i></p> <ul style="list-style-type: none"> • Work with extended families—such as the grandmother who heads the family and may prepare all the meals—instead of focusing on individual family members. • Always be respectful, and explain without being condescending. Out of a sense of <i>respeto</i> (respect) many Hispanic patients tend to avoid disagreeing or expressing doubts to their healthcare professional. • Combine traditional and other treatment approaches. Determine what, if any, traditional healing methods your patients are using and evaluate the potential adverse impact of combining a traditional treatment with other medications or plans. • When non-Hispanic healthcare professionals place themselves two feet or more distance away from their Hispanic patients, they may be perceived as not only physically distant but also uninterested and detached. Overcome such perceptions by sitting closer, leaning forward, giving a comforting pat on the shoulder, or other gestures that indicate an interest in the patient.
<p>Latinos/Hispanics are a diverse group. The following generalizations, based on patient’s area of origin, may help you understand more about your patients.</p> <ul style="list-style-type: none"> • Mexican Americans: <ul style="list-style-type: none"> • Are traditionally present-oriented. • View time as relative to the situation, which allows for a feeling of punctuality even when 15-20 minutes late. • Tend to feel that something is very wrong if oxygen is required. • May keep spiritual amulets, religious medallions, or rosary beads present near the patient, and would be expected to remain with the patient during treatment or activities. • People from Latin America and the Caribbean: <ul style="list-style-type: none"> • Value maintenance of eye contact, especially when discussing issues deemed of a personal nature, such as eating habits. • Value friendly physical contact, such as touching the shoulder or upper arm. • Expect friendliness and being treated with respect, which can help in setting the stage for a collaborative approach to fitness. • View socializing and spending time with family and friends as a vital part of life, so presenting physical activity as a social function may be beneficial. • Eat cakes and sweets as part of a regular diet. 	

Working with Patients

Health Literacy

As you work with patients, consider that they may have low health literacy. Ninety million people in the United States have difficulty understanding and using health information. People with low health literacy have a **reduced capacity to obtain, process, and understand the basic health information and services they need to make appropriate health decisions.** The concept of health literacy includes many components beyond simply reading and writing, including numeracy, listening, and speaking. Many aspects of health literacy depend on cultural and conceptual language.

People with low health literacy have a reduced capacity to obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

Health literacy may impact patient-clinician communication. Low health literacy may mean that patients do not understand drug labeling or medical instructions, with the result that they appear non-compliant. In one study, poor literacy resulted in five times the number of mistakes in interpreting prescriptions and twice the number of visits to the doctor compared to those with adequate literacy skills. Similarly, patients with varied levels of health literacy may not understand health publications, may not give an adequate history, may be unable to provide truly informed consent, and may have difficulty responding to medical and insurance forms.

Patients with low health literacy and chronic diseases, such as diabetes, asthma, or hypertension, have less knowledge of their disease and its treatment and fewer correct self-management skills than more literate patients. While ethnic minority groups are disproportionately affected by low health literacy, the majority of people with low literacy skills in the U.S. are white, native-born Americans. Thus, you may want to assume that many of your patients may have some limitations in their health literacy. Consider the following recommendations:

1. Create a safe environment where patients feel comfortable talking with you.
2. Use plain language instead of medical jargon or technical language.
3. Rather than standing, sit down to achieve eye level with your patient.

4. Use visual models to illustrate a procedure or condition.
5. Ask patients to “teach back” care instructions you give to them.

Verbally teaching back instructions is a simple method to improve patients’ understanding of verbal health information. Simply ask patients to explain back to you the instructions you gave them, or have the patients demonstrate procedures after you have explained them. These techniques should help you reduce miscommunication related to low health literacy.

Pharmacotherapy

Although lifestyle modification with diet and physical activity form the foundation of weight management, appropriate use of anti-obesity medications can contribute to treatment success. AIM-HI supports the initiation of pharmacotherapy with lifestyle modification in adults for the following situations:

1. BMI > 30
2. BMI 27-29 with one or more obesity-related disorders

Data from clinical trials suggest that anti-obesity medications produce an overall net weight loss of 2 to 10 kg with most of the weight shed during the first six months of use.

The Guidelines for Adult Obesity (Appendix R) contains a table of medications that can be used for weight loss. Note that no anti-obesity medication has been approved by the US Food and Drug Administration (FDA) for more than two years of use; however, data have been published with up to four years use. Thus, medication represents a short-term solution to a long-term problem. Until more safety data are available, providers should refrain from prescribing medications for weight loss for durations longer than those approved by the FDA. **Medication without concurrent lifestyle modification is ineffective;** medication should be used in conjunction with diet and physical activity.

The most commonly used medications approved by the US FDA for the induction and maintenance of weight loss include sibutramine (Meridia), orlistat (Xenical), and phentermine (Ionamin). These agents target appetite suppression or inhibition of intestinal absorption to produce weight loss. Other agents used off-label for weight loss include metformin (Glucophage), topiramate (Topamax), bupropion (Wellbutrin), and fluoxetine (Prozac). An over-the-counter version of Xenical, Alli, is a half-strength version of the prescription drug.

Foundations for Fitness

This section of the AIM-HI manual provides educational background information on fitness – physical activity, healthy eating, and emotional well-being. The AIM-HI program has also created some **patient scenarios** you might recognize for your own practice. These scenarios can be found within the AIM-HI toolbox. They were developed to allow you the opportunity to work through some common patient situations with your staff and role-play these types of fitness conversations. They are laminated and can be separated so that you may share them in a staff meeting for awareness, education and further discussion.

Physical Activity and Health

The beneficial effects of physical activity on disease prevention and treatment are well established. Despite the wealth of scientific evidence supporting the promotion of physical activity, the practice of promoting physical activity remains a formidable challenge. The following paragraphs provide an overview of physical activity and some general considerations for those intending to incorporate more activity into their lives.

Overview and Assessment

The first when promoting physical activity is to assess a patient's current level of activity and interest in moving more. Using the **AIM-HI Fitness Inventory** to guide your conversation, you may identify opportunities for the patient to increase movement or "energy out." For example, you may inquire about

- participation in organized sports and social activities,
- household chores,
- yard work,
- walking to work or kids to school, and
- unorganized play (e.g., with children or friends).

See "Every Little Bit Counts," Appendix D. You'll also want to quantify a patient's time spent in sedentary behavior such as viewing television, surfing the Internet or playing computer games. Lastly, you'll need to help the patient identify obstacles or barriers to physical activity. See "Overcoming Exercise Obstacles," Appendix G. For example, negative attitudes, perceived lack of time, unsafe neighborhoods or medical conditions may keep your patients from participating in certain activities. Ask patients to consider walking stairs

or doing a movement during each TV commercial. If the patient has children, they can make a family commitment to stretch or walk in place during each commercial. Acknowledge potential barriers and identify opportunities to make small healthy changes in their daily routine.

Encourage your patients to use the **AIM-HI Food and Activity Journal**, described in more detail on page 18, to collect this information. Journaling is an effective tool enabling patients to assess their current activity level and track progress. This is also an important tool to review during repeat visits.

Prescribing Physical Activity

When discussing changes with patients, you can use the **Fitness Prescription** described on page 16. You may also use the **patient scenarios** for ideas on how to establish the dialogue.

The general health benefits of increasing physical activity extend to patients of all ages and abilities. Guidelines from the US Surgeon General, the US National Institutes of Health and the US Centers for Disease Control and Prevention in collaboration with the American College of Sports Medicine **recommend people participate in 30 minutes or more of moderate-intensity physical activity on most, and preferably all days of the week.** For patients wanting to lose weight or maintain weight loss, the duration of moderate-intensity physical activity needs to be increased to at least 60 minutes per day; however, the majority of your patients would be overwhelmed with this goal. Measuring steps, walking after dinner three times a week or use of stairs at work is much more reasonable for the patient. Some patients will be receptive to steps while others will be more time or event focused. Identifying patient preferences, through a patient-centered conversation, will help you together build a fitness prescription that is specific, actionable and sustainable.

Patients in the "preparation or action" stage may be receptive to the **F.I.T.T. principle** to gain a training effect from their fitness prescription. F.I.T.T. stands for **F**requency, **I**ntensity, **T**ype and **T**ime. Please keep in mind these are general guidelines for individuals of low to moderate fitness levels.

Foundations for Fitness

Strategies for Increasing Physical Activity

For patients who are either overweight or obese, increasing physical activity levels to 60 minutes on most, and preferably all, days of the week is a daunting task.

The **Fitness Prescription** is intended to help a patient set personalized, realistic, actionable and sustainable goals for increasing physical activity.

Here are simple suggestions that might help:

- **Decrease sedentary behavior.** Reduce periods of inactivity by setting limits on screen time (e.g., 1-2 hours/day of television watching, computer usage and talking on the telephone). These limits may prompt patients to choose other pastimes that will promote more activity.
- **Increase daily lifestyle activity.** Walking to work, taking the stairs, taking on household chores should be viewed as an opportunity not an inconvenience. Pedometers, or step counters, are an effective way to monitor and increase a patient's level of physical activity.

The addictive effect of decreasing sedentary behavior, increasing lifestyle activity, participating in planned physical activity or exercise and taking part in active sports and leisure makes a goal of participating in 60

minutes of moderate intensity physical activity very attainable.

Increasing the Likelihood of Success for Patients

It is probably safe to assume most patients know that regular physical activity is an important component of overall health and fitness; however, this belief is seldom sufficient to initiate and maintain a program of increased physical activity. Using one or more behavioral management strategies (shown in the table below) will facilitate the long-term adoption of a physical activity program.

Healthy Eating

Family clinicians can help improve the health of their patients by discussing healthy eating during preventive visits and other “teachable moments.” They should also include practical nutrition recommendations in the treatment plan wherever appropriate.

As with other lifestyle interventions, the clinician's role is to facilitate the process according to the patient's interest and motivation as elicited in the **AIM-HI Inventory** and the patient-centered conversation.

Social Support	Support from family and friends enhances adherence to exercise programs. Peer supports (e.g., tell a friend or bring a friend, exercise buddy system) or professional health educator supports (e.g., telephone follow up from a clinician or physical therapist) are extremely effective strategies.
Self-efficacy	Urge patients to choose activities that interest them and start at a level that they are confident they can do.
Health Contracts	The Fitness Prescription is a written agreement negotiated with the patient to accomplish a health goal. Use the Fitness Prescription to facilitate discussion and help patients set realistic, temporal and measurable goals for physical activity.
Regular Performance Feedback	Provide regular, sincere feedback. Don't underestimate the power of your sincere words as a powerful reward and motivator. Make sure your comments focus on the behavior (e.g. “Wow, you have been exercising consistently for four weeks!”) rather than on the outcome (e.g. weight loss). Also try to make sure that your compliments are related to the patient's specific goals (e.g. “It must feel great to have so much more energy than you did before!”). Feedback fosters adherence with their physical activity program and can help keep them focused on reasonable expectations.
Positive Reinforcement	Encourage patients to identify tangible rewards for reaching short and long term goals. Examples of rewards include depositing a quarter in a jar for each exercise session (to be used to purchase a reward), recording their favorite programs to watch while they exercise or taking a hot bubble bath afterward.

Goals:

- Establish sustainable healthy eating habits using an incremental, non-diet approach.
- Develop optimal health and well-being.
- Prevent and treat chronic disease.
- Achieve appropriate energy balance to reach and maintain a healthier weight .

Benefits:

For those patients who are overweight, even a 5 to 10% weight loss can produce significant health benefits.

Focus on all the health benefits of a change, not just weight loss since improved nutrition and increased activity is beneficial even without any concomitant decrease in weight.

Counsel patients to look for signs of progress that are meaningful to them, for example:

- Increased energy levels and stamina.
- Enhanced function in daily living.
- Improvement in the way their clothes fit.
- Improved health measures like cholesterol levels, blood sugar and blood pressure.
- Improved sense of well-being.

A Non-diet Approach to Healthy Living

Straight weight-reduction diets just don't work for most people in the long run. As patients turn to you for advice and information about various popular diets, you may want to discuss that, while some diets may offer a quick fix, it is often only a short-term solution. For many patients who have tried one diet after another, it is important to help them discover an understanding of WHY diets have not worked for them in the past.

Because the solution to managing weight is more complex than simply knowing what to eat and how to exercise, AIM-HI uses a non-diet approach that allows people to let go of restrictive and complicated diet rules and instead, learn simple steps to lead a healthy lifestyle that can be mastered one manageable piece at a time.

The Eating Cycle

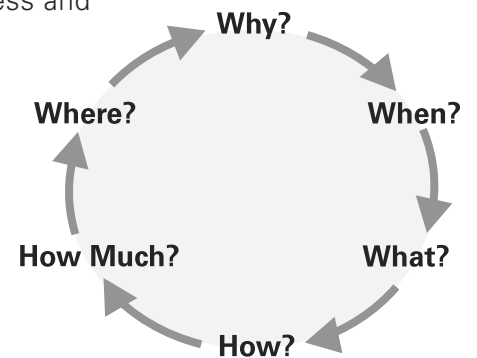
The Eating Cycle, developed by family physician Michelle May, M.D., FAAFP, is a helpful paradigm for understanding the complex issues that affect a person's eating decisions. The Eating Cycle is

focused not just on what and how much people eat, but why they eat in the first place, so it is particularly helpful for patients who have tried dieting without long term success. It helps them learn to distinguish their biologic need for food as indicated by physical hunger from the emotional or environmental cues that trigger an urge to eat or overeat. This allows them to gradually improve their dietary quality and self-regulate their caloric intake in an environment where tempting foods are abundant and sedentary lifestyles are common.

Weight-reduction diets focus on what and how much people should eat without addressing why they are eating in the first place.

A full explanation of the Eating Cycle is beyond the scope of this manual but the main concepts are summarized in the table below, along with conversation starters and "bite-sized" messages that could be discussed during an office visit with a receptive patient.

Keep in mind that this is an incremental process and you should not attempt to address all of these issues at one time.



Foundations for Fitness

Small Changes, Big Results

Guide patients to make realistic, sustainable adjustments to their lifestyle. Small, incremental changes are far more likely to be successful than an “all or nothing” approach.

Encourage them to share their challenges as well as their successes and let them know that they do not need to be perfect to achieve meaningful results. Help them view their mistakes and relapses as a normal part of the process and as an opportunity to better understand why they make certain choices so they can improve those choices in the future.

Some patients will require more intensive intervention and ongoing support than is practical or available in

most medical settings. Identify a “team” of community resources, programs and health care professionals skilled in lifestyle approaches that integrate nutrition, physical activity and behavioral approaches so that you and your office staff can make the appropriate referrals when necessary.

For specific tools to use with patients to address healthy eating, see section “Working With Patients.” This includes practical handouts to support some of the specific small changes a patient may be interested in undertaking. These are just examples; patients may have other goals and the clinician may have other resources they have found useful.

Decision	Possible questions to start the conversation	Bite-sized Messages
<p>Why? Why do I eat?</p>	<ul style="list-style-type: none"> • Why do you think you eat? • Are you aware of any situations of emotions that trigger you to want to eat when you aren't hungry? (Examples: mealtimes, ballgames, certain people, stress, boredom, buffets, getting ready to start a diet) • Have you tried a lot of diets? What happened? How did they work for you long term? Why? 	<ul style="list-style-type: none"> • Instinctive Eating Cycle: Hunger is the primary reason for eating; it is a primitive yet reliable regulator of fuel intake. • Overeating Cycle: Environmental and emotional cues can trigger an urge to eat (or to continue eating) whether there is a physical need for fuel or not. • Restrictive Eating Cycle: Diets can lead to preoccupation with food and feelings of deprivation that eventually lead to rebound overeating.
<p>When? When do I feel like eating?</p>	<ul style="list-style-type: none"> • When do you feel like eating? • How can you tell when you're hungry? • How could you distract yourself from eating until you get hungry? • What could you do to cope more effectively with your emotional triggers for eating, for example: manage stress better, find a hobby, treat yourself to a hot bath, ask for help around the house. 	<ul style="list-style-type: none"> • Ask yourself, “Am I hungry?” whenever you feel like eating. (Help patients develop an internalized mechanism of knowing when to eat.) • Hunger is a physical feeling; it is not the same thing as cravings, appetite or a desire to eat. • Getting too hungry can be a trigger for overeating. • Identify and reduce environmental cues for overeating, for example putting food out of sight, avoiding areas like the break room where food is likely to be found and ordering half-portions or sharing meals. • Identify and cope with emotional triggers for overeating such as boredom, stress, sadness, anger, loneliness, celebrating, or rewarding yourself. (Refer as needed).

Decision	Possible questions to start the conversation	Bite-sized Messages
<p>What? What do I eat?</p>	<ul style="list-style-type: none"> • What do you eat in a typical day? • Do you restrict yourself from eating certain foods then later give-in and overeat those foods? • Are there any areas of your diet that you think could be improved? • What specific change(s) would you like to make? • What health issues do you need to be aware of when choosing food (h/o high cholesterol, family h/o diabetes, BMI > 25, etc.) • What kinds of beverages do you drink? • What types of food do you want to eat when you're eating for emotional reasons? • What kinds of food could you keep on hand to eat when you are hungry? 	<ul style="list-style-type: none"> • All Foods Fit: there are no "good" foods or "bad" foods. • Use balance, variety and moderation to guide your choices. www.mypyramid.gov provides a good general guide to healthful eating. <ul style="list-style-type: none"> Balance - provide your body with the necessary nutrients. Balance eating for nourishment with eating for enjoyment. Variety - eat a variety of foods from the different food groups and a variety of foods within each group. Moderation – consider overall dietary intake, not just the portion size of one particular item. • Ask yourself three questions when deciding what to eat: What do I want? What do I need? What do I have? • Make small, focused, incremental changes, for example, increasing fruits and vegetables, improving the quality of the fluids you drink, lower your saturated and trans fat intake and switching to healthier fats.
<p>How? How do I eat?</p>	<ul style="list-style-type: none"> • Do you eat while distracted, for example, watching TV, driving, working? • Do you think you eat fast? • Do you eat differently in private than you do in public? 	<ul style="list-style-type: none"> • Eat mindfully; stay aware of your body, the food and the ambience. • Minimize distraction: turn off the TV, eat while seated at a table. • Savor each bite, noticing the appearance, aromas and flavors. • Put your fork down between bites.
<p>How Much? How much do I eat?</p>	<ul style="list-style-type: none"> • How do you typically feel after eating? • How does it feel when you have eaten too much food? • What situations or emotions trigger overeating for you? • What could you do to address those triggers more effectively (for example, order less food, get up from the table, turn off the TV, etc.) 	<ul style="list-style-type: none"> • Your stomach is only about the size of your fist so it only takes about a palm-full of food to fill it. • Eating too much can cause you to feel uncomfortable and sluggish. (Help them develop an internalized mechanism of portion control.) • When you eat more than your body needs, it has no choice but to store the extra fuel. • Practice ending your meal when you are satisfied instead of stuffed.
<p>Where? Where do I invest my energy?</p>	<ul style="list-style-type: none"> • Where do you spend (or invest) the fuel you consume? • Are you physically active? • Do you limit your "screen time?" • Do you exercise? What do you like to do? • What else do you do? For example, do you like to play with your children, do you have hobbies, do you volunteer, do you like to travel? • Is there anything else you would like to do that you are not doing now? What are your goals for your relationships, your career, your life? 	<ul style="list-style-type: none"> • The food you consume provides the energy and nutrients to live, work, play and exercise. • When you eat more than you need, the excess fuel will be stored to be used for fuel later. • Increased physical activity in daily living can have a significant impact on your fuel balance. • Exercise will improve your health, increase your stamina and function, and make you feel better. • When you invest your energy in living a full, balanced life, you are less likely to use food to meet your needs, therefore breaking an Overeating and Restrictive Eating Cycle.

Helping Patients Improve Their Emotional Health

People with good emotional health are aware of their thoughts, feelings and behaviors. They have learned healthy ways to cope with the stress and problems that are a normal part of life. They feel good about themselves and have healthy relationships. You can help your patients recognize their emotions and understand why they are having them. Managing emotional health involves sorting out the causes of sadness, stress and anxiety. The following are some other helpful tips you can offer patients.

People with good emotional health are aware of their feelings and behaviors and cope with stress in healthy ways.

Express feelings in appropriate ways. If feelings of stress, sadness or anxiety are causing physical problems, keeping these feelings inside can make one feel worse. Let patients know that it is okay to let loved ones know when something is bothering them. There may be times, however, that they need to ask someone outside the situation, such as a clinician, counselor or a religious advisor, for advice and support.

Live a balanced life. Help your patients understand that they don't need to obsess about the problems at work, school or home that lead to negative feelings. While they don't have to pretend to be happy, they do need to learn positive ways to deal with these negative feelings. You can suggest patients use a journal to keep track of things that make them feel happy or peaceful. They may need help finding ways to let go of some things in life that make them feel stressed and overwhelmed.

Calm your mind and body. Relaxation methods, such as meditation, are useful ways to bring emotions into balance. Meditation can take many forms, including exercising, stretching or breathing deeply.

Take care of yourself. To have good emotional health, it's important to take care of our bodies and have a regular routine for eating healthy meals, getting enough sleep and exercising.

Coping with Stress

Feelings of stress are caused by the body's instinct to defend itself. This instinct is good in emergencies, but if it goes on for too long, stress can cause physical symptoms and anxiety, fear, and tension. You can help patients better deal with stress. First, help them recognize feelings of stress. Early warning signs of stress include tension in shoulders and neck or clenching hands into fists. Second, teach patients to respond to their stress in more positive ways, such as avoiding the situations that cause stress or changing how they react to stress.

Tips for dealing with stress

- Talk with a trusted friend, family member or counselor.
- Set realistic goals at home and at work.
- Exercise regularly.
- Eat well-balanced meals.
- Get enough sleep.
- Don't worry about things you can't control, such as the weather.
- Participate in something you don't find stressful, such as sports, social events or hobbies.
- Prepare to the best of your ability for events you know may be stressful, such as a job interview.
- Try to look at change as a positive challenge, not as a threat.
- Work to resolve conflicts with other people.

Foundations for Fitness

Improving Sleep

Certain lifestyle choices may deprive a person of needed sleep. Patients who tell you they are having sleep troubles may be over-scheduling activities and not taking enough time for quiet relaxation. You can help patients improve their sleep by suggesting some specific changes (see box). Remember that if you are recommending an increase in physical activity, you should tell patients not to exercise just before bedtime, which make it harder to fall asleep. Physical activity in the evening delays the extra release of melatonin at night that helps the body fall asleep. Exercise in the daytime, however, improves nighttime sleep.

Tips for a Good Night's Sleep:

Set a schedule: turn in and get up at the same time each morning. "Sleeping in" on weekends makes it harder to wake up early on Monday morning.

Be physically active: Daily physical activity helps people sleep, although a workout soon before bedtime may interfere with sleep. For maximum benefit, try to get your exercise about 3 hours before going to bed.

Avoid caffeine, nicotine, and alcohol: Caffeine, a stimulant, keeps people awake. Smokers tend to sleep very lightly and often wake up in the early morning due to nicotine withdrawal. Alcohol disrupts REM sleep and keeps people in the lighter stages of sleep.

Relax before bed: You can train yourself to associate certain restful activities with sleep and make them part of your bedtime ritual. Relaxing routines such as taking a warm bath or reading can make it easier to fall sleep.

Sleep until sunlight: If possible, wake up with the sun, or use very bright lights in the morning. Sunlight helps the body's internal biological clock reset itself each day.

Don't lie in bed awake: If you remain awake after 30 minutes, get out of bed and do something else until you feel tired.

Control your room temperature: Maintain a comfortable temperature in the bedroom. Extreme temperatures may disrupt sleep or prevent you from falling asleep.

Appendices

AIM-HI Tools:

- A. Fitness Inventory
- B. Fitness Prescription
- C. Food and Activity Journal

Physical Activity:

- D. Every Little Bit Counts
- E. One Step at a Time — Starting a Walking Program
- F. Getting Started with an Exercise Program
- G. Overcoming Exercise Obstacles

Healthy Eating:

- H. All Foods Fit — Balance, Variety and Moderation
- I. Getting Where You Need to Be
- J. Fat Facts
- K. Think Your Drink!
- L. Am I Hungry?
- M. End Mindless Eating
- N. Search the Shelf!
- O. How to Measure Your Meal

Emotional Well-Being:

- P. Life balance — Investing in You!
- Q. Manage Your Stress
- R. Guidelines for Adult Obesity

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Foundations for Fitness

Emotional Well-being

Physical activity, nutrition, and emotional well-being are **interconnected**. People who don't move their bodies enough or who aren't consuming nutritious meals often lack energy and feel down. Similarly, those who are dealing with stress, anxiety, or depression often don't have the motivation to improve their diet and physical activity; yet, doing so—especially getting more exercise—often will help them feel better. As a primary care provider, you have a clear opportunity to address emotional health both as a cause and an effect of improved nutrition and physical activity.

Physical Activity and Emotional Health

Physical activity **activates serotonin and norepinephrine**, two neurotransmitters associated with mood. Some research suggests that exercise may help synchronize these neurotransmitters, improving mood. Additionally, physical activity **stimulates the production of endorphins**, which produce feelings of well-being, provide for “natural” pain relief, and aid relaxation. Explaining these connections to patients may help them understand why you are prescribing physical activity to help them improve their mood. You will also find that patients who do increase their physical activity will report feeling better emotionally. This mood improvement is excellent **positive reinforcement** for the changes they have made.

Nutrition and Emotional Health

All people eat for emotional reasons, including celebrating, expressing love, or finding comfort in homemade cookies. Across cultures, social events often revolve around eating. Thus, emotional connections to food are part of “normal” eating. Emotional eating becomes maladaptive when it is the primary way that a person copes with emotions.

Emotional triggers for eating include boredom, stress, sadness, anger, loneliness and even happiness. Eating can be a way to comfort, avoid, numb or distract oneself from emotions. Weight problems often result and can be more difficult to resolve. People who are overweight often eat in response to environmental and emotional cues rather than in response to cues of hunger and satiety.

Sleep and Emotional Health

How well people sleep can affect their emotional well-being. Most adults need seven to eight hours of sleep each night. People tend to sleep more lightly and for shorter periods as they age. We do not adapt to getting less sleep than needed; too little sleep creates a “sleep debt” that eventually must be “repaid” (although trying to catch up on sleep later will not completely make up for the lack of sleep). About half of all people over 65 years of age have frequent sleeping problems, such as insomnia.

Sleep deprivation can be signaled by daytime drowsiness (including drowsiness during boring activities), or falling asleep within five minutes of lying down.

Getting too little sleep leaves a person drowsy and unable to concentrate the next day, and may also impair memory and physical performance. Sleep-deprivation also leads to impairments in judgment and reaction time. People who chronically suffer from a lack of sleep, either because they do not spend enough time in bed or because they have an untreated sleep disorder, are at **greater risk of developing depression**.

During deep sleep, activity is drastically reduced in parts of the brain that control emotions, decision-making processes, and social interactions. This suggests that adequate **deep sleep may help people maintain optimal emotional and social functioning** while they are awake.

People can learn tasks better when they are well rested. Further, people who experience sleep deprivation have decreased levels of leptin and increased levels of ghrelin. Leptin released into the blood signals to the brain that the body has enough to eat. Ghrelin stimulates hunger and food intake. It is hypothesized that decreased leptin levels and increased ghrelin levels stimulate a sleep deprived person to overeat.



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