Updated USPSTF Recommendations for Behavioral Counseling Interventions
Gaps, Challenges, and Opportunities

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Heart disease is the leading cause of death in the US and accounted for 693,021 (or 1 in 4) deaths in 2021. The US Preventive Services Task Force (USPSTF) has recently published updated recommendations on behavioral counseling interventions to promote healthy eating and physical activity for cardiovascular disease (CVD) prevention in adults without known CVD risk factors. The recommendations, which were supported by an updated evidence report and systematic review, were given a grade of C based on evidence that behavioral counseling interventions provide a small benefit in improving physical activity levels and healthy eating, as well as a small improvement in CVD risk factors such as blood pressure, low-density lipoprotein cholesterol, and body weight, with little evidence for harm. The grade means that clinicians should individualize the decision to offer or refer adults without CVD risk factors to behavioral counseling interventions.

The updated recommendations are similar to the previous ones in 2017, which received the same recommendation grade and are consistent with recommendations by the American Academy of Family Physicians and the National Institute for Health and Care Excellence. However, the updated USPSTF recommendations are narrower than other organizations, including the American College of Sports Medicine, the American Heart Association, the US Department of Health and Human Services, and the US Department of Veterans Affairs. That is, these other organizations recommend that health care professionals provide behavioral counseling on eating and physical activity to all of their adult patients, regardless of chronic conditions or risk factors. Notably, the only substantive change from the 2017 USPSTF recommendations is that the updated ones did not include studies limited to adults with elevated blood pressure because this research is included in another USPSTF review among adults with known CVD risk factors.

Important Gaps
The current evidence report and systematic review included 113 unique trials, 33 of which were published since the previous USPSTF review. While the evidence base is growing, available research is limited. The review identified 4 main gaps in the literature: (1) limited reporting of intermediate cardiovascular metabolic outcomes or longer-term health outcomes, (2) lack of focus on whether the effectiveness of the included interventions varied among important subpopulations, (3) a need for standardization in the collection and reporting of behavioral outcomes, and (4) insufficient trials evaluating interventions designed to reduce sedentary behaviors.

Apart from the gaps identified by the USPSTF report, others are notable. One is limited literature on the use of wearable activity trackers, which may be a useful tool to increase engagement in physical activity, as well as for providing objective data on physical activity outcomes. Nevertheless, the review included a number of interventions delivered through technology only (ie, web, computer, text message). This shift captures trends toward telemedicine and consumer preferences for convenience. Another gap is the exclusion of interventions that may not be easily replicated or implemented solely through primary care, such as those delivered through work sites, faith-based organizations, retail food outlets, and other community organizations. Nor did any interventions focus on policy, systems, and environmental change approaches (PSEs). This is a shortcoming because PSE approaches are widely considered the most effective for creating large-scale improvements to the food and physical activity environments and addressing food security, reducing diet-related diseases, and promoting health equity. Addressing disparities in eating and exercise behaviors will be fundamental to reducing heart disease, and PSE approaches offer ways to better address the social determinants of health, engage community champions, and foster long-term changes in community context with the greatest potential of positively affecting access to healthy eating and active living. Not including these interventions may be a missed opportunity for understanding complementary settings for influence.

Critical Challenges
The key questions in the review focused on the primary care setting and interventions that could be delivered by physicians, nurses, exercise specialists, registered dietitian nutritionists, or behavioral health specialists, among others. Given evidence of a dose-response effect, where increasing intervention intensity was associated with larger improvements in intermediate outcomes, a reasonable question is whether higher-intensity interventions (defined as more than 6 hours of contact time over the course of the full intervention) can be delivered during primary care visits. Time constraints may—in part—explain why only a fraction of adults without chronic conditions receive counseling on exercise or eating behaviors.
need for more training of physicians in medical school and beyond, along with other allied health professionals, on nutrition and physical activity may also explain the low rates of eating and exercise counseling. Reimbursement incentives for preventive care services is another factor that may help explain suboptimal levels of counseling.

Potential Opportunities

The expansion of reimbursement policies to support behavioral counseling interventions could help; however, the evidence grade of C for this recommendation makes that challenging. That is, the Affordable Care Act requires private health insurers to cover without cost sharing all preventive services with “strong scientific evidence” of health benefits, defined as those recommended by the USPSTF with a grade of A or B, and many Medicaid programs similarly cover these services. Advancing the state of the science regarding the identified limitations of the evidence base will be one important step for improving the current recommendation grade. Exploring reimbursement options for diabetes might be one approach. 10 Besides research, physicians and other allied health professionals should receive better training on evidence-based, culturally, and contextually relevant approaches for behavioral counseling to improve eating, physical activity, and sedentary behaviors. One approach could be networks and other incentive and support systems that help pair physicians with community-based organizations, registered dietitian nutritionists, among other team members such as community health workers, social workers, and case managers that can provide recommendations within the patients’ sociocultural environmental context. Professional societies could play a key role in fostering joint learning environments and collaborative relationships around identifying and disseminating best practices.

The updated USPSTF recommendations emphasize how clinicians should decide together with their patients about behavioral counseling interventions, taking a patient’s individual situation into account. Persons who are motivated to make behavioral changes are most likely to benefit. In addition to increasing the frequency of behavioral counseling for nutrition and physical activity, more could be done to prioritize equity. Specifically, individuals who are at higher risk for developing CVD should be prioritized for the hundreds of specialized programs focused on behavioral counseling, ranging from referral for traditional in-person, one-on-one counseling by registered dietitian nutritionists and physical therapists to community-based programs, commercial online, and digitally supported programs.

Given that medical care is estimated to account for only 10% to 20% of the modifiable contributors to healthy outcomes for a population, physicians could consider how to better leverage other intervening approaches to promote healthy eating and active living outside of the health care system. Specifically, when implementing the USPSTF recommendation, clinicians and other allied health professionals should consider including screening, counseling, and referral for food insecurity and nutritional disparities. Increasingly, across the country, hospitals and health systems are incorporating food insecurity screening as part of their standard patient intake procedures. Food insecurity is an important risk factor for the use of emergency department and inpatient health care services, where a disproportionately large share of health care costs is generated.

Screening for food insecurity in and of itself is of limited value without complementary approaches to help address food and nutrition insecurity. Therefore, screenings should be integrated into a well-organized program that includes referrals to appropriate federal nutrition assistance programs, among other nongovernment charitable food network options. There are more than 15 federal nutrition assistance programs administered by the US Department of Agriculture, which serve tens of millions of individuals in the US. Referrals should also recognize the invaluable role of the charitable food network, which is made up of hundreds of food banks and tens of thousands of food pantries and meal programs across the country. Approaches to refer patients to local options to increase physical activity and reduce sedentary behaviors are equally as important. Besides referrals, physicians and other allied health professionals should engage with the US Department of Agriculture Supplemental Nutrition Assistance Program Education. This federally funded grant program now supports PSE change strategies designed to help people lead healthy, active lives by partnering with state, tribal, and local organizations, including those that foster synergies with clinical settings.

Conclusions

The USPSTF recommendations for behavioral counseling interventions to promote healthy eating and physical activity for CVD prevention in adults without CVD risk factors have not changed. In clinical practice, there are low rates of nutrition and physical activity counseling for adults without chronic conditions. Potential solutions might include better training of physicians, improved synergies with other allied health professionals, and leveraging resources outside of the health care system that promote healthy eating and physical activity.

ARTICLE INFORMATION

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REFERENCES
