Obesity: Evaluation, treatment, & how to talk about it with patients

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Agenda

- Background
- Evaluation
- Treatment
- Talking about weight with your patients

Background

Prevalence (2020)

- Body mass index of ≥ 30
- US adult obesity rate: 42.4%
  - First time national rate exceeded 40%
  - Lowest rate of obesity: Colorado, 23.6%
- US child (ages 2-19) obesity rate: 19.3%
  - Increasing with time, exhibiting earlier onset

Trust for America's Health, 2020

Causes

- Complex health issue with interacting, multifactorial causes
  - Obesogenic environment
  - Hereditary
  - Socioeconomic and sociocultural
  - Individual behaviors (physical activity, diet, medication use)

Hruby & Hu, 2015; Trust for America's Health, 2020

Demographic trends

- Protective factors
  - Higher income (vs lower)
  - More education (vs less)
  - Living in suburban & metro areas (vs rural)
- Risk factors
  - Poverty
  - Discrimination
    - Black 49.6%, Hispanic 44.8%, white 42.2%, Asian 17.4%
  - Food insecurity
    - Increased during COVID-19 crisis

Trust for America's Health, 2020

Consequences

- Associated with:
  - Poorer mental health, reduced quality of life
  - Leading causes of death: T2DM, heart disease, stroke, some types of cancer
  - More serious consequences of COVID infection, including hospitalization and death

Hruby & Hu, 2015; Trust for America's Health, 2020

Recommendations to address

- National organizations recommend physicians screen for obesity & provide intensive behavioral counseling
- However, obesity is not well managed in current health systems
  - Lack of training of healthcare workforce
  - Baseless assumptions of people with obesity
  - Lack of experience working in multidisciplinary teams
  - Lack of training in behavior change strategies

Campbell-Scherer et al., 2020

Role of primary care

- Small portion of adults with obesity ask a healthcare professional about weight loss
  - Of these, most consult their PCP
- Primary care: main point of contact for most people seeking health services
- Numerous articles have detailed strategies to manage obesity in primary care

Campbell-Scherer et al., 2020; Forgione et al., 2018

Evaluation

Evaluation

- 5As model for weight management counseling in primary care:
  - Assess
  - Advise
  - Agree
  - Assist
  - Arrange

Fitzpatrick et al., 2016; Vallis et al., 2013

Assess

- Screening for obesity, comorbidities, patient's willingness to make health behavior changes
- Using appropriate language without indication of stigma & shame
  - Patients prefer providers refer to their weight or BMI
  - Caution against the "personal responsibility" notion

Fitzpatrick et al., 2016

Assess

- BMI & waist circumference (visceral adiposity)
- Obesity-related complications
- History: diet, exercise, sleep, mental health, medications
- Characteristics & comorbidities associated with poor weight loss
  - Binge eating, sleep disorders, depression, chronic pain
  - Weight loss outcomes differ by race/ethnicity

Fitzpatrick et al., 2016; Forgione et al., 2018

Assess

- Readiness to change
  - Barriers: more pressing health or mental health issues, lacking self-efficacy, financial or psychosocial problems
  - If not ready: plan to address barriers, invite patient to inform you when ready, build on patient's confidence
  - If ready: praise efforts, what methods have been successful, ask how you can help, acknowledge their value of health

Fitzpatrick et al., 2016

Advise

- Counseling patient about:
  - Health risks of current weight
    - May influence patient's motivation
  - Health benefits of modest weight loss
  - Individualized diet plans & gradual change → long-term adherence

Fitzpatrick et al., 2016

Agree (on goals)

- Goal setting: key health behavior change strategy
  - SMART: Specific, Measurable, Attainable, Relevant, Time-based
  - Unrealistic goals can lead to failure & disappointment
- Collaborative approach
  - Initial weight loss goal of 5-10% of weight
- Self-monitoring, mobile applications

Fitzpatrick et al., 2016

Assist

- Problem solving: identifying barriers in achieving goals & developing plan with clear strategies to overcome
- ADAPT: Attitude (normalizing), Define problem, Alternative solutions, Predict consequences, Try out solution
- Some patients may require more intensive counseling
  - Consider referrals: behavioral psychologist, dietician, commercial programs

Fitzpatrick et al., 2016

Arrange

- Increase accountability through regular (e.g., monthly) follow-up
  - Assess patient's progress towards goals
  - Review self-monitoring records
  - Problem-solve barriers

Fitzpatrick et al., 2016

Treatment

Treatment

- Important to treat obesity as a **chronic, relapsing, multifactorial disease**
  - Nutrition, physical activity, emotion/behavior, medication
- Primary care counseling alone has limited ability to achieve clinically meaningful weight loss
- More benefit is seen with:
  - Added pharmacotherapy
  - Intensive counseling from dietitian or nurse + meal replacement therapy

Bronner, 2016; Tsai & Wadden, 2009

Nutrition

- Language matters
- Nutrition planning should be individualized
  - No one diet that is better than the rest
  - Depends on patient's motivation, resources, finances, personal preference
- Recommend 25% less calories
  - Not by restriction, but by improving calorie choices
- Focus on mindfulness of eating, including self-monitoring
- Viewing nutrition as a lifestyle change

Bronner, 2016; Taylor, 2020

Physical activity

- Language matters
- Physical activity planning should be individualized
  - Remember: SMART goals
- Get your patients moving – any movement helps
  - Get creative with ideas
- Self-monitoring can be helpful

Bronner, 2016

Emotion/Behavior

- Anxiety & depression are prevalent
  - Can impact eating behavior & adherence (decreased motivation)
- Screen for eating disorders
- Discuss alcohol & substance use
- Assess sleep
- Discuss eating habits
  - Dining out, distracted eating, stress eating, meal planning

Bronner, 2016

Medication

- Anti-obesity medications (& surgery) change the physiology of body regulation & offer best chance for long-term weight loss
  - Cannot replace diet, exercise, & lifestyle modification
  - May help to feel less hungry or full sooner, or make it harder for the body to absorb fat from foods
  - Numerous US FDA-approved medications currently available

Bronner, 2016

Medication

1. Identify medications possibly contributing to weight gain & change patient's regimen
2. Identify if patient meets FDA-approved anti-obesity medication indications
3. Trial medication
   - If no improvement after 3-4 months, consider different medication or increase dose
4. Medication as adjunct treatment

Bronner, 2016

Medication

Medication	How it works	Weight loss at 1 year
Orlistat	Works in gut to reduce amount of fat the body absorbs from food consumed	-5.5 lb with 60 mg -7.5 lb with 120 mg
Liraglutide	Mimics a hormone (glucagon-like peptide-1) that targets areas of brain that regulate appetite & food intake	-13.5 lb
Qsymia (phentermine & topiramate)	May lead to feeling less hungry or feeling full sooner	-14.5 lb with 7.5/46 mg -19.5 lb with 15/92 mg
Contrave (bupropion & naltrexone)	May lead to feeling less hungry or feeling full sooner	-13.5 lb

** Be aware of contraindications & adverse effects of different medications*

Taylor, 2020

Bariatric surgery (referral)

- Promotes weight loss by restricting amount of food the stomach can hold, causing malabsorption of nutrients, or by a combination of both restriction & malabsorption
  - Does not replace diet, exercise, & lifestyle modification!

Talking about weight with your patients

Weight bias & stigma

- Both healthcare professionals & patients with obesity endorse weight bias attitudes & beliefs about obesity
- Patients with obesity perceive biased treatment in healthcare, & this impacts how they access healthcare services
- Avoid making assumptions or judgments about patients' health & behaviors based on their weight

Campbell-Scherer et al., 2020

Weight bias & stigma

- Weight bias can be:
  - Subtle & overt
  - Verbal, physical, relational, cyber
- Can lead to rejection, prejudice, & discrimination
- Individuals affected may be:
  - Reluctant to seek medical care
  - Likely to delay important preventative healthcare services
  - Cancel medical appointments

Bronner, 2016

Weight bias & stigma

- Be aware of the following **misperceptions** of individuals with obesity:
  - Non-adherent
  - Dishonest
  - Lazy
  - Lacking in self-control
  - Unintelligent

Bronner, 2016; Puhl & Brownell, 2006

Obesity terminology

- **People-first language**: recognizes the potential dangers of labeling individuals by their disease
  - Say “patient with obesity” instead of “obese patient”
- Use **preferred/encouraged terms** & avoid discouraged terms

Encouraged	Discouraged
Weight Unhealthy weight Overweight Body mass index Affected by obesity	Morbidly obese Obese Fat

Bronner, 2016; Puhl et al., 2013

Considerations for clinic environment

- Ensure clinic furniture & equipment is appropriately sized for individuals with obesity
  - Chairs, toilets, doorways
  - Scales, gowns, blood pressure cuffs
- Ensure scales are in private areas
- Ensure staff are educated about obesity & weight bias

Kahan, 2018

Other weight bias reduction strategies

- Assess your own weight bias attitudes & beliefs
- Be mindful of patient's previous weight bias experiences & internalized weight bias
- Recognize & acknowledge multiple determinants of weight
- Separate weight from health – explore all causes of presenting problems
- Highlight importance of behavioral goals vs weight loss goals

Campbell-Scherer et al., 2020; Thille, 2019

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