Bariatric Population: A Summary of My Experience

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Introduction

I have been interested in bariatric practices because of my persona struggle with obesity. According to the Centers for Disease Control and Prevention, the obesity rate reached 42.4% in 2017-2018, a far cry from Healthy People's 2020 target of 30.5% (Ogden, 2017). Many individuals are turning to bariatric surgery to lose weight. Throughout the semester, I have been doing an internship at a bariatric rehab facility. The bariatric practice involves different types of procedures for patients who are considered obese and have had their life impacted due to their obesity. According to the American Society of Bariatric Medicine (ASBM), a patient can qualify for bariatric surgery if their "body mass index is greater than 40, more than 100 pounds overweight, or have a BMI greater than 35 with at least one or more obesity-related co-morbidities such as type II diabetes mellitus (T2DM), hypertension, sleep apnea, and other respiratory disorders, non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, gastrointestinal disorders, or heart disease (ASMBS, 2019)"

Nurses follow guidelines issued by the American Society for Metabolic and Bariatric Surgery (ASMBS). Founded in 1983, it is "represented by professional nurses of geographical regions, multiple bariatric nursing experiential levels, and roles, with a familiarity of the full range of bariatric surgical procedures, academic and community environments, and the full range of working program sizes, to establish rigorous standards which have a basis in real-world practice (ASMBS, 2019)." The patient population believes bariatrics is a simple solution to complication problems, and by gaining weight, they can undergo the procedure. My project focuses on educating patients about bariatric practice, how to qualify for it, identify barriers interfering with their weight loss, and create a plan that will help achieve their goals. The intervention will be given to the patients who are overweight but do not need bariatric surgery.

**Needs Assessment**

Contributions to obesity include an environment promoting poor health choices, lack of physical activity, poor eating habits, low socioeconomic status, personal preference, and genetics. Many patients involved in the education session(s) stem from low- and middle- income family homes or have a poor educational background (or both) (Booth, 2017). The educational program will be focusing on the obese population who do not require bariatric surgical interventions, but for those who need traditional weight loss methods through lifestyle modifications. The age of the community will range between 25-65, cover both sexes (male and female), and race Caucasians, African Americans, and Latin Americans). Twenty patients (n=20) will be involved throughout the teaching sessions. An assessment tool was given to patients to fill out (Appendix A).

**Teaching Plan**

The purpose of the teaching session is to promote a healthier lifestyle among the bariatric patient population by addressing a proactive approach towards better health. The goal was to promote wellness education with the focus on improving patient's health and reducing obesity. The teaching plan was a two-month project, either involving weekly or PRN (as needed) appointments one-to-one (1:1) and group meetings. There were five objectives, as recommended by the faculty, to be met. Said objectives were covered in the same sessions and not on separate days. The goals have been heavily impacted due to the COVID-19 pandemic. The majority of the objectives were evaluated via journal entries, telehealth, and sign-in sheets. 1:1 and group meetings addressed most of these objectives within the allotted time of 15-60 minutes.

The first objective was behavioral. After one month of providing education within the facility, 50% of the patient population will have improved outcomes. Patients were to identify factors, current methods on managing their lifestyle, and medical history contributing to weight gain. Methods include 1:1 and group discussion, allowing 30-60 minutes to discuss. The patient (s) would meet once/week. A private room, needs assessment pamphlet, nurse educator, and a nutritional/weight loss journal was used as resources. Teach-back was used to identify the current lifestyle, weight loss methods, and medical history. Patients were given a journal to update progress, and wellness checkups were either completed in-person or via telehealth.

The second objective involves psychomotor traits. After one month of assisting the patients with weight loss interventions, 50% of the patient population will have improved outcomes. To do this, patients received help in creating a food log and activity journal, encouraging the patient to attend wellness meetings, have them discuss current obstacles, and perform physical evaluations to assess the need for bariatric surgery. Return demonstration and a simulated environment were used, providing 15-60 minutes either daily, weekly, or monthly. A private room, physical therapist (PT), occupational therapist (OT), aids, journal, and nurse were used for evaluation to note improvement. PT and OT assessed patient activities of daily living and activity levels to create routines catering to their needs.

The third objective effects the developmental-affective/attitude attribute. With it, 50% of the patient population will follow routine after providing role-modeling interventions. Patients were encouraged to discuss internal and external barriers preventing them from weight loss, such as their health condition, mental issues, stress, and environmental factors. After learning about these factors, SMART (specific, measurable, attainable, realistic, timely) goals would be created. Patients would follow the recommendations set by the American College of Sports Medicine (ACSM) to exercise more than 2.5 hours/week. In conjunction with using a journal, role-play was used to build rapport between the nurse and patient(s). A private room, journal, pamphlets about healthy living, and a team of healthcare professionals were involved in the teaching process. Journal entry, progress points, and patient attendance were collected for evaluation.

The fourth objective focuses on environmental points. It involves 50% of the patient population identifying outdoor factors contributing to a sedentary lifestyle. Patients were to identify said elements and what facilities they can use to improve health. A 1:1 intervention was given, allowing the patient and nurse to discuss the issue for 15-30 minutes. A private room, nurse, journal, and telehealth were used to facilitate care. Teach back, weekly wellness checkups, and journal entries were used to evaluate the patient's understanding.

The final objective focuses on knowledge, in which 50% of the population will follow medication guidelines for chronic conditions and be taught bariatric practices. Medical history and bariatric practices will be reviewed with patients and verbal understanding of regiment. 1:1 would be preferred with an allotted time of 15-30 minutes for privacy. A private room, medication list, health history form, bariatric pamphlet, healthcare workers, and a journal will be used to facilitate care. Knowledge will be assessed via teach-back, verbal understanding, medication schedules, and how patients perceive the current condition.

**Implementation**

The teaching plan was discussed with the healthcare team (physician, office manager, dietician, PT, OT, and the nurse educator), and it was agreed that the program would be 1-2 months long. Bandura’s Social Cognitive Theory was used as the learning module to create a holistic approach in promoting healthy choices (Liebl, 2016). It took place within the private bariatric facility, and private rooms were given to allow for 1:1 sessions. Group classes were offered for patients who were interested in being involved in a small community. Twenty patients, through the referral of local hospitals and other personal care providers, were enlisted into the program. Patients filled out the medical history before meeting with the healthcare team. Patients met for an hour, going over the objectives listed with interventions applied. Patients would achieve either once per week or by telehealth (phone call or webcam).

**Evaluation**

The program far exceeded the expected 50% within the first month, recurring more than 85% of the patient population (17 participants out of twenty). 85% of the group participated in 1:1 meetings and group meetings, yielding open discussion about weight loss ideas, programs they have signed up for, and healthy meal plans. Also, the same 85% have been adhering to SMART goals, losing 1-2 pounds per week, adhering to the ACSM guidelines and food plans. 90% of the patient population performed ADL's and physical activities to create routines that would help patients with their exercise program. Lastly, 100% of the patient population were educated on their medical history, medicine, and bariatric practices. Patients verbally understood that there was no need to have bariatrics, per ASBM guidelines. Due to the COVID-19 pandemic, there was a decrease in follow up due to the personal lifestyle being impacted by the pandemic. 35% of the patient population continued follow-up within the second month.

**Summary**

I enjoyed my time creating a teaching plan for this group and based on recommendations, was given a job. It helped me manage my time and resources that I had available due to the interdisciplinary team sharing a common goal: to help patients achieve a healthier lifestyle. I had to create a similar weight loss program for a pediatric population, so I was familiar with what to expect. The biggest negative and I think many will express the same issue, was the COVID-19 pandemic. It made follow-up and patient recurrent difficult, despite telehealth being an option. I hope to expand my teaching skills into my future career goals.

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Appendix

Medical History Form (Appendix A)

**GENERAL INFORMATION**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **VITAL SIGNS (BASELINE)**

 HT\_\_\_\_\_\_\_\_\_ WAIST CIRCUMFERENCE\_\_\_\_\_\_\_\_\_\_\_\_\_

 WT\_\_\_\_\_\_\_\_\_

 BMI\_\_\_\_\_\_\_\_\_

 BP\_\_\_\_\_\_\_\_\_\_

 PULSE\_\_\_\_\_\_\_

General

Highest education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of residents who live in current household:\_\_\_\_\_\_

Number of children:\_\_\_\_\_\_\_\_

Taking care of anyone handicapped:\_\_\_\_\_\_

**LIST OF MEDICATIONS CURRENTLY TAKING**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEVANT FINDINGS**

\_\_\_\_ Obesity

\_\_\_\_ Type 2 Diabetes mellitus (DM)

\_\_\_\_ Cardiovascular disease (hypertension, cholesterol, myocardial infarction)

\_\_\_\_ Early deaths from heart disease or stroke

**SYMPTOMS** (check off any symptoms you may be experiencing)

\_\_\_\_ Anxiety, avoidance, social isolation (depression component)

\_\_\_\_ Polyuria, polydipsia, weight loss / gain (type 2 DM)

\_\_\_\_ Headaches

\_\_\_\_ Night breathing difficulties (sleep apnea, hypoventilation, asthma)

\_\_\_\_ Daytime sleepiness (sleep apnea, hypoventilation syndrome, depression)

\_\_\_\_ Abdominal reflux (Gastro esophageal reflux disease, gallbladder disease, constipation)

\_\_\_\_Abdominal tenderness

\_\_\_\_ hip or knee pain

\_\_\_\_ Menstrual irregularities

\_\_\_\_ lower leg bowing (Blount’s disease)

\_\_\_\_ limited hip range of motion

\_\_\_\_hepatomegaly (enlarged liver)

**LABS**

Fasting lipid profile, liver enzymes (ALT, AST), fasting glucose, hemoglobin A1C, other

\*current lab values are either filled by patient or are documented from most current records

**DIAGNOSES AND CO-MORBIDITIES (**please circle any known conditions)

Abnormal Lipids

Asthma

Disordered eating (binging, seeking food)

GERD

Hypertension

Depression / Anxiety

Dysmetabolic syndrome

Elevated liver enzymes

Nonalcohohlic fatty liver disease

Orthopedic issues/joint/bone problems

Abnormal menses

Pre-diabetes

Sleep apnea

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BEHAVIORAL ASSESSMENT**

ATTACH BEHAVIOR RISK (sedentary time, physical activity, nutrition)

\*paperwork will be attached if patient is interested in filling out; optional, though it is recommended

CONFIDENCE AND READY TO CHANGE (SCALE 1-5) (please circle a number)

 1 2 3 4 5

**TARGET BEHAVIOR (Only for engaged/ready patients/family) before initiation**

WEIGHT LOSS TARGET ASSESSMENT

BMI: 85 – 94% w/no risks

Maintain weight velocity

BMI: 85 – 94% w/risks

Decrease weight velocity or weight maintenance

BMI: 95% - 98%

Either weight maintenance or gradual weight loss

BMI > 99%

Weight loss of 1 to 2 pounds per week

PATIENT’S ATTITUDES AND BEHAVIOR TOWARD NUTRITION

(for patient to fill out)

**Honor Pledge**
I pledge to support the honor system of Old Dominion University. I will refrain from any form of academic dishonesty or deception, such as cheating or plagiarism. I am aware that as a member of the academic community it is my responsibility to turn in all suspected violations of the Honor Code. I will report to a hearing if summoned.