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Weight Management in Rural Western Kansas Primary Care

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Weight Management in Rural Western Kansas Primary Care

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Abstract
The purpose of this project was to analyze weight management assessments and follow through care at Critical Access Hospitals (CAH) in rural western Kansas (KS). The survey data aimed to provide insight into current weight management programs and barriers to obesity treatment in the rural setting. Upon review of evidence Kansas is ranked 12 out of 51 for highest obesity rate. In the United States approximately 20% of the population is residing in rural areas with increased obesity rates compared to urban and suburban areas (Ritten & Lamana, 2017; stateofobesity.org). Following IRB approval, this project initiated phone contact with CAH leaders and an electronic survey was deployed to them. The collected data disclosed that there are barriers to caring for obese patients in the rural community and initiating formal programming should be considered. Respondents were provided with educational materials following the survey if it was requested.

Problem: Aim
- Current KS obesity rate 34.4% and has doubled over the past 20 years (stateofobesity.org)
- Despite heavily backed obesity recommendation and guidelines, providers are underreporting and under treating obesity (Ritten & Lamana, 2017)
- Rural obesity rates higher than urban and suburban areas (World Health Organization, 2019)
- Purpose/Aim: To determine CAH awareness and resources available to manage and address overweight patients in rural western Kansas.

Review of Literature
- Individuals living in rural areas with higher incidence of obese BMI
- Approximately 20% of the United States (US) population resides in rural areas (CDC, 2015)
- US obesity rate is 39.8%; KS obesity rate is 34.4% (stateofobesity.org)
- Obesity care costs estimated at $147 billion or more yearly (Tremmel et al., 2017)
- Growing need for increase in awareness of the importance of obesity management (Obesity Action Coalition, 2019)
- Obesity is linked to increased risk of comorbidities, most of which are associated with leading causes of death in the US (Woodruff et al., 2017)
- Obesity is identified as a major health concern and is listed as areas of needed improvement for Healthy People 2020 (Healthy People 2020, 2020)
- Rural healthcare organizations less likely to have access to needed resources to treat obese patients including access to affordable food source (ruralhealthinfo.org)
- 50% of providers admit to being uncomfortable discussing weight management with patients (Woodruff et al., 2017)

Methods
Setting/Population
Survey-based project was deployed to 23 CAHs. Leaders were contacted via phone followed by electronic survey to analyze markers at the sites.

Theoretical Framework
Ronald Havelock’s Phases of Change Theory

<table>
<thead>
<tr>
<th>Building A Relationship</th>
<th>Maintenance and Separation</th>
<th>Diagnosing the Problem</th>
<th>Acquire Resources</th>
<th>Selecting a Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation Stage</td>
<td>Establish Relationships</td>
<td>Evaluation</td>
<td>Need for change is understood</td>
<td>Options for change are presented</td>
</tr>
<tr>
<td>Establish</td>
<td>Successful maintenance</td>
<td>Change Desired</td>
<td>Process of developing solutions begins</td>
<td>Implementation</td>
</tr>
<tr>
<td>Change is successful</td>
<td>Monitor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change established</td>
<td>Accepted by all</td>
<td></td>
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</tr>
</tbody>
</table>

Procedure
This study was a nonexperimental, qualitative, descriptive study designed to analyze CAH ability to effectively treat overweight patients in rural health care. Following IRB approval, interventions involved contacting CAH leaders and deploying a self-designed survey. PI also performed follow-up contact to encourage responses and designed resource packet.

Outcomes
Descriptive data was used to analyze survey responses. The project found:
- 3 of 12 responding facilities have a formal weight management program
- 100% of providers in all facilities prescribe weight loss medication
- Only 50% of facilities have an onsite dietician (at least one day per month)
- 8 of 12 facilities have access to exercise physiotherapists or personal trainers (within 60 miles)
- Six facilities received educational material per request

Tools
- CAHs lack formal weight management programs
- CAH leaders perceived limitations to programs include: time, staffing, resources to initiate programs, no onsite dietician, poor reimbursement and provider commitment
- Obesity identified as major health concern for rural communities which aligns with national focus to reduce obesity rates
- Further research is implied to determine individualized plans for formal weight management programs

Conclusion

References