Intensive Behavioral Therapy for Weight Management — Learn About the Potential Role for RDs and Recommendations and Strategies for Performing This Role in Practice
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Since 2008, the obesity epidemic in America has been approaching a plateau; but with almost 70% of the adult population still considered overweight or obese and almost 35% of those obese, we are far from a solution to this important public health problem. As a result, the need for preventive care is evident. Obesity screening for all adult patients is recommended by the United States Preventive Services Task Force (USPSTF). To promote sustained weight loss, those identified as obese should be offered intensive counseling and behavioral interventions.

This continuing education course identifies and examines the potential role for RDs in intensive behavioral therapy (IBT) for weight management and provides recommendations and strategies about how RDs can perform this role in their practices.

IBT for Obesity
RDs faced with the challenge of helping obese clients achieve and maintain a healthy weight for long-term disease prevention need strategies to educate clients and promote behavioral change.

IBT, a process that can be implemented by health care providers for prevention and early detection of obesity, comprises the following three components:

• screening for obesity using BMI measurement;
• dietary assessment; and
• intensive behavioral counseling through high-intensity interventions on diet and exercise.

RDs routinely perform BMI screenings and dietary assessments. Employing behavioral counseling to deliver diet and exercise recommendations and begin the IBT process can be very useful for their clients trying to achieve weight management goals. In addition, many doctors are beginning to recognize the importance of nutrition counseling for obesity and value the expertise of RDs who deliver this treatment, making it an exciting time for RDs to be in this role.

Payment for IBT Services
The Centers for Medicare & Medicaid Services (CMS) was the first payer to declare coverage for IBT for conditions such as cardiovascular disease and obesity for Medicare beneficiaries. CMS will reimburse for this service for beneficiaries with BMI >30 kg/m² at a frequency of one face-to-face visit every week for the first month and one face-to-face visit every other week for
months two to six. If the beneficiary has lost at least 3 kg of weight by the six-month mark of intensive therapy, CMS will continue to cover one face-to-face visit every month for months seven to 12.³

A barrier to the well-trained RD receiving payment for these services lies within CMS’ provisions on coverage for services. Delivery of IBT must be performed in the primary care setting, and “a qualified primary care practitioner,” such as a physician, nurse practitioner, clinical nurse specialist, physician assistant, or other “auxiliary personnel,” must furnish counseling. RDs who don’t have a medical or advanced nursing credential aren’t recognized as qualified primary care practitioners. For RDs in primary care settings to be recognized as auxiliary personnel, a physician must be readily available in the office suite to provide assistance and direction while the service is being provided. Only under this specific set of circumstances is the RD able to bill as “incident to,” limiting many RDs from receiving payment for IBT for Medicare beneficiaries with BMI >30 kg/m².⁴ Although RDs are well prepared to perform BMI assessments, the most qualified to execute reliable nutritional assessments, and often trained in behavioral therapy, they seldom receive CMS reimbursement specifically for IBT in most clinical practices.

Obesity coverage for clinical preventive services is required under the Affordable Care Act for patients with non-Medicare insurance plans who are treated by RDs, based on USPSTF recommendations.⁶ Since the task force doesn’t address the specific services insurance companies should cover, payment differs widely depending on each insured’s benefits package. This course focuses on RDs’ use of IBT for obesity in the context of USPSTF recommendations for patients with RD-delivered IBT benefits. RDs can play an integral role as behavioral interventionists working as part of, or in communication with, a multidisciplinary team of medical doctors and behavioral health professionals for optimal care of the obese patient.

Obesity Treatment Approaches
Researchers have been studying the efficacy of dietary patterns on health outcomes for more than a century. With advancements in nutrition knowledge, discovery of essential vitamins and minerals, and medical breakthroughs, there are fewer instances of nutritional deficiencies and food insufficiency in the United States, but there are growing concerns about preventable chronic diseases. Historically, as consumers learned about links between lifestyle patterns and chronic conditions, they began to seek prescriptive dietary and physical activity recommendations for weight management. Health professionals then turned to evidence-based research to determine prescriptive recommendations to help patients reach appropriate weight management targets.

Weight Management Clinical Trials
More than 20 years of rigorous weight management clinical trials reveal only a few consistent findings about diet and physical activity prescriptions. The first is that all reduced-calorie diets result in clinically meaningful weight loss, regardless of macronutrient profile.⁶,⁷ Second, weight regain occurs after discontinuation of prescriptive dietary and physical activity patterns.⁸ And third, lack of sustainability of weight loss is due to lack of sustainability of behavioral adherence.
These studies demonstrated that dieting alone isn’t enough to promote sustained change, pointing to the need for treatment approaches such as IBT. Unlike the above treatment approaches, IBT focuses on behavioral therapy in combination with education on dietary patterns and physical activity recommendations that fit each individual patient’s lifestyle.

**Behavioral Intervention Trials**
Congruent with the components of IBT stated above, several major behavioral intervention studies show that patients who participate in a comprehensive lifestyle program that includes dietary and physical activity skill development, motivational initiatives, and identification of environmental and social support lose a significant amount of weight when guided by trained interventionists such as RDs.9-11

The benchmark trial for intensive lifestyle interventions is the Diabetes Prevention Program.9 This study focused on three groups of people. The first group took 850 mg metformin, a commonly prescribed diabetes medication, twice daily. The second group received placebo pills instead of metformin. Both the first and second groups were given diet and physical activity information but no motivational counseling. The aim of the third, or “intensive lifestyle intervention group,” was to prevent or delay onset of diabetes through methods to achieve behavioral lifestyle goals such as self-monitoring weight and food intake and attending motivational group counseling sessions, rather than solely focusing on dietary or physical activity prescriptions. Trained lifestyle coaches provided frequent contact and ongoing support throughout the trial to help participants achieve and maintain goals and tailored “toolbox” strategies for individual participants. At one year, the intensive lifestyle intervention group achieved a 58% reduction in the incidence rate of diabetes and lost 7% of body weight. The metformin group only achieved 31% reduced risk and lost 2% of body weight. The placebo group didn’t have a significantly reduced risk of diabetes and didn’t lose a significant amount of weight.9

In a viewpoint paper, “A Call for an End to the Diet Debates,” researchers reviewed the literature on the efficacy of dietary weight loss trials and concluded that the search for an “ideal” diet for weight loss and disease prevention sends mixed messages to the public and reinforces the fad diet industry.12 The only consistent finding in these trials is that adherence, or the degree to which the participants met program goals for diet and physical activity, is associated with weight loss and improvement in disease-related outcomes.

One can conclude from these important benchmark studies that instead of merely providing education, RDs should focus on strategies to improve behavioral adherence.

**Clinical Practice Guidelines**
It’s important to distinguish IBT from MNT. Whereas MNT is a therapeutic approach using specifically tailored diet plans and nutrition education to treat patients with medical conditions such as obesity, IBT includes the screening, assessment, and intensive behavioral counseling to promote sustained weight loss through interventions on diet and exercise.

In 2013, the American Heart Association, American College of Cardiology, and The Obesity Society released new guidelines for obesity treatment that urge doctors to treat obesity as a disease.13 These guidelines serve as a treatment manual for obesity management in clinical
practice and include recommendations for patients to follow a reduced-calorie diet, achieve high levels of physical activity (200 to 300 minutes/week), self-monitor body weight, and be accountable via face-to-face or phone-delivered programs with trained interventionists at an intervention intensity of one to two sessions/month in an on-site comprehensive lifestyle program.

When applying IBT in clinical practice, the above treatment guidelines can be followed in the final component of the three-step process that defines IBT, after screening for obesity and performing dietary assessment: intensive behavioral counseling.

As stated previously, the first two components of IBT are screening for obesity using BMI measurement and performing dietary assessment. According to the USPSTF, there’s good evidence to support the use of BMI for obesity assessment, and it’s routine practice for RDs to perform dietary assessment of all clients. Although specific calorie, macronutrient, and micronutrient recommendations should certainly be made, they shouldn’t be the focus of IBT. This is why the third component of this process, intensive behavioral counseling through high-intensity interventions on diet and exercise, is much more detailed and requires more in-depth discussion.

**Intensive Behavioral Counseling**

Intensive behavioral counseling is one component of the overall process of IBT. It should include education for skill development, strategies to enhance motivation toward goals, and identification of environmental and social support.

**Education for Skill Development**

RDs can educate clients in skill development by following the above stated clinical practice guidelines and advising them to consume a reduced-calorie diet, frequently engage in moderate-intensity physical activity, and monitor body weight. The dietary assessment performed in the previous step of IBT can be used as a tool to establish what “a reduced-calorie diet” means to the individual client. As previously observed, weight management clinical trials of reduced-calorie diets result in weight loss, regardless of macronutrient composition. Educating patients on how to achieve this calorie target within the context of their daily lifestyles is key to helping them develop and implement this skill.

Similarly, it’s useful to get an idea of a client’s baseline physical activity level and educate them about the benefits of working up to achieving 200 to 300 minutes of moderately intense physical activity per week per the 2013 obesity treatment guidelines. According to the Centers for Disease Control and Prevention, fewer than one-half of all adults meet the physical activity guidelines at the most basic level, which means more than one-half of the average RD’s patients are not engaging in 150 minutes of moderate-intensity activity per week, let alone the obesity treatment guideline of 200 to 300 minutes. Like teaching them about following a reduced-calorie diet, educating patients about how to work up to this activity level in their current real-life environment will make it more likely for them to be successful.

The 2013 obesity treatment guidelines, as well as a large body of literature, have demonstrated the efficacy of self-monitoring tools for weight loss. Self-monitoring of body weight and food intake is recommended, but as most RDs know, it’s difficult for patients to
adhere to self-monitoring of food intake. Despite the consensus that food record keeping is an efficacious approach to weight management, people still have difficulty adhering to this behavior. Therefore, there’s a need for strategies to enhance motivation toward self-monitoring and other skills such as consuming a reduced-calorie diet and achieving high levels of physical activity.

**Strategies to Enhance Motivation Toward Goals**

**Consideration of patients’ individual lifestyles is crucial to enhancing their motivation to change and achieve goals.** For someone who eats meals away from the home most days, it wouldn’t be a realistic goal to expect 100% compliance with a shift toward consuming mostly meals prepared at home. However, it can be useful to start with a smaller focus, such as targeting the meal that is most frequently consumed away from the home. For example, if patients describe eating every dinner at restaurants or fast food establishments, RDs might work with them to plan for at least two to three dinners per week to be prepared at home. Motivation to move toward this goal may be determined by the patients’ ability to obtain healthful foods to prepare at home, incorporate food preparation into their current schedules, and plan around special events that may prevent carrying out the goal.

With respect to physical activity, 200 to 300 minutes is much more than what many patients are accustomed to doing; believing that the long-term goal is unachievable may reduce their motivation to get any level of physical activity. The Physical Activity Guidelines also state that some activity is better than none. Therefore, encouraging even a reduction in sedentary time can be beneficial.

A great tool that can be used for self-monitoring activity and can increase motivation to engage in exercise is the use of activity trackers such as accelerometers or even simpler versions of pedometers, or step counters. It can be much less overwhelming for a patient to hear that "every step counts," and that taking the stairs instead of the elevator, parking the car a bit farther away, or getting off the train one or two stops early can add to their overall physical activity goals. Much more intimidating is the idea of getting up to five hours per week of exercise. Other challenges include the need to change into fitness clothes, travel to a gym, and exercise with people who may be intimidating.

Another way to enhance motivation toward achievement of long-term physical activity goals is to encourage patients to choose enjoyable physical activities. Not only are people more likely to engage in physical activity they perceive as enjoyable, but they also tend to consume fewer calories and make better food choices after engaging in these activities. Perhaps this is because they feel good about completing the activities and want to continue treating their bodies well, rather than feeling like the activities were work and that they are entitled to treating themselves to poor food choices. Beginning the IBT process with a thorough interview of patients’ physical activity patterns, level of enjoyment of physical activity types, and access to activities that fit into their daily routines may enhance their motivation and, therefore, make it more likely for them to adhere to their activity goals.

A strategy to keep patients engaged in self-monitoring food intake is to change the way in which food tracking is done. It might be beneficial to start with paper food diaries that allow patients to increase awareness of food items consumed, rather than focusing on quantifying
calories or macronutrients, which might overwhelm patients and discourage the behavior. Once patients are comfortable tracking food patterns on paper, RDs might “graduate” them to using some of the online or smartphone food trackers and connecting their intake record with some quantitative outcome such as a specified calorie goal. Risk of burnout is high with food record keeping; therefore, the recommendation might be to keep food records for a finite amount of time to make the activity more manageable.

**Identification of Environmental and Social Support**

Accountability via face-to-face or phone-delivered programs with trained interventionists is another guideline for obesity treatment and can be implemented in the IBT process through identification of environmental and social support. The RD, as the trained interventionist, can provide support and accountability for clients through face-to-face or phone-delivered sessions. Nutrition experts may suggest that most of the time can be spent on reviewing self-monitoring tools such as food logs and physical activity reports, problem solving any barriers to the achievement of past goals, and setting short-term goals to move patients closer to their long-term goals. The self-monitoring strategies mentioned previously provide accountability to the patients via self-reflection of recorded eating and physical activity patterns, to the professional via weekly weigh-ins, self-monitoring check-ins of tools such as food logs and pedometer reports, and to a group of the patients’ peers during group meetings and online discussions.

Education shouldn’t be the primary focus of an IBT session. According to social cognitive theory, human behavior is driven by personal, behavioral, and environmental influences, of which education or acquisition of knowledge is only a small piece.\(^{18}\) Health knowledge is important for change, but for sustained change, people must build their confidence through experiential learning and key self-regulatory skills such as self-monitoring, problem solving, and goal setting. Social cognitive theory states that people learn and repeat behaviors by observing others, which is why motivation through social networks can be integral to long-term success. Networks can be formed in several ways to provide social support, such as partnering with a friend or family member to work toward common goals, participating in a group to get the support of one’s peers, or even engaging virtually through online forums. When this occurs repeatedly, individuals become conditioned to reproduce the behaviors and form new habits.

**High-Intensity Interventions**

According to the 2013 obesity treatment guidelines, it’s beneficial to deliver IBT through high-intensity interventions incorporating diet and exercise to provide accountability at an intensity of at least one to two sessions per month. USPSTF defines “high-intensity interventions” as the use of the following five major steps, called the 5-A framework.\(^ {19}\)

**Assess:** Ask about behaviors that may interfere with weight loss goals.

These may be food-related behaviors, such as binge eating or emotional eating, or nonfood-related such as chronic pain, depression, or stress. It’s important to identify any of these barriers before moving to the next step. For example, if a client struggles with emotional eating, it would be important to acknowledge the need to set a goal pertaining to that specific behavior, rather than simply to set a goal to discontinue the eating pattern without addressing...
the reason for emotional eating. Reviewing previously set goals might help the patient identify barriers to long-term goal achievement. Throughout the five steps, RDs should remember to stay within their scope of practice. Identifying that underlying issues for emotional eating exist isn’t the same thing as providing suggestions on how to solve those underlying issues, which may be better addressed by an alternate provider, such as a behavioral psychologist.

Advise: Provide education and customize behavior change recommendations.

After the initial assessment step above, educate patients about the benefits of behavior change and the risks of not making changes. For example, RDs should advise clients with identified emotional eating issues to address the underlying reasons for emotional eating, perhaps by seeking the advice of a behavioral health care professional. Sustainable weight loss will be more likely if the RD provides a clear message that the risk of not addressing the specific issues may lead to continued emotional eating and, ultimately, lack of ability to achieve long-term weight loss goals.

Agree: Work with the patient to discuss and decide on appropriate treatment methods and goals.

It’s important not to set goals for patients. The RD’s job is to educate and provide options for behavior change, but it’s ultimately up to the patients to choose what they would like to work on. For example, patients may be ready to identify that emotional eating is a problem but may not be ready to take steps toward discontinuing this behavior. In such cases, RDs may list some options from which the patients can choose when they are ready to take action, such as agreeing to confide in a close family member or friend, attending a support group for people with similar problems, or seeking the help of a psychologist or other licensed behavioral expert who can provide psychotherapy. RDs should encourage patients to choose from among the list of options.

Assist: Use behavior change techniques to counsel patients and facilitate goal achievement.

Helping clients identify and strengthen their skills can build self-efficacy, leading to increased motivation to achieve goals. For example, if patients with emotional eating issues aren’t yet ready to change this behavior but have agreed in the above step to identify a method for facilitating change, RDs might work with them to build their confidence for taking this action. Some options might be to normalize the behavior by sharing statistics on emotional eaters and help set up evidence-based methods for dealing with the behavior. This might include providing patients with a list of local support groups or helping them identify psychologists or social workers covered under their insurance plans. RDs can work with patients to write out specific action plans.

Arrange: Provide ongoing assistance and follow-up on action plans.

Following up on progress with goals and any referrals to alternate resources is crucial. RDs may be able to facilitate connections for ongoing assistance and support by communicating with other providers or community resources. RDs can review patients’ experiences, concerns, and progress and revise goals and action plans as needed.
As mentioned previously, the 2013 obesity treatment guidelines recommend intervention intensity of one to two sessions/month in an on-site comprehensive lifestyle intervention program. For RDs providing IBT under the Medicare-required components for Medicare beneficiaries, the intervention intensity must adhere to the following protocol:

• one face-to-face visit every week for the first month of treatment;
• one face-to-face visit every other week for months two to six; and
• one face-to-face visit every month for months seven to 12, if the beneficiary meets the 3-kg weight loss requirement at six months.³

If the required 3-kg weight loss isn’t achieved during the first six months, a reassessment of readiness to change and BMI can take place for the beneficiary after an additional six-month period.³

Summary and Implications for Clinical Practice
In summary, IBT is a behaviorally focused, patient-centered approach to facilitating sustained change. Based on current US obesity statistics and the rate of weight regain in those who initially lose weight, it’s clear there’s a need for RDs to work with patients toward sustained behavior change.

A multitude of weight management clinical trials have demonstrated that reduced-calorie diets are a short-term fix to a long-term problem of behavioral nonadherence. In addition, behavioral intervention trials have shown that weight regain is common and that it’s of paramount importance that providers focus on strategies to improve behavioral adherence. The 2013 obesity treatment guidelines can serve as a treatment manual for obesity management in clinical practice when incorporated within the IBT protocol.

RDs providing IBT should follow specific guidelines for intensive behavioral counseling, including education for skill development, strategies to enhance motivation, and identification of ongoing support through high-intensity interventions using the 5-A framework.

The first two steps of IBT (BMI screening for obesity and dietary assessment) are components that should be routine practices for RDs, based on intensive training and practicum in these areas to obtain RD credentialing. However, intensive behavioral counseling and behavioral therapy through high-intensity interventions are topics that are often absent from or inadequately addressed in RD training curricula. RDs who provide IBT should be well trained in patient-centered counseling and maximize skills with which to improve patient behavioral adherence.

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References


5. Patient Protection and Affordable Care Act, HR 3590, 111th Cong, 2nd Sess (2010).


Quiz

1. Which of the following describes intensive behavioral therapy (IBT)?
A. Counseling to promote sustained weight loss through high-intensity interventions on diet and exercise
B. A therapeutic approach using specifically tailored diet plans and nutrition education to treat patients with medical conditions
C. A service that RDs are required to provide for all patients with Medicare
D. IBT is the same as MNT

2. Under which of the following circumstances can RDs get Medicare reimbursement for IBT?
A. When RDs provide the service in a specialty obesity clinic
B. When RDs provide the service in primary care settings with the physician present in the office
C. When the patient has a diagnosis of diabetes or end-stage renal disease
D. When RDs provide three or fewer IBT visits per year

3. Which of the following is one of the few consistent findings of weight management clinical trials?
A. The best way for patients to lose weight is to follow a low-carb diet.
B. Patients can lose weight by reducing calorie intake, but all patients gain back all of their weight lost.
C. Patients can sustain weight loss by exercising 200 to 300 minutes per week.
D. Patients who sustain weight loss are those who continue to adhere to prescribed behavioral strategies.

4. Which of the following strategies is part of the 2013 obesity treatment guidelines?
A. Consumption of a reduced-carbohydrate diet
B. One hundred and fifty minutes of moderate-intensity physical activity per week
C. Intervention intensity of one to two sessions/month in an on-site comprehensive lifestyle intervention program
D. Self-monitoring food intake

5. According to the guidelines for IBT, intensive behavioral counseling should include which of the following?
A. Primarily education with a few behavior change recommendations
B. A requirement to keep daily food records
C. Identification of environmental and social support
D. A structured meal plan

ANSWER: C
6. How does the United States Preventive Services Task Force define high-intensity interventions?
A. Interventions that are face-to-face instead of phone-based
B. Interventions that are delivered by RDs
C. Interventions that include weekly meetings for six months, using the obesity treatment guidelines
D. Interventions that follow the 5-A framework

7. What are the 5-As of IBT?
A. Assess, advise, agree, assist, arrange
B. Acquire, alert, advise, agree, assist
C. Attain, advise, assist, arrange, agree
D. Assess, administer, advise, arrange, attain

8. Which of the following describes the “advise” step of the 5-A framework?
A. Counseling patients through their emotional eating issues
B. Educating patients on the benefits of identifying emotional eating issues
C. Setting a goal for the patient to limit emotional eating to no more than two days per week
D. Identifying reasons for emotional eating and ways to solve those underlying issues

9. For RDs providing IBT under the Medicare-required components for Medicare beneficiaries, what is a requirement for providing covered visits beyond six months?
A. One face-to-face visit every week up to one year
B. One face-to-face visit every other week up to one year
C. Medicare will not cover visits beyond six months of IBT delivered by an RD.
D. One face-to-face visit every month for months seven to 12, if the beneficiary has lost 3 kg in the first six months

10. Which of the following should be the RD’s main focus during an IBT session?
A. Getting the patient to lose 5% to 10% of initial body weight over six months
B. Educating the patient on the best ways to lose weight
C. Helping the patient choose and maintain realistic, sustainable behavior change goals
D. Getting the patient to engage in self-monitoring techniques, such as keeping a daily food diary