INTRODUCTION

Obesity is extensively associated with a variety of comorbidities including: diabetes, hypertension, hyperlipidemia, fatty liver disease, obstructive sleep apnea, gastroesophageal reflux disease, vertebral disk disease, osteoarthritis, and increased risk of postmenopausal breast, endometrial, colon, liver, and Hodgkin cancer (Ladd, Bow, Hing, Thoman, & Bog, 2011). Evidence shows that providing education concerning lifestyle changes and diet modifications has a notable effect on the populations' health outcomes and specifically obesity rates (Son et al., 2012). The focus of improving dietary lifestyles should start with low-income populations because they are more likely to have chronic medications and suffer from major chronic diseases (Petrosko-Pennu et al., 2006). The effective methods for distributing nutritional information to such populations are health consultations and counseling. These methods have been shown to be both cost effective and valuable strategies towards positively supporting poor lifestyles habits (Gan et al., 2012). Evidence shows that primary healthcare settings are an ideal location for addressing the issues of obesity and increasing disease burden within a population (de J. Yank, V. Lai, et al., 2013). However, a U.S. national survey reveals that “there is a continuing failure to incorporate weight management into critical practice, especially that of primary care” (de J, Yank, V. Lai, et al., 2013). In fact, Heintzel et al. states that many general practitioners support the notion of implementing weight management and counseling into their practices, but due to a significant lack of time to devote specifically to each patient, they are unable to successfully do so (Heintzel et al., 2016). Currently, there is very little institutional support where obesity prevention and treatment programs are being implemented, and the existing clinics are far from adequate efficient (de J., 2013). These new clinics, methods, and practices towards combating obesity and metabolic syndrome.

This study addressed the overwhelming epidemic of metabolic syndrome and focused on the effects of one-on-one counseling and follow-up methods in participant subjects. The nutritional education methods and nutritional behavioral modification methods were utilized to teach and modify the subjects' nutritional activities. The overall clinical experience and satisfaction of participating subjects were later evaluated. The Nutri One-On-One program concentrated on metabolically compromised subjects and behavioral change techniques: motivational interviewing, one-on-one interventions, nutritional education, and lifestyle counseling to create a positive and notable change to both the subjects and the overseeing attending physicians.

METHODS

The participant subjects were interviewed to gain insight into their daily nutritional routines and patients' anthropometric histories were obtained. Each participant was then encouraged to set a primary health goal. A personalized nutritional lesson was given to address the health goal and current nutritional behaviors. The patient and health coach then arrived at three accountability and support.

REFERENCES


Figure 1: A Flow Chart of Procedural Steps

RESULTS

Personalized one-on-one nutritional health coaching through the Nutri One-On-One study has proven to be successful, as 95% of the study's participants reported that their health goals were still a priority at the one-month follow-up, and the average subject had completed 6.3% of these three health actions at a rate of 75%. The tailored education for these nutrition guidelines and living change continued to create positive behavior modifications within subjects and installed a support system that kept subjects motivated in the use of the lifestyle and health goals. In total, 93% of the subjects achieved their primary healthcare visit, and 88% of subjects reported that the intervention was successful. Overall the intervention was successful as significant level of knowledge was retained, an increase in the primary care visit satisfaction was reported, and considerable achievements of health goals through patient health actions were reported.

CONCLUSIONS

A brief nutritional counseling in a one-on-one environment assists people in adopting healthy lifestyle behaviors. These types of counseling may help prevent and control diseases. Through effective goal setting, motivation, and intervention, and utilization of a one-on-one counseling program, we can develop an intervention program that personalized one-on-one nutritional coaching focused on patient's goal proved to be successful. The education on healthy living, nutrition, and lifestyle techniques created optimistic behavior modification. The follow-up sessions continued to provide reinforcement in sustaining success. This type of counseling should be advocated within the health care system on a more routine basis.