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Implementation of Video-Based Weight Loss Education in Primary Care

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Abstract

Phase II Site Naval Medical Center Portsmouth

Title Implementation of Video-Based Weight Loss Education in Primary Care

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Background An estimated 23.6% of Military Health System beneficiaries and 16% of Active Duty Service Members are obese with a body mass index ≥ 30 . VA/DoD clinical practice guidelines (CPGs) recommend that obese patients be referred to a comprehensive weight loss program. A previous project at Naval Medical Center Portsmouth (NMCP) found low referral rates for obesity-related concerns, due in part to a lack of awareness about existing programs. Time constraints during primary care appointments were a contributing factor. Video-based education can be an effective adjunct to provider counseling about weight loss resources.

Clinical Question In the adult primary care setting, is video-based education about local weight loss programs perceived to be a useful tool for patients and providers compared to current practice to increase awareness of programs and facilitate dialogue with minimal impact on time constraints?

Project Design The project design encompassed the Health Belief Model, current literature, and CPG recommendations to create an evidence-based video about weight loss programs at NMCP. Surveys were used to assess the perceived usefulness of the video.

Analysis of the Results Survey responses from 185 patients and 18 providers were evaluated. Providers identified time constraints (50%) and competing demands (44%) as barriers to discussing weight loss. Patients and providers were not fully aware of available weight loss

programs. Over 94% of providers reported that the video would promote dialogue with patients, and 95% of patients felt more informed after viewing the video.

Implications for Practice The use of a brief educational video about weight loss programs at NMCP may facilitate commitment to lifestyle interventions and improve compliance with the VA/DoD CPG recommendations for obese patients.

Introduction

In fiscal year 2017, 23.6% of adult beneficiaries in the Military Health System (MHS) and 16% of Active Duty Service Members (ADSMs) were obese with a body mass index ≥ 30 (Defense Health Agency [DHA], 2018). Increasing obesity rates across the lifespan are associated with numerous co-morbid conditions and high healthcare costs that directly affect the MHS (Centers for Disease Control and Prevention, 2016; Tanofsky-Kraff et al., 2013). The *Department of Veterans Affairs (VA) and Department of Defense (DoD) Clinical Practice Guideline for Screening and Management of Overweight and Obesity* recommends comprehensive lifestyle interventions for obese patients (Department of Veterans Affairs & Department of Defense[VA/DoD], 2014). There is consistent evidence that sustained engagement in lifestyle weight management programs that include diet, exercise, and behavioral components is associated with more significant weight loss and improved health outcomes, including reduced insulin resistance and cardiovascular risk (Maciejewski, Shepherd-Banigan, Raffa, & Weidenbacher, 2018; Moyer, 2012).

Obesity remains critically under-diagnosed and under-treated, due to several patient and provider barriers to compliance with clinical practice guidelines (Barnes, Theeke, & Mallow, 2015). Patients often cite a lack of motivation and readiness for change as barriers to engagement in weight loss interventions, and they expect substantive, therapeutic conversations with their provider about obesity and weight loss over generic advice (Roberts, Standage, Olaoye, & Smith, 2015; Torti et al., 2017). Meanwhile, providers report inadequate time, poor incentivization, and lack of knowledge of behavioral modification recommendations as barriers to compliance with weight loss guidelines in the primary care setting (Roberts et al., 2015).

Brief educational videos have been shown to be an effective, resource-efficient method of disseminating information to improve knowledge and promote a variety of preventive health-related behaviors (Tuong, Larsen, & Armstrong, 2014). The purpose of this evidence-based project is to describe the development and implementation of a video-based educational offering about local weight loss programs at Naval Medical Center Portsmouth (NMCP) that is sensitive to time constraints in the primary care setting to overcome patient and provider barriers and facilitate better care for obesity management.

Significance of the Problem

The prevalence of obesity among ADSMs continues to increase despite mandatory physical fitness requirements (Tanofsky-Kraff et al., 2013; Tilghman, 2016). Obesity in the military negatively affects retention, advancement, and deployability of service members, posing a threat to national security and mission readiness (Defense Health Board, 2013; Tanofsky-Kraff et al., 2013). Furthermore, obesity-related chronic health conditions, such as coronary heart disease, diabetes, hyperlipidemia, arthritis, chronic pain, and disability cost the Department of Defense (DoD) Military Health System (MHS) more than \$1 billion annually, not including billions more dollars spent treating retirees at VA medical centers (Tanofsky-Kraff et al., 2013).

According to the American College of Cardiology/American Heart Association Task Force and The Obesity Society, weight loss of at least 5% from baseline is associated with clinically significant improvements in diabetes, dyslipidemia, and hypertension (Jensen et al., 2014). Addressing obesity and promoting weight loss lowers the risk of costly complications and comorbid conditions (Bennett et al., 2015; Fruh, 2017; McVay et al., 2017). From an

organizational standpoint, obesity management aligns with the MHS Quadruple Aim model to promote better care, improved health, lower costs, and enhanced military readiness (DHA, 2018).

Results from the class of 2017 Uniformed Services University Doctor of Nursing Practice (DNP) project found that low awareness of available health promotion resources and lack of time to discuss obesity-related concerns contributed to decreased program utilization at Naval Medical Center Portsmouth and its affiliated branch health clinics (Davis, Hall, Jennings, & Smith, 2017). The authors of the class of 2018 DNP project also noted that many of the obese patients who received weight management program referrals did not actively utilize the resources prescribed (Johnson, Waddell, & Robertson, 2018).

Engaging patients to participate in behavioral modification for weight management remains a significant public health challenge (Stubbs, Morris, Pallister, Horgan, & Lavin, 2015). Providers often have a limited ability to discuss obesity and weight loss in primary care due to lack of time to educate and facilitate decision-making, the need to address acute issues, and competing demands in primary care (Carvajal et al., 2013). Inadequate training in behavioral weight management, lack of provider knowledge about modifiable risk factors, and poor incentives to discuss weight issues in primary care are also commonly identified provider barriers in the literature (Carvajal et al., 2013; Roberts et al., 2015).

Brief educational videos have been shown to be an effective, resource-efficient method of knowledge dissemination to promote preventive health-related behaviors, such as vaccine initiatives, osteoporosis prevention, and colorectal cancer screening (Chapman et al., 2010; Kulp,

Rane, & Bachmann, 2004; Zapka et al., 2004). Video education allows for standardized content delivery and allows the clinician to spend less time explaining preventive health information to patients that detracts from the primary reason for their clinical visit (Zapka et al., 2004).

Incorporating video education into the primary care setting can be a useful tool as an adjunct to provider counseling to facilitate better care by increasing knowledge, encouraging the patient to discuss the subject with their provider, and allowing for health-behavior decision-making over time (Kulp et al., 2004; Riley, Freeman, & Marshall, 2016; Taylor et al., 2001).

Clinical Question

In the adult primary care setting, is video-based education about local weight loss programs perceived to be a useful tool for patients and providers compared to current practice to increase awareness of programs and facilitate dialogue with minimal impact on time constraints?

Focus Areas

This project had three primary areas of focus. The first focus area involved extensive groundwork to identify local weight loss programs affiliated with NMCP. The 2017 DNP project authors created a handout of available community health resources to increase patient and provider awareness of programs; however, the authors of this project were unable to locate or utilize this tool. The authors found at least 15 programs intended to support weight-loss at Naval Medical Center Portsmouth (NMCP) and its outlying branch clinics, each with unique characteristics and diverse enrollment processes. Owners of specific programs reported decreased referral rates, sub-optimal utilization and significant attrition, consistent with findings from the Class of 2017 DNP project. Outside of clinical advice and referrals from primary care providers (PCPs), current practice at NMCP utilized posters and handouts for advertising Health

Promotion, Nutrition, and other weight loss resources. Confusion about the weight management programs that are currently available at NMCP and the appropriate referral process inhibited productive conversations in the primary care setting about obesity and weight loss.

The second focus was the development of a brief educational video that aligned with evidence-based literature and subject matter expert input. Although the authors observed 15 unique locally advertised weight loss programs, video content was limited to Health Promotions, General Nutrition, Intensive Weight Management (IMW), and Bariatric Surgery programs available at the Admiral Joel T. Boone Branch Health Clinic and NMCP. These programs highlighted a variety of prominent comprehensive lifestyle interventions that aligned with VA/DoD CPG recommendations. Bariatric surgery is an option for select obese patients (VA/DoD, 2014), and improving access to bariatric evaluation can help to identify appropriate surgical candidates and increase the number of patients who undergo surgery (Miletic et al., 2017). The literature suggested that PCPs are often hesitant to refer obese patients for bariatric surgery (Miletic et al., 2017); consequently, the NMCP Bariatric Surgery program was added to the video to round out the discussion of available options for obesity management.

The final focus was to integrate the video into the routine primary care clinic visits of pre-identified patients with a BMI ≥ 30 and solicit feedback on the experiences of patients and providers who viewed the video. The goal of implementation was to use the video to increase awareness of weight loss programs with minimal impact on known time constraints in primary care. The authors were unable to find a validated assessment tool to measure outcomes related

explicitly to obesity and consequently developed surveys using themes from the literature after a thorough review of the finalized video content.

Relevance to Military Nursing

Healthy body weight is essential to promoting overall wellness, enhancing military readiness, and maintaining the physical fitness level necessary for continued service and deployment across all branches of the United States military (Department of the Navy, 2011; Tanofsky-Kraff et al., 2013). Effective obesity prevention and treatment lead to improved health outcomes and readiness by promoting a healthy military force that is ready to deploy (Department of Defense Workgroup, 2014; Tanofsky-Kraff et al., 2013). Improving provider and patient awareness about weight management programs at NMCP and its affiliated outlying branch health clinics aligns with the MHS Quadruple Aim and supports compliance with the *VA/DOD Clinical Practice Guideline for Screening and Management of Overweight and Obesity* recommendations to offer referrals to comprehensive lifestyle interventions and obesity-management specialists such as registered dietitians and bariatric surgery.

Organizing Framework

The *Iowa Model Revised: Evidence-Based Practice to Promote Quality Care* (Iowa Model Collaborative, 2017) served as the organizing framework for this project. Through the use of this framework, the authors identified a relevant opportunity for change within the institution and formed a team to conduct a review and synthesis of the current literature in order to design and pilot a change in practice. The clinical issue identified was weight management program referral as a barrier to CPG compliance. The authors determined that this topic was a priority at

the organizational level and beyond based on its potential impact on patient outcomes and associated healthcare costs.

The Health Belief Model was the primary theoretical framework used to develop the educational message of the video. The Health Belief Model predicts the likelihood of performing a preventive health action based on the perceived threat of a given disease, the perceived benefits and barriers of the health-related behavior, and cues to action (Janz & Becker, 1984). In the context of the educational video for this project, patients were given cues to action and available resources to address the disease of obesity and its associated health threats of diabetes, hypertension, hyperlipidemia, and sleep apnea.

Project Design

The project design encompassed the Health Belief Model, synthesis of current literature, and VA/DoD CPG recommendations to create an evidence-based educational video to improve the process of information delivery about weight loss programs at NCMP. Implementation of video education in primary care was designed to emulate usual patient throughput with minimal impact on provider time constraints. Surveys were created to solicit patient and provider experiences with the video content.

Evidence Evaluation

The literature review involved an extensive electronic search of multiple reputable databases, namely PubMed, EMBASE, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsychINFO. The search was limited to English-only sources from academic journals from 2000-2018. The references of included studies were manually reviewed to identify any

additional relevant articles. Keyword and text word search terms included: video, video-based, multimedia, attitude (health, knowledge, and attitudes; attitude of health personnel), education, educational, health promotion, health education, prevention. The authors performed a systematic review of the literature to appraise the quality of scientific evidence.

As of January 2019, this search yielded 247 articles from PubMed, 370 articles from Embase, 24 articles from CINAHL, and 27 articles from PsychINFO for a total of 668 articles with 613 articles remaining after the removal of duplicates. A manual search of references identified an additional five articles. The systematic review was conducted using the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) statement (see Figure 1). There were 24 articles eligible for full-text review after screening titles and abstracts. A total of 14 articles met the selection criteria.

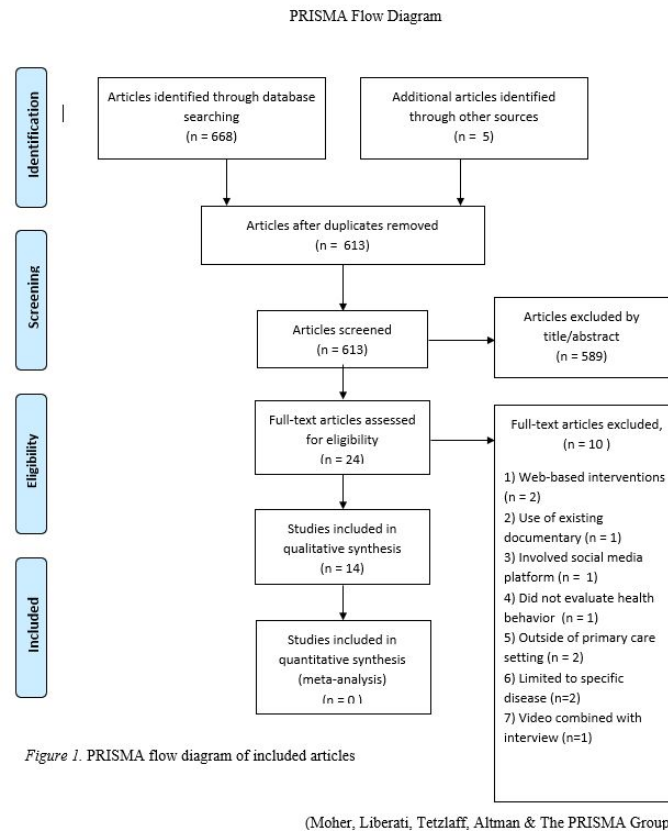


Figure 1. PRISMA flow diagram of included articles

Of the 14 articles reviewed, there was one level I systematic review, five level II randomized control trials, five level III cohort studies, and three level V descriptive/qualitative studies. The authors determined the level I systematic review was of moderate/good quality after the PRISMA checklist was applied. When the CONSORT checklist was applied to the level II studies, all five were good quality. The STROBE checklist was utilized for observational studies. The articles were reviewed and outlined in an evidence table to allow for comparison (see Appendix A).

Educational videos have been shown to be an efficient and effective method of disseminating health information to promote a variety of preventive health-related behaviors, such as vaccine initiatives, osteoporosis prevention, cancer screening, self-breast exam, prostate cancer

screening, HIV testing, and treatment adherence (Chapman et al., 2010; Goodman et al., 2015; Hernandez et al., 2014; Kulp et al., 2004; Tuong et al., 2014; Zapka et al. 2004). A common element in the literature involved the use of video education to prompt further discussion with the provider rather than to replace provider-driven education or provider-patient interaction. The use of media to influence knowledge, attitudes, and behaviors about obesity works by initially increasing awareness, influencing patient perceptions, and inciting motivation to change (Boles, Adams, Gredley, & Manhas, 2014). Several studies in the systematic review utilized the Health Belief Model to guide the development of educational video content (Avci & Gozum, 2009; Brown et al., 2017; Goodman et al., 2015; Tuong et al., 2014).

Although there is some evidence that passive video education tools implemented in waiting rooms can be effective in promoting lifestyle behavior change (Cass, Ball, & Leveritt, 2016), there is insufficient evidence that the mere availability of digital media promotes significant engagement with proposed resources or sustained behavior change (Riley, Freeman, & Marshall, 2016). Active engagement with video materials may require integration within the context of the patient's clinical encounter (Riley et al., 2016; Zapka et al., 2004). Brevity was another critical component to increase the likelihood that a video educational tool can be adopted in the primary care setting (Riley et al., 2016). Many successful video interventions were limited to 5-10 minutes in duration (Goodman et al., 2015; Hernandez et al., 2014; Kulp et al., 2004; Riley et al., 2016; Tuong et al., 2014). Systematic implementation of a brief-educational video should be designed to emulate what would occur in a natural clinical setting with minimal interruption in patient care or impact on workflow (Riley et al., 2016). The work by Riley et al.

(2016) was instrumental in the development of surveys used to assess the perceived usefulness of the video from patient and provider perspectives.

Setting

This project took place at the Admiral Joel T. Boone Branch Health Clinic affiliated with Naval Medical Center Portsmouth. Boone Clinic represents a microcosm of the obese patient population in the greater Hampton Roads, Virginia area that falls under the purview of NMCP. Boone clinic provides care to nearly 25,000 MHS beneficiaries and has nearly 25 PCPs on staff, including physicians, physician assistants (PAs), and nurse practitioners (NPs). A data query of patients at Boone BHC in August 2018 identified 4,885 patients with a BMI ≥ 30 , of which 1,090 were ADSM. This clinic provided the opportunity to implement the video education tool in a scalable setting.

Procedural Steps

In alignment with the revised Iowa Model (2017), the authors considered the organizational resources, constraints, and necessary approvals. The Uniformed Services University of the Health Science (USUHS) Office of the Vice President of Research (VPR) and the NMCP Institutional Review Board (IRB) reviewed and approved this healthcare delivery improvement project.

Preparation of clinicians and materials was another main consideration described within the organizing framework (Iowa Model Collaborative, 2017). The authors briefed the clinic manager, officer-in-charge (OIC), and senior medical officer (SMO) on the project

implementation plan. Input and buy-in from faculty, site directors, clinic leadership, and other key stakeholders were vital to maximize participation and streamline the process for efficient implementation with minimal interruption in patient flow.

This Doctor of Nursing Practice (DNP) project utilized independently-generated surveys to describe the experiences of patients and providers with the educational video and its perceived usefulness (see Appendix F for blank survey forms). For general awareness, the surveys asked providers if they thought their patients knew their BMI and the health risks associated with a BMI >29. Similarly, the surveys asked patients if they knew their actual BMI and the health risks associated with a BMI > 29. The video featured specific program owners from Health Promotions, Nutrition, Population Health, and Bariatric Surgery. Each program owner described the program characteristics, focus areas, goals, and ideal target population. Primary care providers at Boone Naval Branch Health clinic were asked to watch the video and complete an initial survey before it was implemented in the clinic to familiarize them with the video content, available programs, and referral processes. Provider surveys solicited information about where providers found information about new or current weight loss programs and inquired about common barriers in clinical practice to addressing obesity and weight loss. Providers completed a video assessment survey at the end of the two-week intervention period with 5-point Likert scale items about the perceived usefulness of the video, impact on time constraints, patient reactions to the video, and the perceived effect on reducing barriers to discussing weight loss programs with obese patients. Additionally, two open-ended questions asked providers what they liked about the video and what could be done to make the video a better resource.

DNP project leads from the GSN Class of 2019 personally distributed the video to patients with a BMI ≥ 30 during a two-week intervention period. The CarePoint information portal was used to screen the patients scheduled to the primary care teams and identify patients who met BMI criteria at the start of each day. Project leads tracked the arrival and intake of eligible patients to determine if patients could view the video before meeting with their provider or at the end of their clinical visit. Patients completed an initial survey before viewing the video to determine which programs they were aware of, how they heard about the specific program, and the likelihood of talking to their provider about weight loss programs using a 6-point Likert-type question. After viewing the video, the patients were asked to complete a video assessment survey to assess the perceived usefulness of the video, the likelihood of talking to their provider about a specific program, and how/where they would prefer to view similar video-based educational material in the future.

This project did not involve the collection of health metrics or data regarding program referral rates in the post-intervention period. Electronic health record and referral data could be obtained and utilized if appropriately framed and queried for comparison. Post-pilot data can be utilized to determine if the intervention is appropriate for permanent adoption in the clinical setting (Iowa Model Collaborative, 2017).

HIPAA Concerns (IRB)

Identification of patients with a BMI ≥ 30 who were eligible to view the educational video was completed using the CarePoint information portal, and no individual patient identifiers were collected or maintained. The independently generated surveys did not solicit any personally

identifying information, and participants were not required to complete the surveys. There were no concerns for Health Insurance Portability and Accountability Act of 1996 (HIPAA) violation throughout the implementation of this project, and the NMCP Clinical Investigation Department determined that this process improvement project did not require Institutional Review Board (IRB) approval.

Project Results

During the two-week intervention period, 185 patients met BMI criteria and completed an initial survey about general awareness of weight loss programs. After viewing the video, 180 patients opted to complete a video assessment. Patients ranged in age from 19 to 63 with an average age of 40.7 years. BMI ranged from 30.0 to 62.4, and the average BMI was 35.6. More than half of the participants were female (59%). Additional demographics distinguished between ADSMs (27.5%), Dependents (45.6%), and Retirees (26.4%). Before integrating the video in the clinic setting, 18 providers completed an initial survey. Sixteen providers completed a video assessment survey after the intervention period.

Initial Survey Results

From the initial survey responses, the authors found that 89% of patients (n=165) reported knowing that a BMI > 29 increases their risk for obesity-related health conditions (e.g., type 2 diabetes, hypertension, hyperlipidemia, sleep apnea), but only 42% of patients (n=78) stated that they knew their current BMI. Also, only 23% of providers (n=4) indicated that they thought their patients knew their current BMI.

Providers indicated that inadequate time was the most frequently reported barrier to discussing weight loss. Lack of time and competing demands ranked as the most significant barriers by 50% (n=9) of providers. Neither patients or providers were fully aware of available weight loss programs. While 89% of providers (n=16) at Boone clinic knew about Health Promotions and General Nutrition, only 22% (n=4) were aware of Intensive Weight Management, and 66% (n=12) were aware of the NMCP Bariatric Surgery program. Providers reported learning about available weight loss programs by word of mouth (n=5), intranet (n=4), or referral guidelines (n=3). The authors noted that just over 50% of the patients were aware of Health Promotions (n=97) and General Nutrition (n=95) programs, but significantly fewer were aware of Intensive Weight Management (n=36) and Bariatric Surgery (n=35). Approximately 34% (n=63) of patients were not aware of any of the weight loss programs available at NMCP or Boone clinic (see Figure 2).

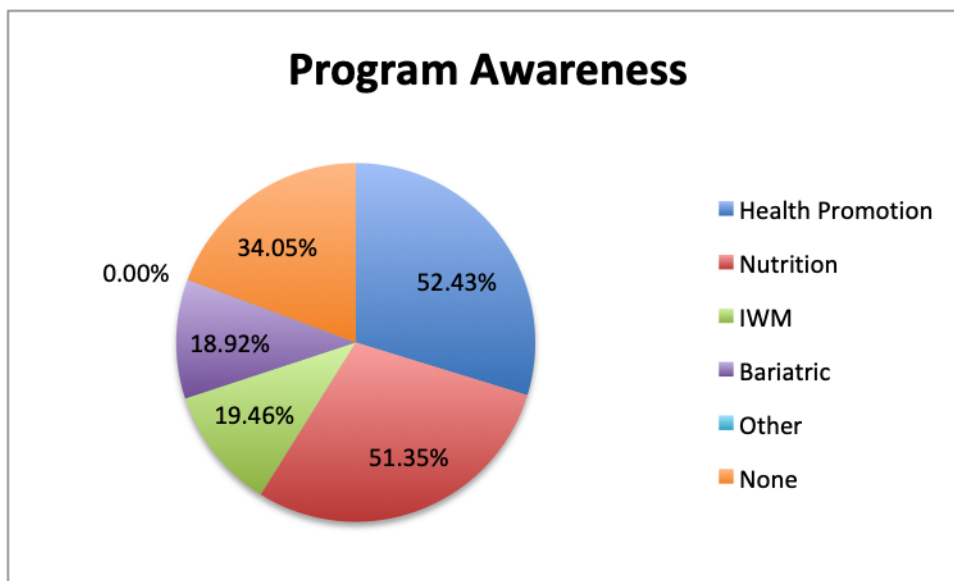


Figure 2. Patient program awareness.

Of the patients who knew of at least some of the available programs, approximately 29% (n=54) heard about them from their PCP. Almost as many patients reported learning about available programs from posters in the hospital or clinic (n=47). Just over 15% (n=29) of patients reported “Other” sources of information, including the Fleet and Family Support Center, Command Fitness Leaders, and telephone messages heard while on hold (see Figure 3).

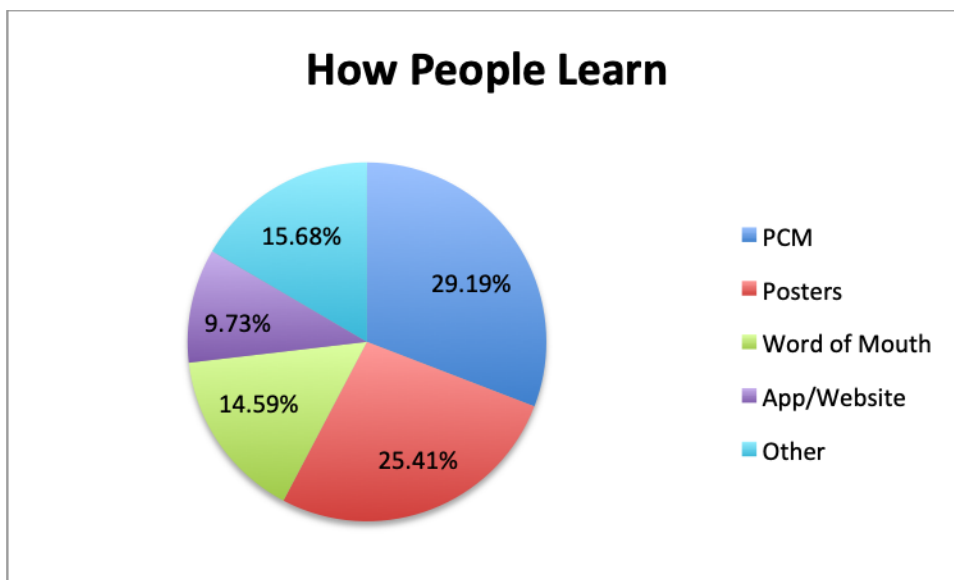


Figure 3. How patients learn about available weight loss programs.

Before viewing the video, over 94% of providers reported a short educational video about weight loss programs would make it easier to speak with patients about weight loss, and 83% of patients indicated the video would make it easier to speak with their PCP about weight loss.

Video Assessment Survey Results

Over 87% of providers (n=14) and over 83% of patients (n=151) agreed or strongly agreed that the video was a useful tool to introduce weight loss programs. Over 81% of providers (n=13) agreed or strongly agreed that the video did not significantly impact time constraints during the patient encounter. Half of the providers (n=8) either agreed or strongly agreed patients seemed to react positively to the video content. Over 68% of providers (n=11) either agreed or strongly agreed the video decreased barriers to talking to obese patients about weight loss programs, and 87% of providers (n=14) indicated they would utilize video-based educational tools in the future.

Provider responses to the open-ended questions, “What did you like most about the video?” and “What would make the video a better resource?” were evaluated for qualitative themes. Themes about what providers liked included that the content covered a variety of programs (n=7), the brevity of the video (n=5), it facilitates communication with patients (n=2), and introduced new programs (n=1). The most frequent suggestions from providers to improve the implementation process was to show the video in the waiting room (n=6) and to incorporate additional educational principles, such as education regarding risks of being overweight and benefits of weight loss (n=3). One provider indicated that showing the video in the waiting room would limit the time impact on the patient visit. Another provider suggested that showing the video in the waiting room would benefit spouses/dependents and reach more patients.

The video assessment surveys directly asked patients how they would prefer to view video-based educational content in the future (see Figure 4). Over 56% (n= 102) said they would prefer having a nurse or medical assistant (MA) show the video in the clinic room while they were waiting for their provider. Comparatively 32% (n=59) said they would prefer to watch the

video in the waiting room, and 16% (n=30) said they would prefer to use the NMCP app/internet.

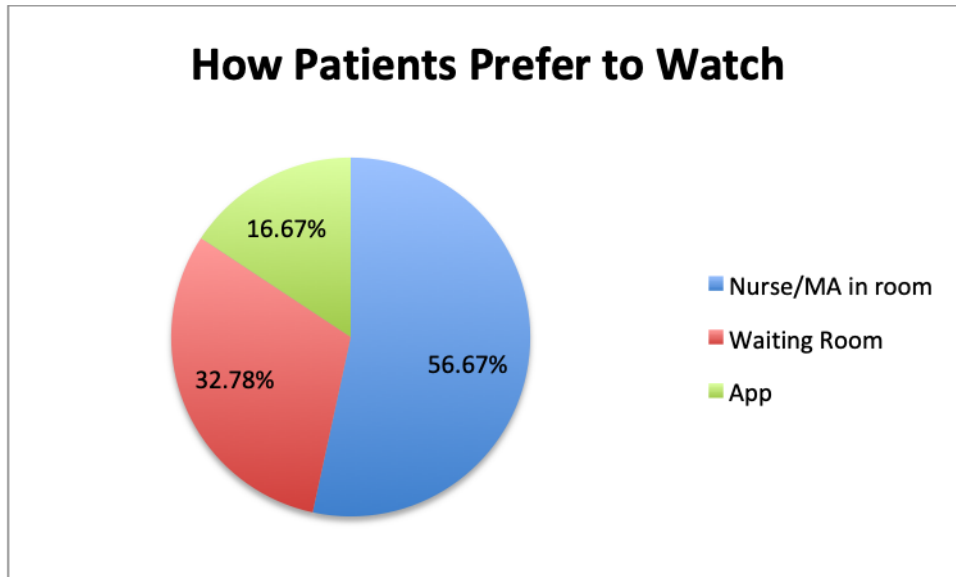


Figure 4. How patients would prefer to watch future educational videos.

Overall 95% of patients (n=171) felt more informed about weight loss programs after viewing the video. Likert-type questions asked patients the likelihood of talking about a specific program with their provider. As shown in Table 1, the majority of patients reported that they were either likely or very likely to discuss Health Promotions (64%, n=116) or General Nutrition (58%, n=105). Additionally, over 50% of patients reported they were likely or very likely to talk with their provider about the Intensive Weight Management program. Fewer patients reported that they were likely to talk with their provider about Bariatric Surgery (20%, n=37). However, there was a high number of “Does Not Apply to Me” responses (n=54) for the Bariatric Surgery program, indicating that patients recognized that they did not meet program criteria.

Table 1

Patient Likert Responses After Viewing the Video

Likert ^a	Health Promotions	Nutrition	Intensive Weight Management	Bariatric
Very Likely	50	49	44	20
Likely	66	56	47	17
Neutral	39	48	42	20
Somewhat Likely	17	16	19	6
Not Likely at All	6	8	18	63
Does Not Apply to Me	1	2	10	54

^aRatings were made on a 6-point Likert scale from 0-5, with 0 indicating the option was not applicable, 1 was the most negative (e.g., “Not Likely at All”), 3 was a neutral response, and 5 was the most positive (e.g., “Very Likely”).

Analysis of the Results

Providers drive decision-making about obesity management and referral to resources based on a BMI of 30 or greater. A major finding in the initial survey results identified that although 89% of patients were aware that BMI >29 has deleterious health effects, only 42% of patients surveyed stated that they knew their own BMI. Furthermore, only 23% of the providers thought their patients knew their BMI. This discrepancy highlights a process gap in which patients are not consistently told their BMI information during clinical visits and consequently may not be aware that they meet the diagnostic criteria for obesity.

Another important gap identified through analysis of the results centered around a general lack of awareness of available programs and where patients and providers were getting information about weight loss programs. Patients cited their PCP as the primary source of information. However, providers stated they learned of existing programs primarily by word of mouth. There was no consensus among providers on where to get up-to-date information. Given

the initial survey responses, there is a general lack of awareness by patients and providers in existing weight loss programs. These findings are consistent with the class of 2017 DNP project results and literature review findings of barriers to discussing obesity and weight loss.

The post-intervention results demonstrated that 83% of patients and 87% of providers felt that the video was a useful tool that would facilitate future discussion. Furthermore, providers indicated that video implementation did not significantly impact their time with the patient. Provider feedback informed suggestions for sustainment and utilization of video education, namely that in order to continue with implementation in the clinic, the process must remain consistently time efficient without interrupting workflow. There were some differences between recommendations for direct or passive viewing of video content between PCP feedback and patient preferences. Several providers stated a preference for passive viewing in the waiting area, whereas the majority of patients desired a direct introduction to video content by a medical staff member in the clinic room.

Organizational Impact/Implications to Practice and Policy

Utilization of video-based education to improve health knowledge and awareness of available resources may facilitate commitment to lifestyle interventions in alignment with VA/DoD CPG recommendations and is consistent with the components of the MHS Quadruple Aim to improve population health, patient experience, reduce cost, and improve readiness. However, video-based education should be considered an adjunct approach because patients expect substantive conversations with their PCP about obesity and weight loss, so (Riley et al., 2016; Roberts et al., 2015; Torti et al., 2017).

The authors recognized several barriers and limitations to implementation and . Clinics may find it difficult to alter daily operations to allow for viewing of video materials during clinic visits in a manner that is feasible and acceptable to PCPs. The method of using CarePoint to identify patients with a BMI ≥ 30 was based on historical height and weight measurements and did not necessarily reflect real-time information. Direct video delivery by the authors to ensure patient engagement was a labor-intensive process that was dependent upon the patient's check-in time, medical staff rooming and intake process, and provider time management. Limited wi-fi and internet streaming capabilities delayed initial viewings. To overcome IT barriers, both of the authors utilized two personal display devices (e.g., laptops and tablets) each with the video content pre-downloaded and saved. Self-reported survey data may have contributed to social desirability reporting bias and overreporting of agreement with impact measures. Patients may have been more likely to select an affirmative response to impact questions. However, an overwhelming majority of patients and providers responded positively to video content. Finally, the authors recognized that any educational video content that discusses the provision of local resources would have limited long-term utility if it is not updated as programs change or new programs arise.

Future Directions for Research and Practice

The focus of this project was to integrate an educational video into the Primary Care clinic to increase awareness of local weight loss programs with a minimal impact on time limitations. The authors did not collect and analyze metrics regarding the effect of the educational video on weight loss program referral rates or change in weight, BMI, or other obesity-related health parameters such as blood pressure, cholesterol levels, or hemoglobin A1C.

Referral data and obesity-related metrics may provide valuable evidence for the continued use of video-based education.

Although this method was effective, time efficient, and well-received by patients and providers, it was labor intensive for the authors to implement and initially inhibited by internet/wi-fi limitations. However, most patients expressed an interest in having future video-based educational content introduced directly by clinic staff while waiting for their provider in the clinic room. Sustained implementation in the clinic setting should be systematic, accounting for clinic flow, local resource allocation, and coordination of staff (Riley et al., 2016). Staff turnover and PCP preference may lead to variation in how the video is used (Riley et al., 2016). High turnover is especially prevalent in a military treatment facility where ADSMs rotate duty stations and deploy. Additional information technology (IT) support and dedicated audio-visual resources may be needed to overcome barriers to the delivery of video content.

There was significant interest from patients and providers to play video content in the waiting area and to a lesser degree on the internet and hospital mobile app. Evidence supports the use of passive video-based education in the waiting room to influence knowledge, attitudes, and intent toward healthy lifestyle behaviors (Besera et al., 2016; Cass et al., 2016). However, online availability of educational media has not been shown to significantly impact subject engagement and demonstrates low levels of access to materials (Riley et al., 2016). NMCP has in-house video production capabilities and current IT infrastructure to support dissemination across multiple audio-visual platforms. Additional cost-benefit analysis is needed to justify additional equipment or monetary resources needed to sustain directed video education in the primary care clinic

passive video education through other existing resources (e.g., waiting room TV, internet, mobile app).

Educational videos are an effective and efficient delivery method to disseminate information for preventive health-related behaviors (Tuong et al., 2014), although few studies in the literature review were specifically related to obesity and weight loss. The establishment of an appointed Primary Care Obesity Champion to oversee an Obesity Treatment Team could maximize the potential to promote and sustain effective obesity management and maintain up-to-date educational resources. Given the positive reception of the educational video developed for this DNP project and based on feedback from PCPs, the audio-visual department at NMCP could be utilized to make brief educational videos that cover a variety of health education topics from health promotion and disease prevention to general disease education and self-care. An in-depth literature review could highlight additional elements that could maximize engagement with educational video content. Furthermore, the benefit of educational videos is not limited to the primary care setting. Outreach to other clinics and departments (e.g., Immunizations, Internal Medicine, Physical Therapy) could gauge interest and feasibility of implementation throughout the hospital.

Conclusion

Obesity in the Military Health System is a costly but undertreated disease. Novel strategies implemented in primary care can help providers and patients overcome barriers to obesity management. This evidence-based practice project demonstrated that video-based education was a well-received and useful tool to introduce weight loss programs to patients and

facilitate discussion with PCPs with minimal impact on provider time constraints. Further research is needed to evaluate outcomes and compare the effectiveness of directed engagement with video content to passive viewing for continued dissemination.

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Appendix A
Evidence Table

AUTHOR, YEAR	Health Promotion	Design	Video duration <10 min	Questionnaire length	Health Belief Model	Primary Care Setting	Direct Viewing (In Clinic)	Passive Viewing (Waiting Room)	LEVEL/QUAL	Findings
Asterbum et al., 2011	Bariatric Surgery	RCT	45 min to review video and literature	10 questions performed prior, immediately post and 3-months post	Not addressed	Bariatric Surgery Clinic	Intervention group verified to have watched video	Viewed in Research office without additional education	2B	Video more effective than brochure at increasing knowledge at 3 months post
Avci et al., 2009	Breast Cancer Screening	Cohort	20 min video and Demo	Formal HEBSECS 58	X	Performed with teachers at schools	Intervention group verified to have watched video	Viewed in Research office without additional education	3C	Video-based and model-based education are effective for changing health beliefs
Besera et al., 2016	Sexually Transmitted Disease	Retrospective knowledge assessment	23 min	22 questions, given 3-months after appointment	Not addressed	STD specific treatment clinic	No opportunity to ask questions about movie	At least 20 min waiting room time for 23min video	3C	Low resource, low-intensity waiting room videos can positively influence STD-related attitudes/behaviors of clinic populations.
Brown et al., 2017	Pneumococcal Vaccine Education	Focus groups/ Likert questions/ open ended questions assessing knowledge and acceptability	<2 min	4-5 items	X	Yes	Viewed prior to appointment in exam room	No	5C	Favorable responses to video with only one refusal on the day the video was shown
Chapman et al., 2010	HPV Vaccination	Pre/post assessing knowledge and acceptability	8 min	32 question scale about beliefs and demographics, 11 non-validated questions (post)	Not addressed	Gynecology or Colposcopy Clinics	Viewing verified in office	No	5A	Improved knowledge and acceptability after video education
Frank et al., 2000	Healthy diet and activity	Video with provider disclosure vs. Video without	112 sec vs. 80 sec	14 initial, 7 after video	Not addressed	Yes	3B	No	3B	Providers who disclose personal information about wellness behaviors positively impact patient motivation
Gimeno-Garcia et al., 2009	Colorectal Cancer Screening	Educational vs. Non-educational video	3-5 min	26 items assessing knowledge attitudes and education	X	Gastroenterology Clinic	Viewing verified in office	No	2B	Video-based intervention significantly reduced barriers to screening and improved participant awareness and compliance with colorectal cancer screening
Goodman et al., 2015	Flu immunization in pregnancy	Educational video vs. Control	3-5 min, produced by CDC	Approx. 20 based on reported variance	X	OBGYN Clinic	Viewing verified in office	No	2B	Video education positively influenced vaccination health beliefs without impacting vaccination rates
Hernandez et al., 2014	Skin Cancer Risk Awareness	Video (cancer prevention) vs. Video (photoaging)	3 min/video	Open ended to inform video production with 13 pre-video & 9 post-video	Not addressed	Dermatology Clinic	Viewing verified in office	No	5A	A Spanish-language video has the potential to make an impact in healthy sun-protective behaviors
Kulp et al., 2004	Osteoporosis Education	Education video vs. Usual Care	10 min	Immediate post exam knowledge assessment and 3-month post assessment	Not addressed	Women's Health Clinic	Viewing verified in office	No	2B	The use of an educational video on osteoporosis seems to improve patient knowledge and may positively impact health-related behaviors.
Riley et al., 2016	Pediatric Behavioral Health	Assess acceptability and usefulness of provided videos	4-5 min each, 7 video topics to choose from	11 questions assessing video	Not addressed	Medical Homeport Pediatric Clinic	Viewing in office and online	No, parents had to ask or choose video	3B	Multimedia interventions for behavior management are likely to be well received, but systematic methods of implementation are needed.
Taylor et al., 2001	Prostate Cancer Screening	Focus groups to inform video development	25 min	Focus groups for video content	Not addressed	Masonic Lodge	Viewing not verified	Video produced to view at home or in public	3B	The preferred forms of educational materials were video and print-based materials, which the research team has recently developed.
Tuong et al., 2014	Various health promotion and educational topics	Systematic Review	5 min- 4 hours (36 min Avg)	No specific recommendation of length or strategy	Recognized to be used in several studies	Various	Various	No specific guidance on type of viewing provided	1B	Video interventions have potential for modifying health behaviors depending on the target behaviors
Zapka et al., 2004	Colorectal Cancer Screening	RCT	15 min	15-20 min phone interview baseline and 4-6mo. Post	Theory of planned behavior	Yes	No	Mail & video to home	2A	Intervention and control groups had same rate of screening at 55%

Appendix B
CITI Certificates



Completion Date 28-Aug-2016
Expiration Date 28-Aug-2019
Record ID 20621858

This is to certify that:

Kayla Horton

Has completed the following CITI Program course:

OUSD P&R Human Research (Curriculum Group)
Biomedical Investigators and Research Study Team (Course Learner Group)
1 - Biomedical Investigators (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)



Verify at www.citiprogram.org/verify/?w3dc01b26-b7db-42f4-a739-588a38866618-20621858



Completion Date 31-Aug-2016
Expiration Date 31-Aug-2019
Record ID 20630920

This is to certify that:

Jimmie Riffle

Has completed the following CITI Program course:

OUSD P&R Human Research (Curriculum Group)
Biomedical Investigators and Research Study Team (Course Learner Group)
1 - Biomedical Investigators (Stage)

Under requirements set by:

Office of the Under Secretary of Defense (Personnel and Readiness)



Verify at www.citiprogram.org/verify/?w9fbce66e-4d10-4cc3-85fb-5fdebb50a89d-20630920

Appendix C

USUHS Form 3202N

**USUHS FORM 3202N
DANIEL K. INOUE GRADUATE SCHOOL OF NURSING
EVIDENCE-BASED PRACTICE/PERFORMANCE IMPROVEMENT PROPOSAL**

VPR Date Stamp

Project Number: GSN-61-10366 (VPR will assign)

Project Title: Video-based Education to Improve Weight Management Referral

SECTION A: STUDENT POC INFORMATION	
1. Name (Last, First, MI): Horton, Kayla R.	Student E-mail: kayla.horton@usuhs.edu
2. Home Address: [REDACTED]	
SECTION B: COMMITTEE CHAIR / SENIOR MENTOR INFORMATION	
3. Name (Last, First, MI): Schramm, Jill	
4. Telephone: 301-295-1159 Fax:	E-mail: jill.schramm@usuhs.edu
5. USUHS Building/ Room No.: Bldg E/1055	
SECTION C: PROJECT INFORMATION	
6. Attach the Abstract for the proposal, including the following sections: Site Location of the Project, Title, Authors, Background or Problem/Issue, Clinical Question/Purpose, Project Design, Anticipated Organizational Impact/Implications for Practice and also include the Proposed Timeline. Single space the abstract and use Times New Roman font, size 12.	
7. Is this proposal related to an active research project of the Chair/Senior Mentor identified in Section B? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, complete below; if no, proceed to Part 8. Project Number: _____ Project Title: _____ Project Start Date: _____ Project End Date: _____	
8. Anticipated period of performance: Project Start Date: 5/1/2018 Project End Date: 5/1/2019	
9. Performance Site(s): Admiral Joel T. Boone Branch Health Clinic, Naval Medical Center Portsmouth	
10. Does this project involve any classified information? (Contact the USUHS Security Office for guidance) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
11. Do you have a funding source for this project? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA If yes, specify the funding agency and the amount provided:	
SECTION D: SIGNATURES	
The following signatures attest to the validity of the above information:	
[REDACTED]	[REDACTED]
Student (Project Point of Contact for the Group) (Signature and Date)	Chair/Senior Mentor (Signature and Date)
[REDACTED]	[REDACTED]
Chair/Program Director (Signature and Date)	Chair/Program Director (Signature and Date)
[REDACTED]	[REDACTED]
DNP Project Director or PhD Director (Signature and Date)	Associate Dean for Academic Affairs, GSN (Signature and Date)
[REDACTED]	[REDACTED]
Associate Dean for Research, GSN (Signature and Date)	Dean, DKU Graduate School of Nursing (Signature and Date)
In light of the above signatures, the project is approved.	
_____ USUHS Vice President for Research	_____ Date

Appendix D

Naval Medical Center Portsmouth IRB Determination

Clinical Investigation Department, Naval Medical Center Portsmouth

620 John Paul Jones Circle, Portsmouth, VA 23708 (757) 953-5939 Fax (757) 953-5298, DSN 377-5939



04 October 2018

Thomas S. Rieg, PhD
Research Director

From: Deputy, Clinical Investigation Department
To: LCDR Kayla Horton, NC, USN and LT Jimmie Riffle NC, USN

Kersten N. Wheeler, MS
Deputy Director
Division Head,
Research Subjects Protection

SUBJ: LETTER OF WAIVER OF IRB REVIEW FOR HEALTHCARE DELIVERY IMPROVEMENT PROJECT

Jane G. Brockman, BA
Division Head,
Research Resources


1. Your project titled, "NMCP.2018.0130: Video-based Education to Improve Knowledge and Attitudes about Weight Loss Programs at Naval Medical Center Portsmouth" does not require IRB review. Navy policy states that these types of healthcare delivery improvement projects are exempt from IRB review.

Joanna E. Fishback, DVM
Major, VC, USA
Division Head,
Laboratory Animal Medicine

2. Projects that do not require IRB approval are not eligible for Clinical Investigation Department travel funds.

3. You will still need to obtain publication approval for the project which is required for all works presented or published outside of NMCP.

4. I remain available and may be reached at (757)953 5939.


K. N. WHEELER

Appendix E

Naval Medical Center Portsmouth Public Affairs Officer Clearance

IV. THIS SECTION IS TO BE COMPLETED BY THE AUTHOR:

Name (Last, First, MI): Horton, Kayla, R		Corps: NC	Service: USN
Rank: LCDR	Position: Other	E-mail: kayla.r.horton.mil@mail.mil	
Phone: [REDACTED]	Pager: N/A	Publication type: abstract	
Department: Nursing Research	Dept. Head (name and rank): CDR Elrod	Deadline for NMCP approval (Allow 10 business days): 05APR19	
Directorate: DPE	Director (name and rank): CDR Barrett	Deadline for BUMED approval (Allow additional 35 business days): N/A	
Submission title: Implementation of Video-Based Weight Loss Education in Primary Care			
OCONUS presentations may require higher level approval. Is conference OCONUS? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Via this request, three conferences or journal articles for this manuscript/abstract/presentation may be approved in the same calendar year. Complete the section below, with today's submission as your first or only conference/journal.			
Conference/Journal/Other 1: Uniformed Services University Graduate School of Nursing DNP Project Presentation			Date: 16MAY19
Conference/Journal/Other 2: Click here to enter text.			Date:
Conference/Journal/Other 3: Click here to enter text.			Date:
Previous approval? No			

ANSWER THE FOLLOWING QUESTIONS:	Yes	No
Is it possible that members of the media or the public will be in attendance?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does your submission include the required identification (name, rank, corps, and command)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does it include the required disclaimer?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does it contain the required copyright statement?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Have you completed the required research integrity training?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

IF YOUR TOPIC IS HUMAN RESEARCH RELATED COMPLETE THE FOLLOWING:		
Does the study have IRB Approval?	<input type="checkbox"/>	<input type="checkbox"/>
PI name:		

Study title: Click here to enter text.		
If approved by another institution, name of institution:		
The protocol number is:		
Have you attached the most recent IRB approval letter or continuing review?	<input type="checkbox"/>	<input type="checkbox"/>
Does it contain the required CIP (IRB approval) statement?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOUR TOPIC IS ANIMAL RESEARCH RELATED COMPLETE THE FOLLOWING:		
Does the study have IACUC approval?	<input type="checkbox"/>	<input type="checkbox"/>
PI name:		
Study title: Click here to enter text.		
If approved by another institution, name of institution:		
The protocol number is:		
Have you attached the most recent IACUC approval letter or continuing review?	<input type="checkbox"/>	<input type="checkbox"/>
Does it include the required CIP (IACUC approval) statement?	<input type="checkbox"/>	<input type="checkbox"/>
Does it include the required animal welfare statement?	<input type="checkbox"/>	<input type="checkbox"/>
If applicable, does it include the required animal tissue use statement?	<input type="checkbox"/>	<input type="checkbox"/>
If hemorrhage or trauma related, does the methods section mention that the animal was anesthetized?	<input type="checkbox"/>	<input type="checkbox"/>
Is this a Combat Trauma Research Group protocol?	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information
Other DoD agency or command to which this material has been submitted for approval. Uniformed Services University of the Health Sciences
Submission Date: 12MAR19
Optional Comments: Click here to enter text.

V. TO BE COMPLETED BY PUBLICATION OFFICER:

<p>Department Head Recommendation: <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Approve with comment <input type="checkbox"/> Return to author for revision, discussion <input type="checkbox"/> Disapprove <input type="checkbox"/> Forward for higher level review Comments: Name/Signature: CAPT Craig Cunningham Date: 19MAR19</p>	<p>Director Recommendation: <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Approve with comment <input type="checkbox"/> Return to author for revision, discussion <input type="checkbox"/> Disapprove <input type="checkbox"/> Forward for higher level review Comments: Name/Signature: CDR Rhett Barrett Date: 17MAR19</p>
--	---

<p>Public Affairs Recommendation: <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Approve with comment <input type="checkbox"/> Return to author for revision, discussion <input type="checkbox"/> Disapprove <input type="checkbox"/> Forward for higher level review Comments: Name/Signature: Ms. H. Christina Johson Date: 15MAR19</p>	<p>CID Recommendation: <input checked="" type="checkbox"/> Approve <input type="checkbox"/> Approve with comment <input type="checkbox"/> Return to author for revision, discussion <input type="checkbox"/> Disapprove <input type="checkbox"/> Forward for higher level review Comments: Name/Signature: Ms. June Brockman Date: 18MAR19</p>
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Author Notification Date: 20MAR19

By: LT Jared Grigg



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PAO approval 190315c

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Cc: "Grigg, Jared P LT USN NAVHOSP PORS VA (US)" <jared.p.grigg.mil@mail.mil>

Fri, Mar 22, 2019 at 10:30 AM

LCDR Horton,

All of your submissions were approved (abstract, PPT, etc.) - even though your final document only says abstract. Please feel free to use this email as documentation of that fact. You do not need to complete an additional RPPA. Please let me know if you have any questions.

Thanks,

June

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Medical Editor
Head, Research Resources Division
Clinical Investigation Department
Naval Medical Center Portsmouth
Phone: 757-953-5939
Fax: 757-953-5298
.....

Appendix F

Blank Survey Forms

Implementation of Video-Based Weight Loss Education in Primary Care

Providers (Initial Survey)

1) Do your patients know their body mass index (BMI)?

Yes No

2) Do your patients know that a BMI greater than 29 puts them at increased risk for obesity-related health conditions like high blood pressure, diabetes, and sleep apnea?

Yes No

3) Have you discussed any of the following weight loss programs available at Naval Medical Center Portsmouth or the branch health clinics with your patients?

___ Health Promotions (Ship Shape, Diabetes Awareness, Heart Healthy, Exercise, etc.)

Yes No

___ General Nutrition

Yes No

___ Intensive Weight Management

Yes No

___ Bariatric Surgery

Yes No

4) Where do you get information about new or current weight loss programs that are available at NMCP and the associated referral requirements (e.g. rejected referrals in CHCS, Referral Guidelines on desktop, NMCP intranet, other)?

5) Would a short educational video about weight loss programs at Naval Medical Center Portsmouth or the branch health clinics make it easier to speak with your patients about weight loss?

Yes No

6) Evidence-based literature identifies several common barriers in clinical practice to addressing obesity/weight loss. Rank the following barriers in order of magnitude as it relates to your practice from 1-6 (1 = most significant barrier, 6 = least significant barrier).

___ Lack of time within the patient encounter

___ Competing demands/acute issues take precedence

___ Not enough training in behavioral weight management

___ Lack of knowledge about modifiable risk factors that contribute to obesity

___ Lack of incentive to address obesity

___ Other:

Implementation of Video-Based Weight Loss Education in Primary Care

Providers (Video Assessment Survey – shown after viewing)

1) Do you feel that this video will facilitate dialogue about your patient’s body mass index (BMI)?

Yes No

2) The video is a useful tool to introduce weight loss programs at NMCP to patients.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

3) The video did not significantly impact time constraints during the patient encounter.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

4) Patients seemed to react positively to the video content.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

5) The video decreased barriers to talking to obese patients about weight loss programs at NMCP.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

6) Would you utilize video-based educational tools in the primary care clinic in the future?

Yes No

7) What did you like most about the video?

8) What would make the video a better resource (e.g. the video should be shorter/longer, the video should be played in the waiting room, the video should be available online, the video needs more/less content, etc.)?

Implementation of Video-Based Weight Loss Education in Primary Care

Patients (Initial Survey)

1) Do you know your body mass index (BMI)?

Yes No

2) Are you aware that a body mass index (BMI) greater than 29 puts you at increased risk for obesity-related health conditions like high blood pressure, diabetes, and sleep apnea?

Yes No

3) Are you aware of the following weight loss programs available at Naval Medical Center Portsmouth or the branch health clinics? Select all that apply.

Health Promotions (Ship Shape, Diabetes Awareness, Heart Healthy, Exercise, etc.)

General Nutrition

Intensive Weight Management

Bariatric Surgery

Other:

No, I am not aware of these programs.

4) If you selected any of the programs listed above, how did you hear about it?

From my PCM

From a poster in the clinic/hospital

Word of mouth from a friend/family member/coworker

From the NMCP App/Website

Other

5) How likely are you to talk to your provider about weight loss programs?

Not likely at all	Somewhat likely	Neutral	Likely	Very likely
1	2	3	4	5

6) Would a short educational video about weight loss programs at Naval Medical Center Portsmouth or the branch health clinics make it easier to speak with your PCM about weight loss?

Yes No

Implementation of Video-Based Weight Loss Education in Primary Care

Patients (Video Assessment Survey – shown after viewing)

1) Was your body mass index (BMI) discussed at today’s visit?

Yes No

2) The video is a useful tool that introduced me to weight loss programs at NMCP.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

3) How would you prefer viewing educational video content? Rank preference from 1 (most preferred) to 3 (least preferred).

___ A nurse/medical assistant shows the video in the clinic room while waiting for my PCM

___ On the TV in the waiting room

___ Through the NMCP App/Website

4) After viewing the video, I feel more informed about weight loss programs at NMCP.

Yes No

5) How likely are you to talk to your provider about Health Promotion programs?

Does not apply to me	Not likely at all	Somewhat likely	Neutral	Likely	Very likely
0	1	2	3	4	5

6) How likely are you to talk to your provider about General Nutrition counseling?

Does not apply to me	Not likely at all	Somewhat likely	Neutral	Likely	Very likely
0	1	2	3	4	5

7) How likely are you to talk to your provider about the Intensive Weight Management program?

Does not apply to me	Not likely at all	Somewhat likely	Neutral	Likely	Very likely
0	1	2	3	4	5

8) How likely are you to talk to your provider about Bariatric Surgery?

Does not apply to me	Not likely at all	Somewhat likely	Neutral	Likely	Very likely
0	1	2	3	4	5

Appendix G

Doctor of Nursing Practice Project Completion Verification Form



Appendix G: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

**DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form**

The DNP Project titled: *“Implementation of Video-Based Weight Loss Education in Primary Care”* was completed at Naval Medical Center Portsmouth and the Admiral Joel T. Boone Branch Health Clinic by the following student(s):

<i>(type student name)</i>	<i>(signature)</i>	<i>(date)</i>
<u>Kayla Horton</u>		<u>05 APR 2019</u>
<u>Jimmie Riffe</u>		<u>05 APR 2019</u>
_____	_____	_____
_____	_____	_____

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>	
<u>Jill Schramm, DNP, FNP-C, BC-ADM, CDI</u>		<u>10 April 19</u>	Senior Mentor
_____	_____	_____	Team Mentor
_____	_____	_____	Team Mentor
<u>Meedecssa Morgan, DNP, FNP-C</u>		<u>5 APR 2019</u>	Team Mentor & Phase II Site Director

For RNA Students only - add the following additional signature for final verification of project completion:

<i>(type name)</i>	<i>(Signature)</i>	<i>(Date)</i>
RNA Project Director	_____	_____