



Behavioral Health &
Wellness Program

University of Colorado Anschutz Medical Campus
School of Medicine

DIMENSIONS: Well Body Toolkit for Healthcare Providers

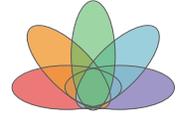
SUPPLEMENT

Priority Populations: Low-Income



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The DIMENSIONS: Well Body Toolkit for Healthcare Providers Supplement,
Priority Populations: Low-Income was developed by the University of Colorado
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Why Focus on Low-Income Populations?

The 146.4 million Americans (48% of U.S. population)¹ living with low-incomes or in poverty face significant health risks.² In the United States, mortality rates differ by economic status.³ People with low-incomes die sooner than their more wealthy counterparts and this disparity is increasing. These individuals get sick more often and are at greater risk for almost all major diseases including cancer, heart disease and diabetes. Clearly individuals with low-incomes need and deserve more focused attention from healthcare providers to foster healthy living. In fact, their lives often depend on it.

- In 1980, life expectancy at birth was 2.8 years longer for the highest income groups.
- By 2000, life expectancy was 4.5 years longer for the highest income groups.⁴

Access to healthcare, healthy food⁵ and safe places for exercise⁶ are factors that impact health for low-income populations. Healthcare providers need to arm themselves with a better understanding of these factors, the barriers to healthcare, and how health can be improved to assist low-income populations build healthy lives.

Definition of Low-Income

For this toolkit, “low-income” includes all individuals who encounter economic barriers to achieving a healthy lifestyle. This includes individuals living in poverty, working families, or anyone who faces health challenges due to economic limitations.

About This Toolkit

This supplemental toolkit provides guidance for healthcare providers who want to provide evidence-based obesity and weight management treatment to persons with low-incomes. Weight management interventions for the low-income population are very similar to evidence-based strategies for the general population. However, providers may feel unprepared or ill-equipped to address obesity with patients facing economic challenges.

This supplement provides information about this population and how to partner with patients to help them reach their health goals. It is designed to be used in conjunction with the [DIMENSIONS: Well Body Toolkit for Healthcare Providers](#), which contains evidence-based information about assessment, skills building, and interventions to provide support and resources to patients around weight management.

Weight and Health

Obesity rates are increasing for all income and educational levels in the United States.⁷ While internationally, the obesity epidemic has different consistent patterns across income levels:

- In low-income countries, obesity affects mostly adult women from wealthy and urban environments.
- Whereas in high-income countries, obesity affects both genders and is disproportionately greater in disadvantaged groups.⁸

Various factors impact obesity. Logically, access to abundant food increases obesity while food deprivation leads to lower body mass index. However, the relationship between food and health is not that simple. Individuals with greater economic status have access to healthy food, resources for maintaining a healthy weight and safe places to exercise. While individuals who live

in low-income settings more often eat unhealthy foods, lack resources for healthcare, are less educated about nutrition and have limited access to safe environments for physical activity.

In 2009, 14.3% of the U.S. population lived in poverty. Certain populations, particularly vulnerable populations, have higher rates of poverty including: recent immigrants; farm workers; single-parent families; people with disabilities; people with mental health and substance use disorders; the homeless; victims of domestic violence; veterans; people with criminal justice involvement; the working poor; portions of the elderly population; and victims of natural disasters.¹⁶

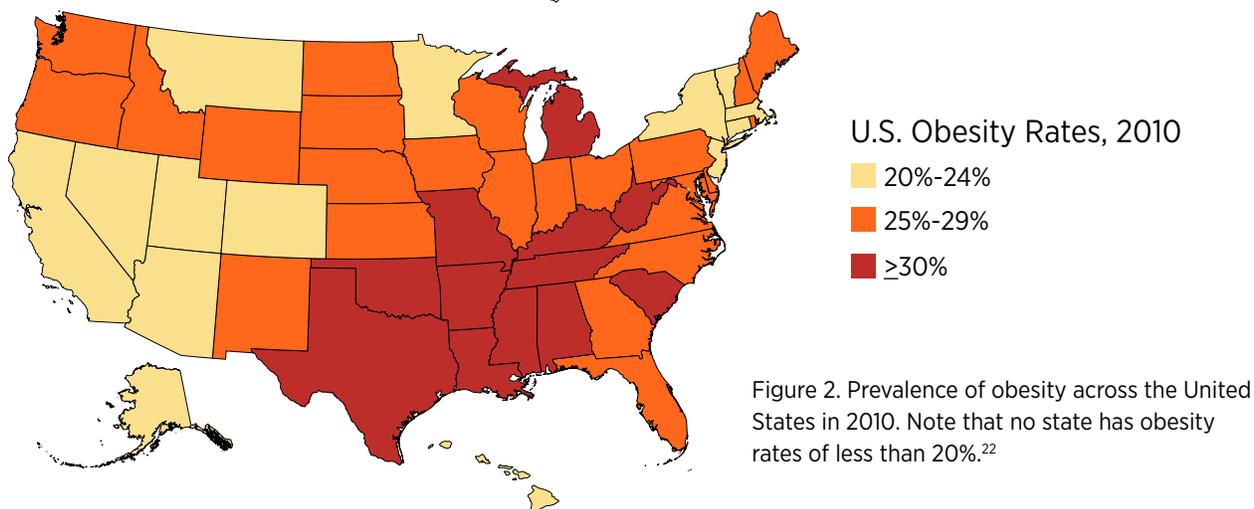
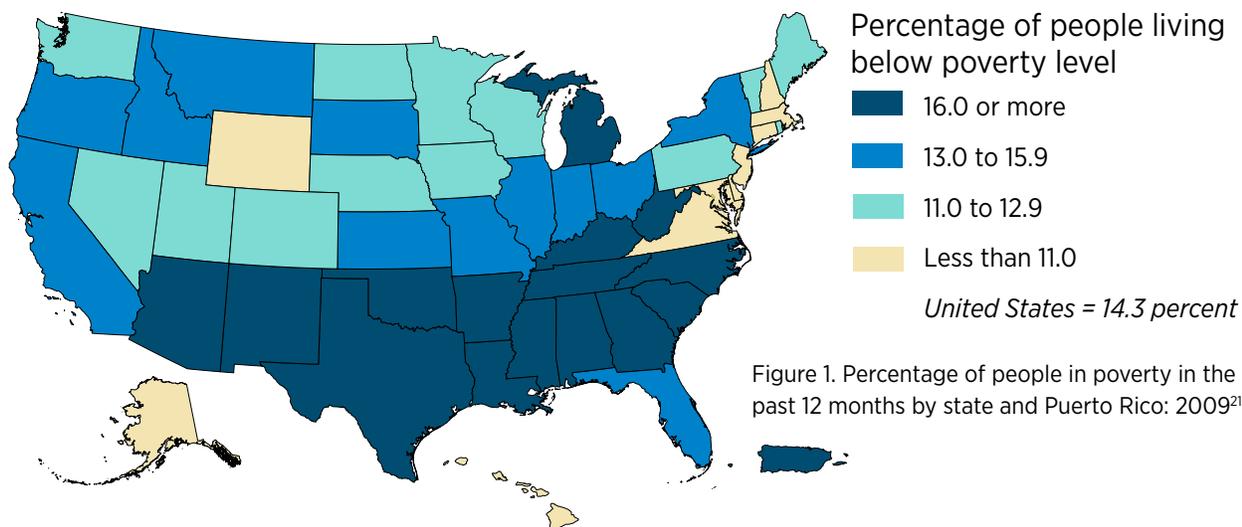
WHAT IS CLEAR...Obesity and low-income status double the risk for poor health.

- Obesity leads to an increased risk of diabetes, cardiovascular disease, hypertension, certain cancers⁹ and other conditions such as stroke.¹⁰
- Low-income status is a well-documented social determinant of health.¹¹
- Individuals living in poverty experience poor health outcomes.¹²
- Obesity and Type II Diabetes often follow socioeconomic status with the highest rates among individuals with the lowest levels of education and incomes.¹³
- Low-income populations face greater barriers to weight control as a result of limited access to healthy food¹⁴ and activity¹⁵ as well as other resources.

Did you know...

- In 2010, 36% of Blacks, 35% of Hispanics, 14% of Whites and 23% of other races had income below the poverty level.¹⁷
- Compared with their urban counterparts, rural residents are more likely to be older, be poor, be in fair or poor health, and have chronic health conditions.¹⁸
- Rural residents are less likely to receive recommended preventive services and on average, report fewer visits to healthcare providers.¹⁹
- LGBT persons experience structural barriers including difficulty obtaining health insurance since many employer-sponsored insurance plans do not recognize same-sex unions.²⁰

The following images illustrate the prevalence of poverty and obesity in the United States.



Consequences of Overweight and Obesity

People with low-incomes often experience worse health, are at higher risk for chronic disease, and are more likely to die prematurely.²¹ Individuals who are obese or overweight are also at greater risk for a number of serious medical conditions. Because income status and weight are both risk factors for disease, individuals who are low-income and obese are at even higher risk for other chronic diseases.

Cardiovascular Disease

In recent decades, the risk of death due to cardiovascular disease was greater among individuals of low-income than among individuals of high income in the United States.²² Lower income individuals have 50% higher risk of heart disease.²³

Low-income Americans are at greatest risk for coronary heart disease but have the least access to programs promoting health and lifestyle change. Primary care physicians are often the only resource for preventative care for individuals living in poverty. However, the majority of physicians feel generally unprepared to help patients achieve dietary and lifestyle changes, and are specifically limited in their ability to provide targeted nutrition interventions to low-income populations (e.g., using language for a lower literacy).²⁴

Diabetes

Diabetes may be up to two times more prevalent in low-income populations. Low-income patients with diabetes have an increased rate of hospitalization for acute diabetes related complications. Low-income neighborhoods have a higher prevalence of diabetes than do wealthy neighborhoods.²⁵

It has been speculated that the increased risk of diabetes is related to the increased prevalence of obesity within low-income populations.²⁶ Access to healthy food is an important contributing factor. Households that lack consistent access to adequate food due to lack of money and other resources are called “food-insecure.” Adults living in food-insecure households may be more likely to under-report a diagnosis of diabetes to their doctor.²⁷



Reproductive Needs

Reproductive health for low-income women is worsened by poverty, low-educational attainment, and lack of access to timely and appropriate health care. Low-income women experience disproportionately higher rates of unintended pregnancy, sexually transmitted disease, and poor birth outcomes as well as shorter survival times for cervical and breast cancer.²⁸

Cancer

Regardless of insurance status, low-income individuals are much less likely to receive recommended screenings for breast, cervical, and colorectal cancers than individuals of higher incomes.²⁹

Sleep Apnea

Individuals with low-income are less receptive to Continuous Positive Airway Pressure (CPAP) treatment than groups with higher income.³⁰

Asthma

Asthma is more common in lower income groups than in higher income groups. This may be related to differences in lifestyle behaviors and environmental exposure between the groups.³¹

Osteoarthritis

An increased risk for osteoarthritis is associated with having lower levels of education and living in a community with a household poverty rate greater than 25%. Behavioral and lifestyle factors that may contribute to this relationship are dietary factors, depression, self-efficacy, and helplessness.³²

Dementia

Higher levels of education are associated with lower rates of dementia. Lifetime practice of higher cognitive functions and occupational attainment are also associated with lower rates of dementia.³³



Contributing Factors

Stigma and Discrimination

In addition to added health risks, individuals who are living in poverty and who are overweight or obese often experience stigma and discrimination. Economic discrimination may be an important factor that influences the effects of poverty on physical health.³⁴ Growing evidence also indicates that individuals who are overweight and/or obese face stigma and discrimination from the general public, employers, and healthcare providers: “Weight bias translates into inequalities in employment settings, healthcare facilities, and educational institutions, often due to widespread negative stereotypes that overweight and obese persons are lazy, unmotivated, lacking in self-discipline, less competent, non-compliant, and sloppy.”³⁵

Stigma and discrimination present significant barriers to individuals receiving treatment for weight management. Individuals with a higher Body Mass Index (BMI) report more barriers to treatment including: “I feel/think I am too heavy” and “I am afraid people will treat me unfairly or badly.”³⁹ Unfortunately this perception is supported by evidence.

Growing Stigma

- The prevalence of weight discrimination has increased by 66% in the last decade and is similar to rates of racial discrimination, especially for women.³⁶
- Low-income individuals believe that the greater society views them as a burden, lazy, irresponsible, and “choosing” an “easy life” by disregarding opportunities.³⁷
- Perceived discrimination can have a significant negative effect on mental and physical health. It also produces heightened stress and may lead to unhealthy behaviors.³⁸

Healthcare Providers and Discrimination

Healthcare providers contribute to stigma and impact patients' engagement in services as well as their health outcomes.

- Physicians are cited as the second most common source of weight discrimination.⁴⁰
- Patients report physicians make “inappropriate” comments about their weight.⁴¹
- Higher patient body mass index (BMI) is associated with lower physician respect.⁴²

In addition, numerous findings show that healthcare providers endorse stereotypes about obese patients and often blame them:

- 50% of physicians viewed obese patients as “awkward, unattractive, ugly, and noncompliant.”
- One third of the physicians saw obese patients as “weak-willed, sloppy, and lazy.”
- Nurses also saw obese patients as “lazy, lacking in self-control, and noncompliant.”
- Medical students reported that their stigmatization of obese patients was because they believed patients were to blame for their weight problems and because they caused the students extra work.⁴³

Stigma also leads healthcare providers to change their practice (spend less time with patients, avoid discussing weight, etc.) with individuals who are overweight and obese.⁴⁴ In addition, providers often feel ill-equipped to manage weight problems and have low expectations of success.⁴⁵ Healthcare provider stigma about obesity can also act as a barrier to ongoing management of both obesity and diabetes.⁴⁶

As a result of the stigma that many patients experience regarding weight and economic status, patients may experience information about weight as discouraging. Appropriate advice may even

Weight stigma is a social justice issue and a public health priority. “Stigmatization of obese individuals threatens health, generates health disparities, and interferes with effective obesity intervention efforts.”⁴⁹

be perceived as patronizing by patients with obesity.⁴⁷ When patients internalize the stigma they perceive from healthcare providers, it may obstruct healthy coping and empowerment to manage their weight.⁴⁸

Stigma towards low-income status and obesity *combined* make access to appropriate healthcare even more challenging for individuals. For these reasons, it is essential that healthcare providers increase their self-awareness about any bias or stigma they hold and build tools for engaging their patients to develop strong alliances that can enhance health outcomes.



VIDEO: Weight Bias in Health Care. Yale University, Yale Rudd Center:

This video provides practical advice for providers on how to improve the clinic environment to reduce the experience of stigma. Simple changes such as thoughtful waiting room set-up, clinic staff approach, how to ask questions, etc.

<https://www.youtube.com/watch?v=IZLzHFgEOAQ>

Building Trust and Reducing Impact of Stigma

1 Acknowledge that stigma exists and that patients may have had previous experiences that are negative.

- “I know that sometimes it can feel like healthcare providers are judging you for your weight. I want you to know that I am not. I want to support you in your health and understand your experience.”

2 Meet patients where they are in terms of understanding weight and the impact on their health.

- “Do you have concerns about your weight? What are you most worried about?”
- “What is your understanding of how weight impacts your health? Can I clarify or explain anything for you?”

3 Empower patients through normalization, empathy, and support.

- “I know it can be daunting to think about change and that’s why I am here to support you. We can work on this together.” Perhaps share your own experience of change—eating differently, stopping smoking, or increasing your physical activity.
- “It sounds like you are really interested in making some changes in your health behaviors. What are some things that you want to do to get started?”
- “You’ve done a good job taking some steps towards change. How have you been able to successfully make these changes?”



Environmental Factors

Individuals with fewer economic resources experience many barriers to leading healthy lives. Due to environmental factors, they often lack the resources or the knowledge to achieve health. However, low-income individuals want to be healthy, know they need to make behavioral changes, and are motivated to change. In fact, many individuals living with obesity have tried numerous treatments for weight loss - the higher a person's BMI, the greater the number of treatments attempted.⁵⁰ In addition, patients have higher levels of motivation for weight management than physicians perceive.⁵¹ It is important for healthcare providers to recognize their patient's motivation to change as well as address the barriers preventing that change.

Access to Healthcare

In general, low-income populations have reduced access to high-quality care. While people with low-incomes are more likely to be uninsured, inferior quality of care has been demonstrated regardless of health insurance status.⁵²

MYTH: Low income patients are too stressed with daily living to make changes for long-term health

Many healthcare providers believe that the stressors of housing instability, food insecurity, raising children, and unsafe neighborhoods are overwhelming. In addition, they view people with low-incomes as living in "chaos" or continual "crisis." As a result, providers shy away from discussing chronic disease, believing their patients have "enough" to manage and can't tackle yet another problem.

FACT: Low-income patients die as a result of unaddressed chronic disease

Although providers are trying to be empathetic with patients, this is a dangerous decision for patients and furthers health disparities for this population. It is vital that healthcare providers balance patient "crisis" with long-term health.

Healthcare providers often avoid talking about the cost of care with patients. This can be detrimental to patient outcomes, particularly for low-income patients.

- 63% of patients reported the desire to talk with physicians about out-of-pocket health costs; however, only 35% of physicians and 15% of patients report ever talking about costs.⁵³
- Many seniors do not tell their doctors when they do not adhere to medication regimens due to cost.⁵⁴
- Patients who face cost-related barriers to accessing health care believe that doctors should play a role in reducing out-of-pocket costs.⁵⁵
- Barriers to discussing costs from the patient's viewpoint include rushed, impersonal visits and clinicians who are not adequately informed about costs.⁵⁶
- Specific communication strategies may matter less than trust in one's physician, which enhances patients' willingness to discuss costs.⁵⁷

Access to Healthy Food

Food insecurity refers to the inability to afford nutritionally adequate and safe foods. Most adults living in food-insecure households report being unable to afford balanced meals, worrying about the adequacy of their food supply, running out of food, and cutting the size of meals or skipping meals. Many adults with severe levels of food insecurity report problems with hunger because they cannot afford food and subsequently have to go without food.

- On average, households that report being food-insecure at some time during the year are food-insecure for a period of 7 months during the year.⁵⁸
- U.S. adults living in food-insecure households consume fewer weekly servings of fruits, vegetables, and dairy. They also consume lower levels of micronutrients, including the B complex vitamins, magnesium, iron, zinc, and calcium. These dietary patterns are linked to the development of chronic disease, including hypertension, hyperlipidemia, and diabetes.⁵⁹
- Both food-insecurity and obesity can be linked to having fewer economic resources to access enough nutritious food.

Many low-income neighborhoods lack full-service grocery stores where locals can buy a variety of fruits, vegetables, whole grains, and low-fat dairy products. These residents are then limited to shopping at small neighborhood convenience and corner stores. Even when healthy food is available, it is often of poorer quality in lower-income neighborhoods, which reduces the appeal to consumers. Neighborhood residents with better access to supermarkets

tend to have healthier diets and reduced risk for obesity. Available healthy foods are often more expensive, as opposed to unhealthy foods such as refined grains, added sugars, and fats which are generally inexpensive and readily available in low-income communities. Households struggling to buy enough food try to stretch their budgets by buying cheap, energy-dense foods that are filling and maximize calories per dollar. These less expensive, energy-dense foods typically have lower nutritional quality.

What Food Stamps Can Buy

Households can use Supplemental Nutrition Assistance Program (SNAP) benefits to buy foods for the household, such as breads, cereals, fruits, vegetables, meats, fish, poultry, dairy products, seeds and plants. Households cannot use SNAP benefits to buy beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products, vitamins, medicines, foods that will be eaten in the store, and hot foods.⁵³

Access to Safe Environments

Lower income communities have fewer avenues for physical activity including fewer parks, green spaces, bike paths, and recreational facilities.⁶⁰ The lack of access to these spaces makes it difficult to lead a physically active lifestyle. Crime, traffic, and safety are additional common barriers to physical activity in low-income communities. Because of this, people are more likely to stay indoors and engage in sedentary activities.

Targeted Marketing

Low-income populations are exposed to disproportionately more marketing and advertising for obesity-promoting products that encourage the consumption of unhealthy foods such as fast foods and sugary beverages. These advertisements also encourage sedentary activity such as television shows and video games.^{61,62}

Psychological Factors

Increased Stress

Low-income families face high levels of stress due to the financial and emotional pressures of food insecurity, low-wage work, limited access to health care, inadequate and long-distance transportation, poor housing, neighborhood violence, and other factors. Stress can lead to weight gain through stress-induced hormonal and metabolic changes as well as unhealthy behaviors.⁶³



PBS Documentary Series “Unnatural Causes...is inequality making us sick?”

A seven-part documentary series exploring racial and socioeconomic inequalities in health. Discusses the impact of poverty-caused stress on health.

<http://www.unnaturalcauses.org>



Assessment and Intervention Planning

Healthcare Providers Have an Important Role to Play

Healthcare providers are valued and respected by their patients. Through strong relationships, they can dramatically impact patients' lives and behavior. Although low-income patients may be facing greater barriers to health, healthcare providers continue to have an ability to address both acute and long-term health needs. When it comes to obesity, it is vital that providers embrace the opportunity to use the physician-patient relationship to talk directly about weight management with every patient.

Interventions — “Let’s Talk”

The most important interventions healthcare professionals can offer to individuals living with low-income and obesity are straightforward and brief. Talk with patients about weight management in an empathic and caring manner. Simply talking to patients about their weight can be helpful.⁶⁴ Ask permission to discuss weight and economic barriers to health with questions like:

“Would it be okay if we discussed your weight today?”

“I’d like to talk with you about weight management. Can we have a conversation today?”

“Would you like to talk about weight management?”

“I understand that some options for healthy living are challenging due to expense. Can we discuss these challenges so I can support you in healthy living?”

As you ask these questions, be willing to explore patients' motivation and listen for what matters most to them - listen for “change talk.” Use this information to guide them to consider change. Research shows that patients with a BMI of 25 or greater whose physician told them they were overweight or obese were 6-8 times more likely to view their weight as a potential health concern. In fact, these patients had 5-8 times greater desire to lose weight and described more than twice as many recent attempts to lose weight. **But 25 to 50% of patients with a BMI 25 or greater have never been told they were overweight or obese.**⁶⁵

Economic Barriers

Talk about economic challenges patients face. Providers need to understand the barriers preventing patients from making changes as well as engage their patients in conversations about these barriers. It can be helpful to explore the factors discouraging them from building a healthy life and to brainstorm ways to partner with them to find solutions.

C

Care about costs and economic barriers.

O

Open financial conversations with patients.

S

Suggest possible barriers and skills needed to normalize patient experience.

T

Talk about stigma and discrimination to validate their experience.

S

Support patients in exploring resources.

Resource for Patients

How to Discuss the Cost of Health Care Treatments with your Provider.

<http://www.medicalpracticeinsider.com/best-practices/patient-care/talking-points-broach-when-tackling-costs-patients>

Become a Resource

An important element of assisting low-income populations with weight management is informing patients about resources. It is essential that providers work to be aware of resources both locally and nationally that can support patients in their behavior change.

Contact State Public Health Department to learn about state-based programs. Ask for information regarding local County Public Health Departments in your area to learn about regional specific programming targeting obesity for residents. <http://www.cdc.gov/mmwr/international/relres.html>.

Contact State Medicaid Departments. Many low-income individuals qualify for Medicaid programs or insurance under the ACA expansion of Medicaid. Learn what your state's Medicaid plan covers for obesity treatment and what other resources are available.

Stay informed on Federal Nutrition Programs This resource includes general information on nutrition as well as links to state programs and updates. <http://frac.org/federal-foodnutrition-programs/>

Build Strong Relationships

The most powerful tool a provider has is their relationship with their patient. A strong trusting relationship between healthcare providers and their patient is the best foundation for these conversations and the most likely to lead to successful partnerships towards obtaining health.

In addition to the strong relationship foundation, other ways that providers can adjust their practice for low-income populations include:⁶⁶

- Use of more simple language
- Demonstrate empathy for the patient's experience
- Provide free medication samples
- Adjust the medication plan to match the person's resources
- Reduce or waive fees or postpone payment
- Request help from other providers, social caregivers, and specialists⁶⁷

Skill Building

Low-income populations who live with obesity need education and skills to support healthy eating. Examples of skills include learning about healthy foods, shopping for these foods, and how to cook new foods. When healthcare providers talk about learning new information and building skills as normal components of weight management, they reduce the potential for shame or embarrassment that may arise with patients who do not know the information or are afraid to ask. Similarly, having resources (i.e., handouts on fruits and vegetables, recipes, videos and websites) available for patients on these topics allows individuals to go home with information and “digest” the content over time and at their own pace.

Resources For Building Skills

USDA SNAP-Ed Connection - Recipe Finder

<http://recipefinder.nal.usda.gov/>

American Heart Association - Nutrition Education Handouts and Resources

http://www.heart.org/HEARTORG/GettingHealthy/NutritionCenter/HealthyDietGoals/Nutrition-Education-Handouts-and-Resources_UCM_321883_Article.jsp

Center for Disease Control and Prevention - Healthy Eating for a Healthy Weight

http://www.cdc.gov/healthyweight/healthy_eating/

Center for Disease Control and Prevention - Healthy Recipes

http://www.cdc.gov/healthyweight/healthy_eating/recipes.html

The American Journal of Public Health - Using the Food Stamp Program and Other Methods to Promote Healthy Diets for Low-Income Consumers

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920974/>

Learn about Federal Nutrition Programs

<http://frac.org/initiatives/hunger-and-obesity/what-is-the-role-of-the-federal-nutrition-programs-in-combating-overweight-and-obesity/>

Targeted Programming

There are a few national and regional programs specifically designed for weight management. These are highlighted to assist providers in exploring options for patients within their local settings. Recommendations are also provided for how to learn about local programs that may be available for low-income populations as well as additional resources. In addition, the changes to documenting obesity and meaningful use as a result of the Affordable Care Act are reviewed briefly.

Name of Program	Description and Resources
<p>Veteran Affairs MOVE! Program</p>	<p>In collaboration with the Veterans Affairs (VA) Central Office and field staff, the VA National Center for Health Promotion and Disease Prevention (NCP) has developed a VA Weight Management and Physical Activity Initiative. The formalized primary prevention approach Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) includes assessment and treatment procedures, clinical algorithms, and patient and provider information and instructional materials.</p> <p>Details about the program can be found at: www.move.va.gov</p> <p>Move! Success Stories: https://www.youtube.com/watch?v=bh9kHTbyKKw</p>
<p>Medicare’s Intensive Treatment for Obesity</p>	<p>Medicare is a federal program for the elderly or disabled. CMS has clearly defined screening and intervention for obesity with specific intervention and session rates.</p> <p>Medicare is provided for:</p> <ul style="list-style-type: none"> • People age 65 or older; • People under age 65 with certain disabilities; • People of all ages with End-Stage Renal Disease. <p>If a patient is enrolled in Medicare and has Part B, then the CMS intensive treatment for obesity is available. Medicare follows the CMS recommendations for intensive obesity treatment, which includes:</p> <ol style="list-style-type: none"> 1. Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m²); 2. Dietary nutritional assessment; and 3. Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Name of Program	Description and Resources
<p>Medicare’s Intensive Treatment for Obesity (cont.)</p> <p>CMS defines “Primary Care Practitioner” as an individual who</p> <p>1. Is a physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or</p> <p>2. Is a nurse practitioner, clinical nurse specialist, or physician assistant.</p>	<ul style="list-style-type: none"> Reimbursement for these services is provided if the beneficiary with obesity is competent and alert at the time of the counseling and if the counseling is delivered by a qualified primary care physician or other primary care practitioner and in the primary care setting: <ol style="list-style-type: none"> One face to face visit every week for the first month; One face to face visit every other week for months 2-6; One face to face visit every month for months 7-12, if the beneficiary meets the 3kg (6lbs) weight loss requirement. Re-assessment must occur at the 6-month visit to determine the amount of weight loss. To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy. For individuals who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of BMI and their readiness to change is appropriate after an additional 6-month period. <p>For more information from CMS on the program: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ICN907800.pdf</p>
<p>The Affordable Care Act and Meaningful Use Criteria</p>	<p>The Patient Protection and Affordable Care Act (ACA) improves prevention and obesity coverage through a range of provisions that seek to promote general prevention and obesity-related preventive efforts and coverage. The addition of meaningful use quality measures has significant implications for primary care providers. Providers will be clearly mandated by 2014 to offer some level of screening, intervention, and tracking of low-SES patients with obesity and weight management needs. A Meaningful Use Core Clinical Quality Measure requires that adults have a BMI documented and if abnormal, a follow up plan must be documented.</p> <p>For more information on Meaningful Use: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html</p> <p>http://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/clinical-quality-measures</p>

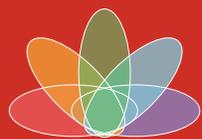
End Notes

- ¹ Based on US Census Bureau data, 97.3 Million American are low-income defined as earnings between 100 and 199 percent of the federal poverty level. 49.1 million additional Americans have incomes below the federal poverty level. Hope, Y. (2011, December, 5). Census Shows 1 In 2 People Are Poor Or Low-Income. *The Associated Press*. U.S. Census Bureau (2011, September 3). Income, Poverty and Health Insurance Coverage In The United States: 2010. *U.S. Census Bureau*.
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