



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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FORT SAM HOUSTON, TEXAS 78234-6000

MCCG

09 MAR 2012

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Screening and Prevention of Adult Overweight and Obesity

1. The Army Family is not immune to the obesity epidemic in America. Clinical data for 2010-11 indicate that 67 percent of Army adult family members and retirees enrolled at Army Military Treatment Facilities (MTF) are overweight or obese. TRICARE Prime spends an estimated \$1.1 billion annually to treat problems associated with being overweight or obese.

2. Performing a Body Mass Index (BMI) assessment at every reasonable opportunity encourages individual actions, provides necessary data for synchronized longitudinal surveillance, and accurately characterizes the problem of obesity in the Army Family. Proper documentation provides information which can be used to affect quality outcome measures as assessed by the AMEDD Balanced Scorecard. It also creates a potential method for PBAM HEDIS reimbursement.

3. I direct all MTFs to have their primary care teams perform the following actions to promote decrease rates of obesity:

a. Objectively measure the height and weight of patients at each outpatient visit and enter data into the vital signs section of AHLTA. BMI will automatically calculate in both the vital signs and clinical encounter notes section.

b. Assess patient's BMI using guidelines from the Centers for Disease Control and Prevention (<http://www.cdc.gov/healthyweight/assessing/bmi/index.html>). Consider each patient individually, taking into account body composition, particularly heavily muscled or very athletic individuals.

c. Document, if applicable, the appropriate diagnosis into the patient's problem list. This places the diagnosis in the forefront of the patient's medical issues and can be addressed within the context of future visits.

d. Address weight status and provide education, regardless of risk, on the prevention and treatment of overweight or obesity, at least annually. Provide referrals as appropriate.

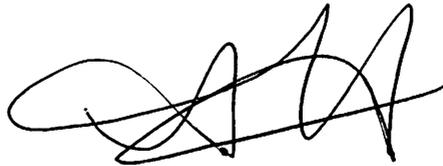
e. Implement the VA/DoD Clinical Practice Guideline (CPG) for the Screening and Treatment of Overweight and Obesity. The CPG and accompanying Toolkit are excellent resources that include evidence-based guidelines and patient education

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materials to assist primary care providers. Find the CPG on the Quality Management website: <https://www.qmo.amedd.army.mil>.

4. Actively addressing obesity supports MEDCOM's transition from a healthcare system to a system of health. I appreciate your support with incorporating these guidelines into your practice to improve quality of life and reduce the long-term costs associated with obesity.



PATRICIA D. HOROHO
Lieutenant General
The Surgeon General and
Commanding General, USAMEDCOM

2 Encls

1. ASD(HA) memo, 17 Oct 11
2. Information paper, 24 Oct 11



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

17 Oct 2011

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)
COMMANDER, JOINT TASK FORCE, NATIONAL CAPITAL
REGION MEDICAL
DIRECTOR, TRICARE MANAGEMENT ACTIVITY

SUBJECT: Guidelines for Management and Prevention of Adult Obesity

Adult obesity rates in the United States have reached epidemic proportions. Nationally, 33.8 percent of adults are obese and 68 percent are either overweight or obese. Based upon 2010 data, 26 percent of adults enrolled to Military Treatment Facilities (MTF) in the Military Health System (MHS) were considered obese, and 66 percent of adults were either overweight or obese, which is comparable to national rates. Obesity is a serious concern in the MHS, and work remains on this critical issue as it does impact military readiness.

To decrease rates of overweight and obesity in MHS adults, I am requesting that the Surgeons General direct all primary care providers to:

- Objectively measure a patient's height and weight at each visit, assess the patient's Body Mass Index (BMI) using Centers for Disease Control and Prevention (CDC) guidelines to determine if the patient is overweight or obese, and enter the appropriate diagnosis into the patient's problem list (if applicable).
- Provide all patients with appropriate education and counseling on the prevention and treatment of being overweight or obese, at least once yearly, regardless of risk.
- Discuss with patients the actions they can take personally and within their family to help prevent overweight and obesity. Address healthy eating habits, increased physical activity, and decreased time using electronic devices for entertainment (screen time).
- Follow the Veterans Health Affairs/DoD Clinical Practice Guideline for the Screening and Treatment of Overweight and Obesity in their practices

To decrease the rate of overweight and obesity in adults receiving care in the purchased care sector, TRICARE Management Activity (TMA) will develop and implement a communication plan to encourage network primary care providers to accomplish these same measurement, diagnosis, documentation, treatment, and prevention efforts whenever a TRICARE beneficiary is seen by them.

In order to assess compliance with these guidelines in MTFs, TMA is developing measures to follow the prevalence of overweight and obese beneficiaries in the direct care system, as well as documentation of the appropriate diagnosis on a patient's problem list when his/her BMI meets the CDC definition for overweight or obese.

WA
10/24/11

A referenced guidance document providing more detailed information on the background and reasons for these directives can be found in attachment 1. Additionally, attachment 2 contains a list of resources to aid providers as they implement this policy in their practice.

Updates to these guidelines will be published as required to reflect significant advances from ongoing research in the field of adult obesity management. Questions may be directed to John P. Kugler, M.D., MPH, Deputy Chief Medical Officer, Office of the Chief Medical Officer, TMA, Falls Church, Virginia, (703) 681-0064.

A handwritten signature in black ink, appearing to read "Jonathan Woodson". The signature is fluid and cursive, with the first name "Jonathan" and last name "Woodson" clearly distinguishable.

Jonathan Woodson, M.D.

Attachments:
As stated

Guidance: Management and Prevention of Adult Obesity

Attachment 1

Background

Adult obesity rates in the United States have reached epidemic proportions. Results from the 2007–2008 National Health and Nutrition Examination Survey indicate that 33.8 percent of adults in America are obese¹. Over two-thirds of American adults are either overweight or obese (68 percent). Obesity is a risk factor for many different chronic diseases such as diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers, and arthritis². Excess mortality, primarily from cardiovascular disease, diabetes, and certain cancers is related to higher grades of obesity^{2,3}. Of the conditions related to obesity, type II diabetes is the most closely linked, with significant increases in the prevalence of diagnosed diabetes in the United States from 1988–1994 through 2005–2006⁴.

While reports on rates of adult obesity within the Military Health System (MHS) generally show that they are lower than comparable rates nationally, it is still a serious concern. Data from the Department of Defense's (DoD's) electronic medical record, Armed Forces Health Longitudinal Technology Application (AHLTA), during 2010, that were subsequently extracted from the Clinical Data Mart, show that 26 percent of adults were considered obese. However, the combined rate of overweight and obesity in adults was 66 percent, very similar to the national rate. Work still needs to be done to decrease rates of obesity in MHS adults and to help those in the overweight category reach a healthy weight and not progress to obesity.

Measurement, Diagnosis, and Documentation

The U.S. Preventive Services Task Force recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Body Mass Index (BMI), which is a measure of body weight adjusted for height, is a useful tool to assess body fat and to determine whether an individual is overweight or obese. BMI is defined as weight (in kilograms) divided by the square of height (in meters). To appropriately calculate a patient's BMI, a patient's weight and height should be objectively determined. A patient's self-reported height and weight should not be used. A person with a BMI of 25 to 29.9 kg/m² is defined as overweight, while someone who has a BMI of 30 to 40 kg/m² falls into the obese category and a BMI of greater than or equal to 40 kg/m² constitutes morbid obesity, according to Centers for Disease Control and Prevention's (CDC's) definitions. While CDC's definitions should be used for diagnosis in most cases, each patient should be considered individually, taking into account their body composition, particularly in heavily muscled or very athletic individuals.

In order to properly document and provide necessary care, primary care providers should, at each visit, ensure that the patient's objective height and weight are measured; assess the patient's BMI using CDC's guidelines to determine if the patient is overweight or obese; and, if the patient is found to be in either category, to enter the diagnosis into the patient's problem list. The patient's height and weight should be entered into the vital

signs module of AHLTA, which will automatically calculate the BMI and display it with the other vital signs. If a patient falls into any of the CDC categories listed above, an appropriate diagnosis should be entered into the patient's assessment and problem list. This will ensure that whenever the patient is seen, whether by a primary care practitioner or a specialist, the diagnosis will be in the forefront of the patient's medical issues and can be addressed within the context of the particular visit. Nutritional counseling provided at a visit should be documented using appropriate codes by linking to the obesity or overweight diagnosis in the patient's assessment portion of the progress note in AHLTA. In addition, all patients should receive appropriate education and counseling, at least once yearly, regardless of risk, on the prevention and treatment of being overweight or obese. A list of resources to help providers accomplish this can be found in attachment 2. TRICARE Management Activity (TMA) will develop and implement a communication plan to encourage network primary care providers to accomplish these same measurement, diagnosis, documentation, treatment, and prevention efforts when a TRICARE beneficiary is seen by them.

Treatment and Management

The MHS has already dedicated itself to the implementation of Patient-Centered Medical Homes (PCMHs) across our primary care venues, providing improved care coordination and integration. In order to incorporate our efforts of combating obesity, primary care providers should follow the Veterans Affairs/DoD Clinical Practice Guideline for the Screening and Treatment of Overweight and Obesity (http://www.healthquality.va.gov/obesity/obe06_final1.pdf) in their practices. Similarly, TMA will encourage network primary care providers to follow nationally recognized, evidence-based clinical practice guidelines for the screening and treatment of overweight and obesity. Additionally, TMA will review and update, as appropriate, its nutritional and obesity counseling benefits.

Prevention

While the development of weight reduction strategies needed to treat patients once they are diagnosed as being overweight or obese is necessary, initiatives focusing on changing lifestyle behaviors to prevent obesity are imperative. In order to halt the obesity epidemic, efforts must be targeted at all patients and their families. Primary care providers should discuss with patients the actions they can take personally and within their family to help prevent overweight and obesity. This discussion should address healthy eating habits, increased physical activity, and decreased time spent watching television and using electronic devices for entertainment (screen time). The previously described communication plan will additionally encourage network primary care providers to counsel their patients on obesity prevention when a TRICARE beneficiary is seen by them.

Community Involvement

While medical guidance is important, obesity prevention encompasses behavioral changes and activities in many areas of life and within the entire family. Programs available on military installations, and in the community, such as in schools, wellness centers, youth programs, and recreation centers, as well as changes in food environments,

such as commissaries, cafeterias, and vending machines to make healthy foods more accessible are integral as well. TMA will support obesity prevention initiatives in non-medical areas.

References

1. Flegal K, Carroll M, Ogden C, Curtin L Prevalence and Trends in Obesity Among US Adults, 1999-2008. JAMA, January 20, 2010; 303(3);235-241.
2. Malnick SD, Knobler H. The medical complications of obesity. QJM. 2006;99(9):565-579.
3. Flegal KM, Graubard BI, Williamson DF, Gail MH. Cause-specific excess deaths associated with underweight, overweight, and obesity. JAMA. 2007;298(17):2028-2037.
4. Cowie CC, Rust KF, Ford ES, et al. Full accounting of diabetes and pre-diabetes in the US population in 1988-1994 and 2005 2006. Diabetes Care. 2009;32(2):287-294.

INFORMATION PAPER

MCHB-IP-HBH
24 October 2011

SUBJECT: Quality of Adult Body Mass Index (BMI) data in Medical Records

1. Purpose: To provide guidance on objective measuring and recording of height and weight for accurate calculation of BMI

2. Facts:

a. Body Mass Index (BMI) is a nationally recognized, inexpensive, and easy-to-perform method to screen for possible weight problems in adults. It is calculated from a person's height and weight and is a fairly reliable estimate of body fat for most individuals. An elevated BMI may indicate an increased risk of developing overweight or obesity-related diseases. BMI is also one of the best measurements for assessing overweight and obesity in the population.

b. MEDCOM uses BMI data to determine quality outcome measures as assessed by the AMEDD Balanced Scorecard and track performance of the BMI HEDIS measure. Army Public Health requires BMI measures to better characterize the Obesity epidemic, develop smart policies, and for assessment and evaluation of community obesity prevention initiatives.

c. Vital information collected during medical encounters at Army medical treatment facilities (MTFs) display a variety of problems in the documentation of height and weight. Discrepancies primarily occur from lack of recorded values, self-reported measurements, no standardization of measurement procedures, and improper data entry. Data quality issues include rounding of measurements, biologically impossible values, and inconsistent documentation of height and weight.

d. 65% of MTF medical encounters of adult patients include a measured BMI, resulting in only 79% of enrolled beneficiaries with a documented BMI on record within the last year.

e. Standardized procedures for determining and recording objective measurements of height and weight in all outpatient settings are necessary. A self-reported height and weight measurement is unacceptable. The following guidelines provide standardization in the collection of clinical height and weight metrics.

(1) Document anthropometric measurements in the vital signs entry section of AHLTA as part of each adult patient encounter in primary care clinics. AHLTA automatically calculates a BMI.

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SUBJECT: Quality of Adult Body Mass Index (BMI) data in Medical Records

(2) Height or stature. Measure without shoes using a stadiometer or other equivalent device. Use a stated height only if a measured height has been taken within the last year and the stated height matched the height measured earlier in the year (include a comment indicating the height was stated by patient, not measured).

(3) Weight. Weigh all patients on a medically calibrated scale as part of each outpatient visit. Stated weights will not be recorded as an official weight in the vital signs entry section of AHLTA. Record weight to within the closest pound. To compensate for clothing, use the following guidelines:

- Civilian clothes without shoes – subtract 3 lbs to compensate for clothing
- PT uniform (shorts and t-shirt) or equivalent without shoes – subtract 0 lbs
- ACUs with boots – subtract 7 lbs to compensate for uniform
- ACUs without boots – subtract 3 lbs to compensate for uniform

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Approved by: Ms. Laura Mitvalsky