Implications of the New Recommendation on Behavioral Counseling Interventions to Promote Healthy Eating and Physical Activity

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Lifestyle behaviors, including diet and physical activity, are leading determinants of health in the US and around the world.1 These behaviors are heavily influenced by sociocultural circumstances, such as levels of education and income, community environment, and prejudice and structural racism. Thus, government, community, and other systems-level approaches are paramount for addressing the disease conditions and health disparities caused by poor lifestyle.2,3 At the same time, within existing sociocultural circumstances, different people have differing diet quality and activity levels, which can also improve or worsen over time. Furthermore, the behavior of individuals, when summed, can drive the environment by shifting demand and thereby supply of healthier foods and opportunities for exercise and also can influence cultural norms. Thus, a focus on individual behavior change is one part of the solution for achieving better lifestyle and well-being for all.

In this issue of JAMA, the US Preventive Services Task Force (USPSTF) presents an updated recommendation,4 based on an updated systematic evidence review,5 on behavioral counseling interventions to promote healthy diets and physical activity for primary prevention of cardiovascular disease (CVD) in adults 18 years or older without CVD risk factors. Consistent with a recent government report,6 the USPSTF recognized that a large proportion of CVD can be prevented by addressing modifiable lifestyle risks and that most US adults do not consume healthy diets or engage in sufficient physical activity.

Critically, for this report, the USPSTF focused on adults without known CVD risk factors—ie, without hypertension, dyslipidemia, impaired glycemia, metabolic syndrome, or estimated 10-year CVD risk 7.5% or greater. While this group might seem representative of the general population, lifestyle-related conditions such as high blood pressure, high cholesterol levels, and prediabetes are so common among US adults that the group to whom the USPSTF recommendations apply represents a very small proportion of the US adult population: only an estimated 12.2%, based on national data from 2017-2018; and only an estimated 6.8% of adults with obesity are further excluded.7

For this segment of healthy adults, the USPSTF “recommends that clinicians individualize the decision to offer or refer adults to behavioral counseling interventions to promote a healthy diet and physical activity (C recommendation),” with moderate certainty for a small net benefit. Intervention delivery can be individual, group-based, or both, with or without telephone or electronic follow-up; or delivered remotely through any combination of print materials, telephone calls, and other technology. Goal setting, problem solving, and self-monitoring are typical behavioral counseling techniques, as are use of motivational interviewing or portions of the “5 A’s” Model (assess, advise, agree, assist, arrange). Behavioral counseling interventions can be delivered by a range of specially trained professionals, with interaction times ranging from 30 minutes to 6 hours over 6 months or longer. The USPSTF also notes that individuals who are interested and ready to make changes may be most likely to benefit and that success may be better if counseling can be tailored to patient motivations and goals, activity level and ability, preferences, overall health status, and neighborhood environmental circumstances.

Because USPSTF recommendations are based on published science, it is important to consider the strength of the underlying evidence for this updated recommendation. Importantly, the USPSTF identified adequate evidence that behavioral counseling interventions provide a small benefit in improving dietary outcomes, physical activity levels, and resulting CVD risk factors (blood pressure, low-density lipoprotein cholesterol level, body weight/adiposity) and that these interventions do not cause meaningful harms.4,5 However, the USPSTF identified limited data to directly assess the effects of behavioral counseling interventions on CVD events and mortality.4,5 Given the scope of health, equity, and economic consequences attributable to lifestyle-related conditions, this is a critical evidence gap, ripe for meaningful new federal and private sector investment in research.8

What does this recommendation mean for clinical practice? As summarized in Table 2 of the new USPSTF report, the recommendation to individualize the decision to offer or refer adults to behavioral counseling interventions applies to the relatively small proportion of US adults without obesity, hypertension, dyslipidemia, prediabetes, or diabetes. For everyone else—the great majority of US adults—clinicians should provide or refer them to intensive behavioral counseling.9,10 Moreover, the USPSTF has identified larger health benefits for behavioral counseling interventions among individuals with CVD risk factors or obesity,9,10 as compared with individuals with no risk factors. Yet such counseling is not occurring in practice: nationally, only an estimated 25% of patients with diabetes and 15% of other patients receive any diet or exercise counseling.11 Barriers to implementation may include insufficient clinician education about the science of behavioral counseling, nutrition, and physical activity; absence of efficient, widely used screening and tracking tools for lifestyle in
Much remains to be done. Further health systems innovations can incorporate and prioritize action on diet and physical activity, including improved clinician education, health record screening and tracking, evidence-based behavioral counseling, referrals to appropriate services, and corresponding reimbursement and quality-of-care standards. These actions could help increase the provision of and referral to intensive behavioral counseling to improve diet quality and physical activity. To increase the likelihood that such efforts also could reduce health disparities, these strategies should be combined with health systems approaches to address social determinants of health, such as food insecurity, housing, transportation, employment, and education. At the same time, the US and other nations will not achieve better health, advance health equity, or reduce health care spending until they equally emphasize and invest in public health and prevention policies to improve nutrition and physical activity outside the health care system.

ARTICLE INFORMATION

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