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Guide for the Management of Obesity in the Primary Care Setting

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STOP OBESITY ALLIANCE
STRATEGIES TO OVERCOME & PREVENT

Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

Sumner M. Redstone Global Center for Prevention & Wellness

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American Board of Obesity Medicine

American Society of Metabolic and Bariatric Surgery

American Association of Clinical Endocrinologists

American Association of Nurse Practitioners

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Guide for the Management of Obesity in the Primary Care Setting

National Health and Nutrition Examination (NHANES) data indicate that over 40% of U.S. adults have obesity and that 11.5% of women and 7% of men were affected by severe obesity (BMI ≥ 40) in 2017-2018.[i] In 2009, obesity accounted for more than $140 billion in annual medical expenditures in the United States.[ii] Although the last decade has seen significant improvements in the safety, efficacy, and availability of behavioral, pharmacological, and surgical treatments for obesity, fewer than 5% of eligible individuals are treated with these modalities.[iii] Previous research to understand and address the low utilization of effective therapies for obesity indicates that gaps in provider training in obesity management are an important barrier to effective obesity care.[iv,v] Even with trained clinicians, insufficient insurance coverage for obesity treatment may also be a barrier.

Because of their frequent and ongoing contact with patients, health care professionals including physicians, nurse practitioners, physician assistants, and others are well positioned to prevent and manage obesity. The increasing prevalence of obesity and its associated complications make competencies in obesity management essential for providers.[vi] However, the majority of providers lack knowledge and understanding of obesity treatment guidelines,[vii] and many find it challenging to start weight-related conversations with patients. Current diagnostic and treatment guidelines primarily focus on metabolic and cardio-

metabolic comorbidities[viii] with little to no focus on patient-centered outcomes, including quality of life or activities of daily living.

Patients may face social and economic barriers to accessing healthful foods, opportunities for physical activity, and clinical treatment options. Provider attention to the social determinants of health is imperative for effective obesity treatment.[ix] To improve the treatment of obesity, guidance for providers must address the barriers that prevent providers from effectively addressing obesity management. Providers report that the most significant obstacles to obesity counseling are discomfort with opening the conversation, lack of time, insufficient training, limited reimbursement, and inadequate availability of effective risk-related tools, like medications, tracking tools and dietary strategies.[x] Biased and stigmatized interactions with healthcare providers may also complicate care. While schools and training programs in some disciplines have begun to prioritize training and education in obesity management, incorporation of some of the most-effective evidence-based approaches for management of obesity are not routinely or widely included in primary care practices.[xi,xii,xiii]

Substantial differences exist between patients and providers in attitudes towards obesity treatment. Providers are much more likely to believe lack of patient motivation is a barrier to obesity treatment, and patients are much more likely to consider their weight and weight loss a personal responsibility rather than a medical issue.[xiv] Establishing trust and open communication between the provider and patient is essential to understanding these differences in beliefs and expectations. The observation that patients who receive a diagnosis of obesity are more likely to engage in weight management compared to their undiagnosed peers emphasizes the importance of patient-provider relationship.[xv] After obesity is diagnosed, shared decision-making is vital to the obesity treatment process.

Weight stigma may constitute a significant barrier to care. People-first language may reduce weight bias by not labeling patients by

their weight or their disease. The term "patient with obesity" is more appropriate than the phrase "obese patient." [xvi] Patients may find the term "unhealthy weight" to be more motivating than the term "obesity," which many consider stigmatizing.[xvii] When making a diagnosis of obesity, it may be helpful for providers to acknowledge to the patient that "obesity" is often perceived as an undesirable term because it has been associated with stigma, but that it is a clinical diagnosis, not a judgement.[xviii]

Providers should emphasize that obesity is a disease, not a label or choice, and educate the patient about the impact of obesity on health and quality of life. Respect for patients includes ensuring that waiting areas, bathrooms, exam rooms, scales, blood pressure cuffs, and gowns accommodate all sizes and abilities.

We recognize that patients visit primary care for various complaints. For an acute care visit, attention should focus on the chief complaint. Many patients may not be coming in for a weight-related conversation. If time permits and if it seems appropriate, the provider could ask: "Is there a future time when it may be appropriate to talk about how your weight and health may be affecting each other, and how we might work together to address it?"

Guide for the Management of Adult Obesity in Primary Care

When weight counseling is appropriate, health care professionals need a short, accessible, practical, informative guide for obesity treatment. The treatment of obesity in the primary care setting can be divided into three sections: pre-encounter, encounter, and post-encounter. The following guidance for health care professionals' treatment of obesity includes permission to discuss obesity, while addressing weight bias; diagnosis of obesity; and shared decision-making in the management of obesity.

We recognize that what follows may not be possible to accomplish in one visit. The direction these discussions take should depend on the interest and engagement of the patient and the demands on the provider's time.

Pre-encounter

Providers should ask patients to fill out a pre-visit questionnaire to provide important information prior to the encounter. Suggested pre-screen questions include:

- *Have you ever had difficulty managing your weight?*
- *Age of onset and maximum weight?*
- *Family history of unhealthy weight?*
- *What factors have led to your weight gain, weight loss, or sustained weight loss?*
- *Do you believe your weight is impacting your health or quality of life? How?*
- *Have you had negative experiences with health care providers about your weight?*
- *How do you think I can help you better manage your weight?*

Gather information during the pre-encounter to start a weight-related conversation with the patient, including diet and physical activity history; medications; existing co-morbidities or risk factors; stress; sleep; quality of life (QOL), depression and surgical history.

Weigh the patient with permission.

- Ask the patient *"May we measure your weight today?"* If the patient chooses not to be weighed, respect their decision. Providers need to recognize that patients may have had stigmatizing healthcare experiences and may find being weighed and discussing their weight uncomfortable.
- Discomfort regarding weight can be addressed by weighing patients in a private setting, and sensitizing the health care team to how the weight is measured, entered into the medical record and communicated with the team and patient.
- Weight is a vital sign and is used for more than calculating BMI, e.g., weight-based dosing of medications and assessment of co-morbidities like congestive heart failure. It is important to emphasize this to patients.
- Health care teams should measure weight, assess weight trajectory, and communicate their importance to the patient.
- Obesity is a disease beyond weight. Weight is one element of the risk profile.

Use BMI and other metrics to design care.

- Prompts can alert providers when a patient's BMI is ≥30, (or ≥27 if other obesity, related co-morbidities exist), or the diagnosis of obesity can be pre-populated on the problem list.
- "Severe obesity (BMI ≥40)" rather than "morbid obesity" is the preferred term in all documents.
- Using BMI alone to diagnose obesity or overweight is not ideal because it does not reflect fat distribution, body composition, or race/ethnicity. Whether an increased BMI is attributable to increased frame size or muscle mass vs. body fat composition can be confirmed by inspection.
- Stage the severity of disease based upon the obesity-related complications present.[xix]
- Tracking weight trajectories and combining them with other health and risk data can inform care and alleviate some of the concerns associated with exclusive reliance on BMI.

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Encounter

Pre-screen

- BMI and weight trajectory
- 24h dietary recall
- Personal weight history
- Medications
- Physical activity
- Existing comorbidities or risk factors
- Stress
- Sleep
- QOL
- Depression

" Is now a good time for us to discuss how your weight and health may be affecting each other and how we can work together on it? "

Yes.

No.

Questions for Patient

- What concerns you most about your weight?
- What is the single most important outcome that you hope to acheve with weight loss?
- What would stand in the way of achieving this outcome?
- Is there a first step that you are ready to take?
- What impact will the changes we have discussed have on your life?
- Obesity is a chronic problem. What frequency and type of follow-up would be most helpful?

Provider:

" I understand that you may not be ready to discuss your weight. However, I am concerned about the impact of your weight on your health. There may be some things that we can do together in the future. Please make a follow up appointment if you'd like to discuss this in the future. "

Response from Provider

- Acknowledge concerns
- Link obesity to comorbidities
- Provide resources
- Schedule follow-up or referral

Encounter: The 6 "A"s Model for Weight Management Counseling [xx, xxi]

Ask

- If the physical examination and pre-screen data indicate obesity, ask permission to discuss the patient's weight.
    - *"Is now a good time for us to discuss how your weight and health may be affecting each other and how we can work together on it?"*
- If the patient agrees, ask the patient what terms they would prefer using to discuss their weight (e.g., unhealthy weight, BMI).
- Best practices for starting a weight-related conversation may differ across the patient population; social and cultural determinants of health and disparities need to be taken into consideration.
- Listen to and acknowledge patient concerns (e.g., physical, psychological, QOL).
- Avoid paternalism.
- Examine your own bias as a provider and actively work to care for the person with the disease.
- Consider the diagnosis of obesity and the patient's sensitivity. The coding language in electronic health records can be stigmatizing.

Assess

- Refer to pre-screen data collected in the pre-encounter: BMI; weight history; diet history; medications; physical activity; existing comorbidities or risk factors; stress; sleep; QOL; depression.
- Refer to regularly taken blood tests (lipids, comprehensive metabolic panel, Hemoglobin A1c).
- Assess for weight-related comorbidities (e.g., Type 2 Diabetes, Dyslipidemia, Hypertension, Obstructive Sleep Apnea (OSA), Osteoarthritis, Non-alcoholic Fatty Liver Disease (NAFLD).

- Further ascertain patient's weight history and BMI trajectory by assessing **O**nset, **P**recipitating factors, **Q**uality of life, **R**emedy, **S**etting, and **T**emporal pattern (OPQRST).
- Obesity focused physical examination.
- Assess expectations.

ADVISE

If the patient is interested in talking about weight:

- Focus on the positive aspects of health improvement through obesity care and weight management.
- Follow U.S. Preventive Services Task Force guidelines to offer or refer when a patient's BMI is ≥30 to intensive, multicomponent behavioral interventions.[xxii]
- Convey the challenge of weight management and the potential for weight cycling.
- Use shared decision making to establish next steps.

If the patient is not interested in talking about their weight:

- Respect their choice and express willingness to work together on the issue in a future office visit and reassess at a future visit.

AGREE

- Establish trust and shared decision-making.
- Provider responses are cued by the patient's questions and concerns.
- Recommendations may differ based on the patient's cultural or religious background.
- Collaborate on goal setting using SMART (**s**pecific, **m**easurable, **a**ttainable, **r**elevant, and **t**ime-based) tool.[xxiii]
- Discuss the effectiveness of different modes of treatment.

Assist

- Treatment options can be presented electronically and/or through written materials.
- Leverage the entire care team. Discuss referrals to registered dietician nutritionists (RDN) and other providers, such as community providers, licensed social workers, certified obesity medicine providers, and behavioral health specialists.

Arrange

- Schedule a face to face or telehealth visit follow up to assess progress.
- In consultation with the patient, referrals for lifestyle management and behavioral changes should be to RDNs, commercial weight management programs, or behavioral health specialists. In patients with severe obesity or patients who have repeatedly struggled to lose weight, discuss referral to an obesity medicine specialist, evidence-based, comprehensive weight management center, or bariatric surgery center should be considered.
- Know, identify and develop regional resources, such as reimbursement frameworks, obesity medicine specialty practices, and bariatric surgical centers of excellence.
- Assist with coordination of care and follow up with patient as needed.

Post-encounter

Yes.

The patient IS interested in pursuing treatment of obesity:

- Provide patient with checklist/handout with shared decisions.
- Schedule a follow-up visit focusing on obesity to assess progress.
- The best ways to measure progress: change in weight, BMI, change in waist circumference, improvement of co-morbidities, improved QOL.

No.

If the patient IS NOT interested in pursuing treatment of obesity:

- Does this decision reflect a lack of financial or physical access to follow up?
- Educational materials may be provided for the patient's consideration.
- Indicate availability for future discussion and shared decision making during regular care.
- Provider should reassess readiness to change on future clinic visits (could be done by check-in team).

Tips and Standard Operating Procedures for Expediting Patient Flow

- **Obesity management in the office requires a team approach.**
  - Provide in-service education for *all* personnel - front desk, medical assistants, health care providers, back office.
  - All personnel must be trained in avoiding bias and stigma, importance of providing resources and the chronic care nature of obesity management.
  - Catalog resources for referral (obesity specialist or endocrinologist, surgeon, psychiatrist, psychologist, nutritionist, physical therapist, health coach, community programs, commercial programs locally or on-line, and others).
  - Obtain the appropriate chairs, scales, private weighing areas, blood pressure cuffs and gowns to accommodate patients with obesity.
- **Standard operating procedures and time-savers:**
  - Develop standard operating procedures for determining benefit coverage, prior authorization, referral.
  - Use assessment forms for home or waiting room use: weight history, drivers of gain, drivers of loss, current diet and exercise pattern, current comorbidities, symptom check list, motivation for weight loss (why now?), behavioral and eating practices that might be barriers to the lifestyle changes that are necessary for a successful outcome, current ability for self-efficacy, resiliency, and coping resources to manage stress.

Use downloadable education tools *(How much weight do I need to lose? Can medications affect my weight?)* provided in attached resource guide.

Endnotes

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