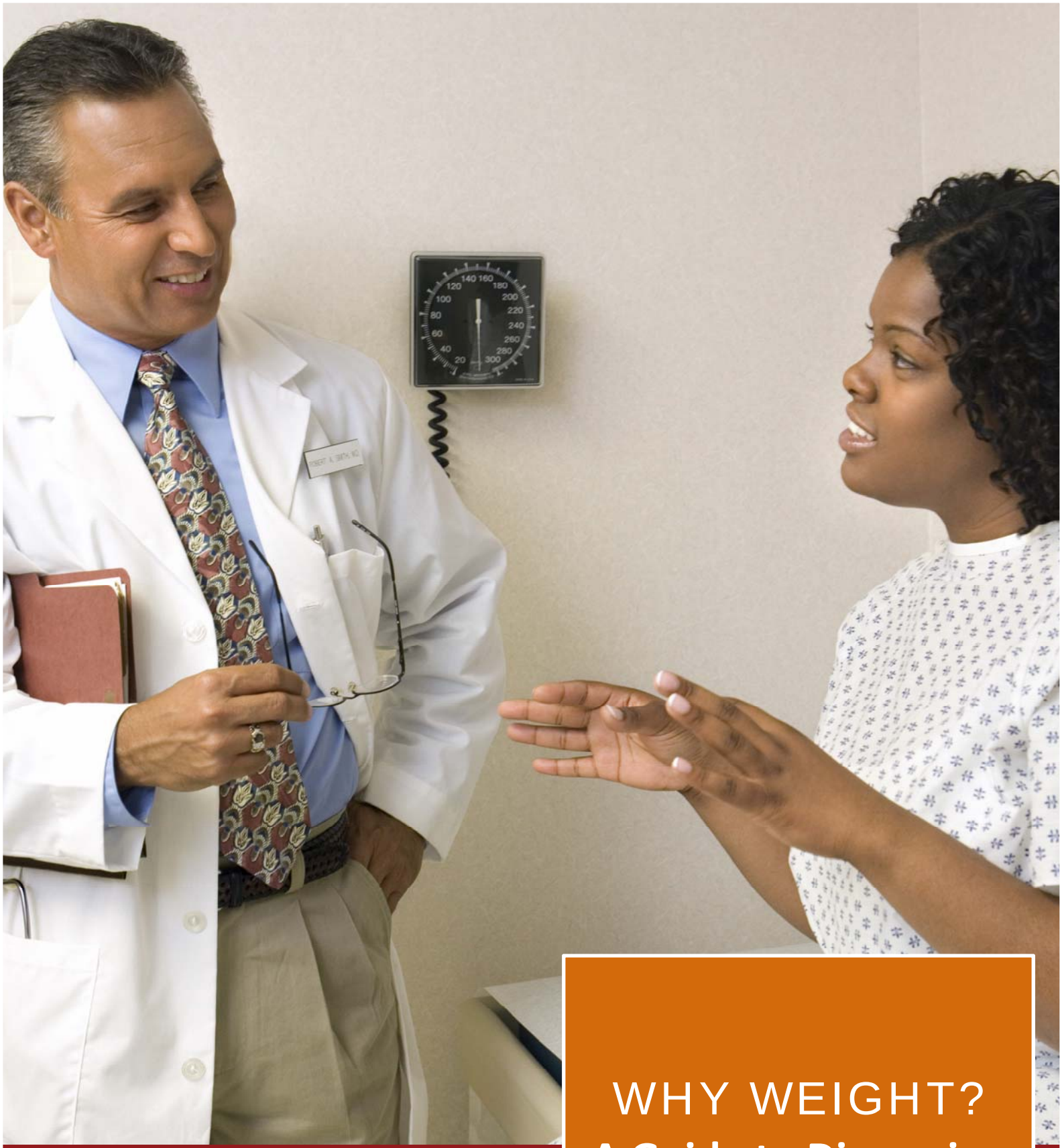


WHY WEIGHT?

A Guide to Discussing Obesity & Health With Your Patients

STOP OBESITY ALLIANCE
STRATEGIES TO OVERCOME & PREVENT

CREDITS & ACKNOWLEDGEMENTS

This guide was developed in partnership between the obesity research team at Milken Institute School of Public Health at the George Washington University and the STOP Obesity Alliance communications team at Chandler Chicco Agency:

- William H. Dietz, MD, PhD, George Washington University
- Scott Kahan, MD, MPH, George Washington University
- Cristy Gallagher, George Washington University
- Christine Petrin, George Washington University
- Kaushika Prakash, George Washington University
- Gina Mangiaracina, Chandler Chicco Agency
- Melissa Warren, Chandler Chicco Agency
- Sarah Slotnick, Chandler Chicco Agency

The STOP Obesity Alliance would like to thank and acknowledge the following individual experts and organizations for reviewing and providing input on the guide:

- Angela F. Ford, PhD, MSW, Black Women's Health Imperative
- April Barbour, MD, GW Medical Faculty Associates
- Arya Mitra Sharma, MD, PhD, FRCPC, University of Alberta
- Bradley J. Needleman, MD, FACS, Ohio State University Surgery, LLC
- Brook Belay, MD, MPH, Centers for Disease Control and Prevention
- Dawn K. Wilson, PhD, Society of Behavioral Medicine
- Donna Ryan, MD, Professor Emeritus, Pennington Biomedical Research Center
- Ginger Winston, MD, MPH, GW Medical Faculty Associates
- Joe Nadglowski, Obesity Action Coalition
- Marijane Hynes, MD, GW Medical Faculty Associates
- Patricia Nece
- Patrick O'Neil, PhD, Medical University of South Carolina
- Pepin Andrew Tuma, JD, Academy of Nutrition and Dietetics
- Samuel Lin, MD, PhD, MBA, American Medical Group Association
- Scott Butsch, MD, MSC, Massachusetts General Hospital
- Ted Kyle, RPh, MBA, The Obesity Society
- Wendy K. Nickel, MPH, American College of Physicians

About the Tool

Weight is a complex and sensitive issue, and conversations about weight can be challenging. Many factors are at play, not least of which may include feelings of failure, shame, and concerns about being judged by health care providers. Many providers have concerns about how to begin conversations about weight, what words to use, and how to communicate about weight while supporting their patients in ways that are empowering and nonjudgmental. Providers report minimal, if any, training on obesity, inadequate resources for effective conversations, and insufficient clinical time to devote to conversations about weight. Research has shown that behavioral and medical treatment can be effective, but improvised and uninformed discussions may disengage, stigmatize, or shame patients, to the detriment of the provider-patient relationship, obesity treatment goals, and patient outcomes.

This provider discussion tool, developed by the Strategies to Overcome and Prevent (STOP) Obesity Alliance, addresses many of these concerns. Our goal is to help providers have more effective conversations about weight and health with their patients. The guide focuses on skills for building a safe and trusting environment with patients and facilitating open, productive conversations about weight. It also provides potential scenarios that providers may face and suggests ways to approach the conversations.

We began the development of the tool by conducting an audit of available materials and research regarding these issues. This information, provided in Appendix A, informed an expert roundtable convened in May 2014. Roundtable participants were from a range of backgrounds including obesity practice and research, primary care practice, nutrition education, women's health, minority health, and the patient community. Our discussions focused on how to help providers initiate and sustain productive conversations about weight and health in real-world practice settings and the constraints that limited these conversations.

This tool has been reviewed by a selected panel of experts and members of the STOP Obesity Alliance.

Thank you for taking the time to read this guide. Engaging health care providers like you will improve conversations about weight and health and encourage people to conduct more active dialogues with their health care providers.

Sincerely,
William H. Dietz, MD, PhD & Scott Kahan, MD, MPH

William H. Dietz, M.D., Ph.D.
Director, STOP Obesity Alliance

Scott Kahan, M.D., M.P.H.
STOP Obesity Alliance

THE FAST FACTS: What You Need to Know About Discussing Weight & Health With Your Patients

As providers ourselves, we understand how limited your time is. That's why we put together the key below. For more information on any of these key points, you can click on the hyperlink which will direct you to the specific section.

- **Why talk about weight?** Many patients want and expect weight loss guidance from health care providers. Weight-related discussions with providers can influence patient engagement in weight loss efforts.[1] Having the conversation and formally diagnosing and documenting overweight or obesity strongly predicts having a treatment plan in place and subsequent weight loss success.[2] The United States Preventive Services Task Force (USPSTF) guidelines recommend intensive, multicomponent behavioral interventions for patients with BMI over 30 kg/m^2.[3] This recommendation is largely based on a 2012 systematic review that showed intensive counseling led to an average 6% body weight loss, along with improved comorbidities and cardiovascular disease risk factors.

- **Why isn't addressing obesity about eating less and exercising more?** Understanding the complexity of obesity is an important prerequisite for productive conversations about weight. Provider misperceptions about causes of and contributors to weight gain and obesity can lead to blaming and shaming patients for their weight difficulties, undermining productive conversations, and provider-patient relationships.[4] While providers cannot manipulate a patient's genome or his/her environment, knowing that these factors can contribute to difficulties managing weight is essential to building an informed and empathic approach to talking with patients. It is also important for providers to recognize the biology opposing weight loss. In our obesogenic environment, weight gain is common and sustained weight loss is difficult.

- **What are the barriers to talking about weight?** Lack of time, reimbursement, training, and effective tools and treatments are among them. The first and perhaps most important barrier is not knowing effective ways to initiate and continue productive conversations about weight management.

- **Why don't patients with obesity seek help?** Many patients avoid or delay medical treatment due to concerns that their providers will not treat them with compassion and respect, or that their struggles will be dismissed as "not trying hard enough." In other cases, patients are concerned that their provider's office will lack the equipment to properly accommodate them. Patients also may avoid seeking help from providers because they feel that their providers don't have insight on their condition or can't provide sufficient counsel.

- **What is holding a patient back from addressing their excess weight?** Most patients with obesity have tried – often repeatedly – to lose weight and improve their health. At any given time, patients may be in one of five stages of behavior change: pre-contemplation, contemplation, preparation, action, or maintenance.[5] Assessing patients' stage of change can help determine how to assist them in moving forward. Repeated weight loss and weight regain emphasizes the need to focus on sustaining weight loss from the outset of therapy.

- **Why should I attempt to undertake a disease as broad and challenging as obesity?** Obesity treatment may feel like a futile undertaking. Yet, there is a range of effective and evidence-based treatments available. With excess weight affecting more than two-thirds of U.S. adults, providers are in a position to create a positive impact. Moderate, sustainable weight loss, such as 5-10% sustained weight loss, can have a positive effect on health improvements.

- **What can I learn about my patient to help us engage in a productive discussion?** Health behavior decisions are heavily influenced by our environments and social norms. Taking some time to learn about your patients' everyday lives, including their home and work environments and families, can lead to better understanding of the challenges they face and inform conversations about weight.

- **What are some important considerations I need to know before I talk to my patients about weight?** Recognize that weight is about health, not appearance. Be aware that weight is a personal and often sensitive topic and tailor your interactions and words in ways that are productive, not stigmatizing. Be aware of your own attitudes toward weight and obesity, so that you can compassionately interact with patients on matters of weight.

Why Should Providers Discuss Weight With Patients?

Health care providers are uniquely situated to address overweight and obesity. Many patients want and even expect weight loss guidance from health care providers. Patients seek a trusting relationship with their providers, and many choose providers whom they believe have the confidence to raise difficult issues like obesity.[9] In one survey, 85% of patients said they look for information about how to achieve and maintain a healthier weight on their own, and yet 57% of those trying to lose weight feel discouraged because of unsuccessful attempts to lose weight in the past.[10] Having the conversation and formally diagnosing and documenting overweight or obesity is the strongest predictor of having a treatment plan in place and subsequent successful weight loss.[11]

Appreciating the complexity of obesity is an important prerequisite for productive conversations about weight. Provider misperceptions about causes of and contributors to weight gain and obesity can lead to blaming and shaming patients for their weight difficulties, undermining productive conversations, and doctor-patient relationships.[12] It's important for health care providers to appreciate that many overlapping factors play into weight gain and obesity.

Two out of three patients seen by health care providers have overweight or obesity.[6] However, many providers hesitate to broach the sensitive topic of weight with patients, even when it is an underlying factor in the patient's decision to seek medical attention. Even moderate weight loss of 5-10% can significantly reduce key risk factors, such as blood pressure, glucose, insulin, and triglycerides; decrease medication needs; and significantly lower the risk of developing arthritis, sleep apnea, cardiovascular disease, and numerous other diseases.[7] Moderate weight loss also may lead to improvements in other factors, such as energy levels and fatigue, mobility, and mood.[8] The benefits of weight loss are substantial, and they can begin with a conversation.

While individual choices and attention to health behaviors, such as diet and physical activity, are certainly relevant, the environment is an important determinant of the choices that can be made.[13] Globally, community, and societal changes over the past century have led to a progressively "obesogenic" (obesity-causing) environment.[14,15]

Genetics is another strong determinant. Twin and family studies suggest that 40–70% of the inter-individual variation in obesity risk and body mass index (BMI) can be attributed to genetic factors.[16,17] Although we cannot change the genes that make patients susceptible to obesity, we can change the environments and the choices that lead to excessive weight gain.

It is also important for providers to recognize that physiology opposes weight loss. Intentional weight loss leads to physiologic adaptations, such as changes in levels and activity of various hormones like ghrelin and leptin, as the body attempts to conserve energy stores. In part, these responses lead to slowed metabolism and increased hunger, making it difficult to continue weight loss and predisposing to regain. These physiologic changes begin to explain why patients often regain lost weight, despite often wanting to continue to lose more weight.[18,19]

Overcoming Barriers to Create Opportunities to Have Conversations About Weight

Providers report several challenges and barriers to addressing weight with their patients, as described below. While these are real concerns, many of these barriers are being addressed by structural changes in our health care system and new discoveries in obesity management. For example:

- **Lack of time**
  Opportunity: While time limitations are relevant challenges for many clinical goals, including obesity management, productive interactions can be relatively short. Initial discussions will set the stage for ongoing conversation. Further, strategic use of a team-based approach, such as including dietitians or nurses and referral to obesity specialists, internet resources, or commercial programs, can extend providers' impact.

- **Insufficient reimbursement for obesity counseling**
  Opportunity: This is changing. For example, Medicare now encourages and provides reimbursement for obesity counseling in primary care. Further, several coding strategies can help maximize reimbursement and opportunities for clinical conversations about weight and health.

Language to use[20]	Language to avoid
Overweight	Fat
Increased BMI	Obese
Unhealthy weight	Diet
Healthier weight	Exercise
Eating habits	
Physical activity	

Effective for claims with dates of service on or after November 29, 2011, Medicare will recognize **HCPCS code G0447**, Face-to-Face Behavioral Counseling for Obesity, 15 minutes. G0447 must be billed along with one of the **ICD-9 codes** for BMI 30.0 and over (**V85.30-V85.39, V85.41-V85.45**). The type of service for G0447 is 1 (**ICD-10 codes will be Z68.30-Z68.39, Z.68.41-Z69.45**).

- **Lack of training, tools, and confidence**
  Opportunity: This, too, is changing, because we've been working hard to incorporate education about obesity into medical and health professional education. Still, there are many opportunities for additional training, e.g. obesity medicine fellowships and Continuing Medical Education. Most professional societies, such as the American College of Physicians, the American Association of Family Physicians, the American Association of Pediatrics, the American Association of Nurse Practitioners, and others, offer tools, guidance, and continuing education on obesity. The American Board of Obesity Medicine offers formal Board Certification for providers wanting to learn even more and perhaps focus their clinical practice in obesity medicine. The Obesity Society's *Treat Obesity Seriously* campaign offers interactive resources for providers. Click here or go to page 15 for additional resources.

Futility of obesity treatment outcomes

Opportunity: It's important for providers to appreciate the range of effective and evidence-based treatments available. Research and systematic reviews have demonstrated the efficacy of several treatments, including behavioral counseling, numerous behavior modification techniques, FDA-approved pharmacotherapy, and bariatric surgery. When appropriately prescribed, these treatments not only help patients to achieve clinically-meaningful weight loss but also can lead to improvements in several risk factors and health outcomes.

Discomfort raising the topic

Opportunity: Read on, that's what this guide is all about.

Weight stigma, or negative attitudes about one's weight, is another barrier to good care. In many cases, weight bias leads patients to avoid health care. Patients who experience weight stigma may also be predisposed to more weight gain.[21] Awareness of our own attitudes and perceptions about obesity and patients who present with excess weight likely will foster a greater openness to the discussion of weight. We recommend using "people-first" language. Instead of referring to a patient as "obese," it's helpful to say that the patient "has obesity," just as we say that a patient has diabetes or cancer.

Considerations for Fostering Effective Communication About Weight and Health

Patient Accommodation

Many patients avoid or delay medical treatment due to concerns that their providers will not have furniture, equipment, or an environment that accommodates their needs. [22,23,24,25,26,27,28] In a typical primary care setting, a significant proportion of patients are too heavy to fit into office furniture and medical equipment. In fact, recent data shows that 14% of American adults have BMI >35 kg/m^2, the equivalent of carrying 75 lbs or more excess weight.[29] While practices that specialize in obesity need to pay attention to structural issues, such as having wider doorways and bariatric exam tables, here are some modifications that any practice can institute:

- Provide wide-based, higher weight capacity chairs, preferably armless, available in the waiting area and other patient areas
- Consider specialized bariatric chairs, when possible
- Offer large size or even thigh-sized blood pressure cuffs
- Provide a higher capacity scale, ideally to >500 lbs (be sure that the scale is situated in a private or near-private area to minimize the anxiety and discomfort associated with being weighed)
- Make bathrooms wheelchair accessible and ADA compliant and have pedestal toilets rather than wall-mounted toilets, if possible
- Have extra-large gowns available
- Educate your staff about obesity and weight bias

When structural or large-scale changes aren't possible, be mindful and attentive to patients who won't fit well in your office. For more information on finding appropriately-sized medical equipment, view this resource from the Rudd Center for Food Policy & Obesity.

Communication Strategies to Build Trust and Connections

Here are some suggested ways to address accommodations with patients:

- *"I'm sorry that our exam room doesn't fit you comfortably. Can we talk in another room where you can be more comfortable?"*
- *"Is there something that we could do to help you feel comfortable?"*
- *Situations may arise where a patient is unaware of terminology such as obesity, waist circumference, and sleep apnea. Providers should find ways to simply define these words to improve understanding. For example:*
    - *"The term 'obesity' refers to an unhealthy amount of excess weight."*
    - *"Waist circumference measures the distance around your stomach. It is an alternate way to assess a patient's risk for disease."*
    - *"A person suffering from sleep apnea will have trouble breathing in his or her sleep. Excess weight often can make this problem worse."*

Finally, a supportive staff is essential. Front desk, clerical, and nursing staff are often the first points of contact for patients. These initial interactions and impressions often set the stage for productive conversations later in the visit (or even in subsequent visits). As with all patients, staff should be courteous and attentive, regardless of a person's weight. They should understand that patients may be in discomfort. Most importantly, joking or making comments about a patients' weight or size is unacceptable. The tips provided in this guide may be helpful to share with office staff.

Beginning the Conversation

Weight and obesity are sensitive and personal topics. Discussing weight can be a difficult experience for the patient, leaving him or her open to feelings of embarrassment, fear, and blame.

Start by listening.[30] For patients who have not had experience with weight loss efforts, this may be the first time they have ever discussed their weight. They may not be familiar with the negative impacts of an unhealthy weight. In such cases, discussing some of the adverse health aspects of obesity and how obesity may affect the quality of their life can be valuable. For others, past experiences of being criticized or blamed for their weight difficulties by health care providers may make them reluctant to discuss their weight struggles.

As in other topics of medical discussion, start with an empathetic statement and ask permission before bringing up this personal topic. If the patient makes it clear they do not want to have this discussion today, respect that choice and table the conversation for another time.

Discussion Starters for Beginning the Conversation

- *"You mentioned a number of symptoms, such as fatigue and aching knees, which may be related to excess weight. Would you like to talk about this to see if we can help you feel better?"*
- *"Would it be okay if we discussed your weight?"*
- *"Are you concerned about the effect of your weight on your health? Do you feel that affects your quality of life? For example, do you find it difficult to do everyday things like walking up a flight of stairs?"*
- *"Our measurements indicate that you are carrying excess weight. Excess weight can be unhealthy for you and strain your body, making it work harder than it needs to work. Excess weight also increases your risk for diabetes, heart disease, high blood pressure, stroke, and cancer. The good news is that moderate weight loss has been shown to greatly reduce the risk of these diseases. If you're interested, we can talk a bit more about weight and related topics, such as physical activity, and then work together to create a plan of action."*

Discussion Starters for Beginning the Conversation (CONTINUED)

Body Mass Index (BMI) can be a confusing concept, especially if the patient has never encountered the term before. Even those patients who are familiar with BMI might have some misconceptions about what this metric actually represents.[31]

- *"Body Mass Index – or BMI – is a measurement that helps determine how much excess weight you are carrying. BMI is calculated from a person's height and weight. While it can be a useful way to quickly detect excess weight, it is not a specific measure of excess body fat – or who you are. For example, a bodybuilder may have a BMI that indicates he or she may be overweight, yet his or her excess weight is usually due to bone and muscle. So in addition to looking at your BMI, we look at other measures like waist circumference, especially if weight may be causing health issues like high blood pressure, sleep apnea, or diabetes. All of this information helps us determine the extent to which excess weight may be harmful to your health."*

Assessing Readiness

While many patients with overweight or obesity likely have attempted weight loss previously, there are also those who do not consider their weight to be a problem. For these patients in particular, it may be helpful to assess their readiness for behavioral change in order to inform the conversation. [32,33,34]

One approach characterizes patients in one of five "stages of change": pre-contemplation, contemplation, preparation, action, or maintenance.[35] Assessing which stage best characterizes your patient will inform your approach and recommendations.

Questions to Assess Patient Readiness

Here are some suggested ways to address readiness with patients:

- *"How likely are you to consider a couple of small lifestyle changes, specifically ones that would lead to increasing physical activity and eating healthier, to improve your health?"*
- *"If your friends and family knew you were trying to increase your physical activity and eat healthier, how much support would you receive from them?"*
- *"How much support would you like to receive from me should you choose to increase your physical activity and eat healthier?"*
- *"Would you be willing to incorporate 'extra' physical activity in your daily routine?" (Cite examples, such as taking the stairs rather than elevator, walking pets, parking further away in parking lot, etc.)*

Communication Strategies

Many providers express concern about offending patients by bringing up the topic of weight. There are many techniques to help start these conversations. For example, motivational interviewing (MI) is a collaborative, goal-oriented style of communication designed to assist the patient in attaining specific goals within an atmosphere of acceptance and compassion. [36,37] The objective of MI is not to solve the patient's problem but to help the patient begin to believe that change is possible, resolve ambivalence about change, and help develop some momentum toward achieving his or her health goals. MI techniques are designed to help motivate the patient in a collaborative nature, understand the patient's perspective, and assist the patient in finding his or her own solutions, while affirming the patient's freedom to change, thereby allowing the patient to discover his or her own motivation. This strategy encourages positive feedback and use of "change statements," while avoiding judgment, confrontation, or unwelcome advice.[38]

Many of these same concepts are included in the "FRAMES" model:

Feedback	Present feedback to the patient in a way that is respectful and has impact. Feedback can include information about how unhealthy behaviors are harming the individual and should be based on information gathered in patient interviews, reports, and objective measures. Ensure that your communication reflects the patient's statements of concern.
Responsibility	Emphasize that the patient has the responsibility and freedom to change or not.
Advice	Provide clear and direct advice about the importance of making lifestyle changes and suggest different ways that this can be accomplished. Advice should recognize that the patient makes the ultimate choice.
Menu	Offer different alternatives for the patient to choose. For example, *"There are different ways that people successfully change their lifestyle behaviors. Perhaps we can spend a few moments talking about this, so that I can share some of these strategies with you. You can tell me which of these might make the most sense for you."*
Empathy	It is important to listen to and reflect on the patient's statements and feelings. This approach ensures that you understand the patient and that the patient feels understood by you, both of which foster productive communication. Expressing empathy involves communication that is warm and supportive and demonstrates that you are paying attention to the patient's verbal and nonverbal communication.
Self-efficacy	Part of your goal in MI is to help instill optimism and confidence that he or she can make meaningful behavior changes. The message to your patient is that "you can change."

See below for examples of active listening and "people-first language" consistent with motivational interviewing and FRAMES:[39]

Communication Strategies to Promote Active Listening

- *"What things would change if you accomplished your weight loss goals?"*
- *"I'd like to learn more about your eating and physical activity habits. What types of activities do you enjoy? What types of foods do you typically eat?"*
- *"What changes to your eating and physical activity habits do you think you could reasonably make?*
- *"Let's work together to create a plan that will work best for you."*
- *"May I offer you suggestions based on what you've told me?"*
- *"I appreciate your willingness to discuss these issues with me."*

Examples of People-First Language

- *"The woman was affected by obesity." - instead of - "The woman was obese."*
- *"The man with obesity was on the bus." - instead of - "The man on the bus was obese."*

The Importance of Managing Expectations and Setting Goals

It's important to work with patients collaboratively to develop weight and health-related goals. Many patients have unrealistic expectations of how much weight they will be able to lose. One study demonstrated that patients expected to lose nearly one-third of their body weight with diet and exercise, which is more weight than the average patient loses even with bariatric surgery.[40] The reality is that weight loss usually occurs relatively slowly, is varied, and typically is far less than the patient (and provider) expects.[41]

While large weight losses are unlikely and especially unlikely to be sustained, there is good evidence that moderate, sustainable weight loss can have a big impact on health. Achieving 5-10% body weight loss can lead to numerous improvements in health risk factors, energy, improved activities of daily living, and overall functioning.

SMART is an acronym for goal-setting: Specific, Measurable, Achievable, Realistic, and Time-sensitive. Using these as a rule of thumb can help create actionable plans that are more meaningful for patients.[42]

Specific Goals: Set specific objectives and goals, such as establishing a start date or agreeing on an explicit behavior change step.

Measureable Goals: Weight and behavior change goals should be measureable, such as aiming for a 10-minute walk after lunch on weekdays.

Achievable Goals: Unrealistic goals get in the way of motivation. Achievable weight loss goals, such as aiming to lower calorie intake by 300 calories per day, rather than overly restrictive diet goals, may improve success. As discussed earlier in this guide, 5-10% body weight loss goals are realistic and can significantly improve health.

Relevant Goals: It goes without saying that we are more motivated to accomplish things that matter deeply to us. For one patient, losing weight to be able to move better is more meaningful, whereas another patient may feel getting off medication is more motivating.

Time-sensitive goals: A mutually-agreed upon timeline for achieving a specific goal aids motivation. Ask your patients what is reasonable to achieve today? This week? This month?

Goals should be reassessed and adjusted as needed. Roadblocks, setbacks, or life events will happen over the course of a long-term weight loss strategy. Acknowledging the possibility of setbacks during the initial goal setting stage and developing strategies to address them will help patients move past these when they happen.

Conversation Starters to Address Realistic Goals With Patients

- *"It is fantastic that you have decided to work to improve your health and reduce your excess weight. What goals do you have in mind?"*
- *"Let's discuss some goals that go beyond your weight. What can be done to improve your quality of life? Quality-of- life improvements could include finding it easier to walk up a flight of stairs, to carry groceries, to pick up your grandchildren, to sleep better at night, or even to improve your golf swing. Other health goals could include decreasing body pain or lowering blood pressure."*
- *"Losing weight and sustaining weight loss is a delicate, challenging balance. It is not just about will power. Let's talk more about the challenges you may face individually so we can create a realistic view of what to expect and set weight loss goals that make sense for you."*
- *Many patients will come to you with goals already in mind; however, these goals are often unrealistic. Sharing evidence-based models of successful weight loss may help your patient to determine a realistic goal.*
- *"While reality TV shows or magazines may tout extreme weight loss, those results are not realistic in an everyday setting. Losing and maintaining weight loss is a marathon, not a sprint. The average weight loss for most people is approximately 5-15%. This loss may be less than you expected, but the good news is that it can greatly improve your health. At the end of the day, improving your health and creating a lifelong commitment to healthy lifestyle behaviors are two huge successes. Having a goal weight can keep you motivated, but true success will come from daily, sustainable, and enjoyable eating and physical activity practices."*
- *"Research shows that most weight losses take longer than expected. In fact, it sometimes takes a year or longer. While everyone is different, these models remind us that weight loss is a long-term process. How can we think about your goals in a way that takes into account what science and research tell us about this process?"*

Conversation Starters to Address Realistic Goals With Patients (CONTINUED)

Often, patients attempting to lose weight have already tried several options. [43] **Patients may approach their physician frustrated that after "trying everything" they have not yet found success in their weight loss efforts. Often what they mean by such statements is that they have previously lost weight but have been unable to sustain their weight loss. The distinction is crucial, insofar as it shifts the focus of the discussion from weight loss to weight maintenance after weight loss.**

- *"I understand how frustrating it can be to try many different weight loss methods without success. Weight loss is a challenging endeavor that requires a plan that works best for you. There is no one option that fits all. While certain methods haven't worked, we can explore what will work for you. Let's discuss some treatment options that you haven't tried yet."*
- *"I would love to tell you there is a magic pill or secret exercise that will work instantly. The idea of a 'quick fix' is enticing to us all. Unfortunately, there is no magic when it comes to losing weight. Choosing an option that requires strict adherence to a rigid diet or exercise routine makes it difficult to follow that plan for an extended period of time. Let's discuss ways to lose weight that address the challenges of both losing weight and keeping it off."*
- *"I realize that you have repeatedly lost weight only to regain it again. I understand that you worked very hard each of those times, and it must be challenging to feel that your effort didn't pay off. It's important not to view your previous attempts as 'failures,' but rather as learning opportunities. Weight loss is a marathon, not a sprint, and we will continue to work together until we find a strategy to help you lose weight and keep it off."*
- *"We do not have to rely on a single treatment option to help you attain your goals. If one strategy isn't working, we can try adding on another strategy or shifting to a different approach. We will find the method that works best for you."*
- *"It can be frustrating to feel that your hard work isn't paying off. However, it is important to remember that even modest weight loss results in improved health outcomes like having more energy, lower cholesterol levels, and reduced risk factors for chronic diseases such as diabetes and heart disease."*

Many patients may feel reluctant to set goals if they feel overwhelmed by the financial burden of a healthy lifestyle. [44,45,46]

- *"Healthy eating can be costly, but the costs of obesity and its related health problems can be costly too. There are ways to make healthy eating more affordable. Many websites offer resources for healthy eating plans, grocery shopping lists, and daily menu recommendations. Let's take a look at some of these resources available to you to see how we can incorporate them into your treatment plan."*

Listening to and Understanding a Patient's Situation and Context

Our choices and decisions are heavily influenced by the environment in which we live. Taking time to learn about patients' everyday lives, including their home and work environments, interpersonal relationships, family dynamics, stressors, and cultural preferences, can lead to better understanding of the challenges they face and a more informed perspective from which to support them.

Environmental factors, such as the availability of community resources and safe and affordable places to be active, also impact the choices patients make about their diet and exercise. If the patient lives in an environment with minimal access to fresh fruits and vegetables or if they don't feel safe outside, it can be difficult for them to follow diet and exercise recommendations.

Stress from both personal and environmental factors can lead a patient to make unhealthy choices, even if he or she is aware that changes to the way they live are needed. During times of high stress, some people respond by stress eating or emotional eating. Others are especially likely to eat high-calorie foods and are less likely to get the recommended amount of exercise.[47]

Learning more about the patient and his or her lifestyle, home and work environments, and personal relationships is an important first step in talking with your patient about weight and health.

- *"Is there a grocery store in your neighborhood that has fruits and vegetables?"*
- *"Do you feel that you can afford fresh fruits and vegetables?"*

Conversation Starters to Discuss Culture, Tradition, and Social Support

There are several aspects of culture to consider when discussing weight with a patient, including meals, food sources, family structure, eating routines, and finances. Patients might assume you know their cultural traditions, so respectfully asking for more information is not only a learning opportunity but will allow them to spend time reflecting on their lifestyle and where there might be room for improvement.[48,49]

- *"Tell me more about traditions you may have with your family. Where do food and physical activity play a role?"*
- *"Cultural traditions are an important part of who we are. While maintaining tradition is important, there may be ways to integrate healthier options into the parts of your culture that are important to you. Let's work together to come up with some ideas on how to incorporate healthy lifestyle choices into your home."*
- *"Family-based physical activity and healthy eating are great ways to ensure that health takes on a central role in your family. What are some ways we can involve your entire household in your efforts to become more active and eat healthy foods?"*

Some cultures embrace particular hairstyles or types of clothing that can be major barriers to physical activity. Many traditions have specific rules regarding what can be worn in front of members of the opposite sex. This could make it challenging, particularly for women, to be physically active.

- *"I understand that your traditions might determine the type of physical activity you can do or where you can comfortably exercise. Let's discuss ways to be physically active in your own home or within your community. There may be resources available to you that might help you feel more comfortable making these important lifestyle changes."*

Conversation Starters to Discuss Culture, Tradition, and Social Support (CONTINUED)

Research shows a positive association between the use of support groups and weight loss, with the strongest correlation in women. If a patient already has a well-defined, supportive group of friends or family members, encouraging the patient to rely on a support system could help him or her to lose weight.

- *"It sounds like your family is supportive of your desire to lose weight. It's great that you have such a supportive group to help you! What are some ways we can use their influence and support to help you reach your goals?"*
- *For patients who lack understanding friends or family, influencing these weak support systems might not be the best option. Rather, encourage these patients to form new friendships and networks that will encourage a healthy lifestyle.*
- *"I understand it must be frustrating to feel so eager to make healthy lifestyle changes, only to be met with resistance from your friends and family. Finding and building new support systems could help you overcome the opposition you are facing in your personal life. Community groups and online resources might be a great way for you to find the support you need to make these healthy changes."*

The Impact of Trauma and Need for Trauma-Informed Care

Studies largely have confirmed the association between traumatic childhood experiences or abuse and the development of eating disorders and obesity, especially severe obesity. One manifestation of this is binge eating disorder, which is three or four times more common in patients who report a history of childhood sexual abuse.[50] Early adverse experiences also may disrupt the body's metabolic system. Providers should be aware of the physiological and psychological impact that traumatic experiences can cause. When a history of trauma is identified, precautions should be taken to ensure patient safety, such as asking about current mental state and thoughts of self-harm. Survivors of trauma require an extensive range of resources that are often beyond the capacity of a primary care provider or practice. However, remaining cognizant of the need for trauma-informed care is crucial to providing a supportive environment and successfully initiating a conversation.

Providers Concerns About Their Own Weight

You may worry about how your own weight or health habits impact the discussion you have with your patient. Body image and concerns about weight affect all of us. Yet it's important to remember that weight is about health, not appearance. Explaining this to your patients can help them to feel more motivated to discuss their weight with you and may ease some of the tensions around this conversation. Studies show that patients trust and respect health care provider advice, regardless of the provider's weight status.[51] Recognizing that weight is about health, reiterating that message with your patients, and remembering to be aware of actions, attitudes, and words that may be stigmatizing can help to allow for a more open and productive conversation with your patients.

Additional Resources

Alliance for a Healthier Generation, American College of Sports Medicine, and Bipartisan Policy Center: *Teaching Nutrition and Physical Activity in Medical School* focuses on options for improving medical education and training in topics that have an important role to play in the prevention and treatment of obesity and chronic diseases.
http://bipartisanpolicy.org/library/report/teaching-nutrition-and-physical-activity-medical-school-training-doctors-prevention

American Association of Family Physicians: This organization's "Obesity" collection features content on weight and related issues, including bariatric surgery, childhood obesity, diet, exercise, lifestyle counseling, and weight loss maintenance. Topics include screening, diagnosis, prevention, treatment, complications, best practices, and patient education.
http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=19

American Association of Pediatrics: *Pediatric ePractice* is an online-based office designed to help providers prime their offices for effective prevention, assessment, and treatment of childhood overweight and obesity. The resources are organized to align with the workflow of a typical office and the associated tasks that align to each room. Each room contains a variety of tools and resources informed by the expected context of that portion of a patient visit.
http://www.pep.aap.org/

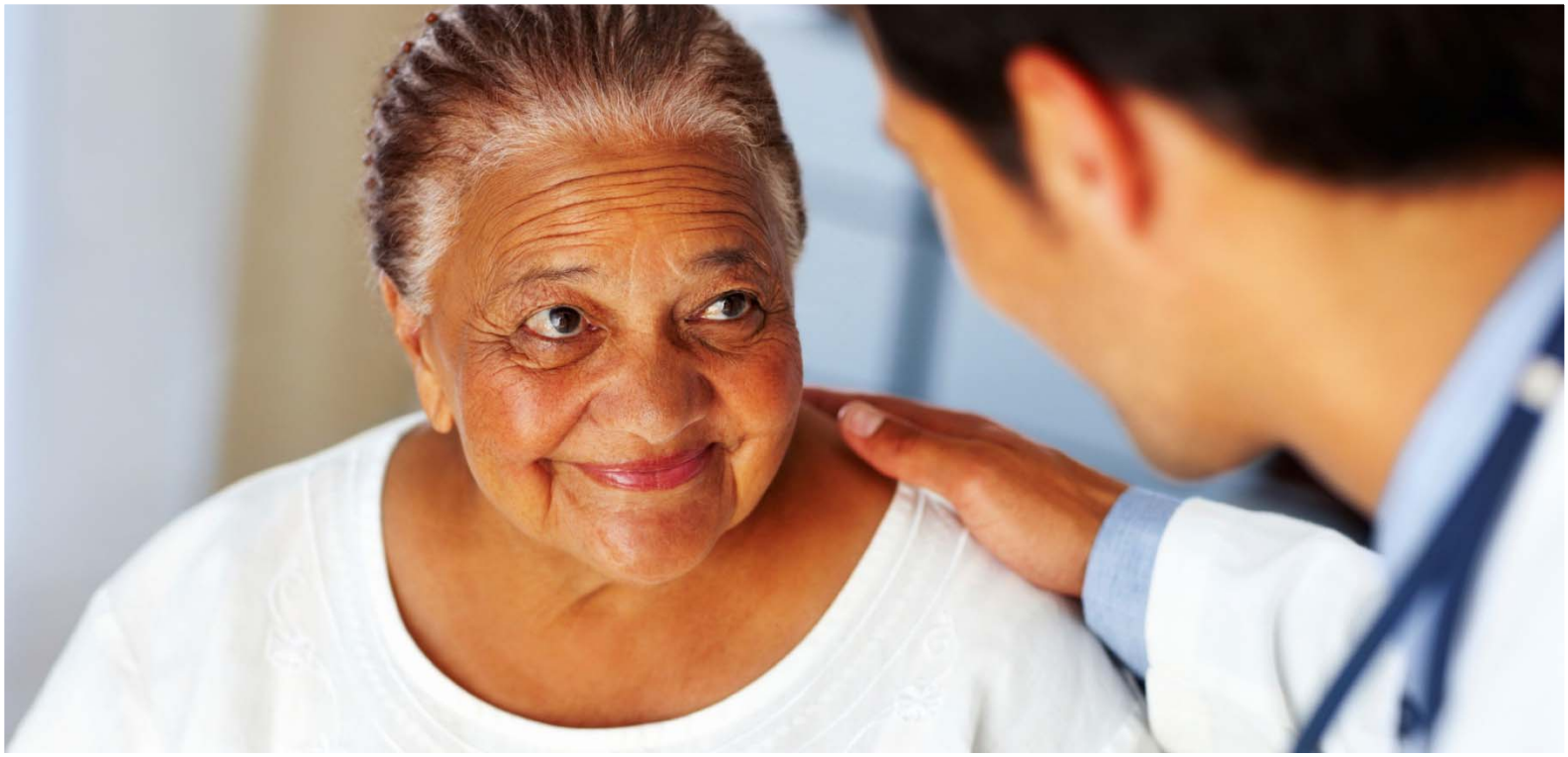
American Board of Obesity Medicine: This website provides information on certifications in obesity medicine, including information on exam details and preparation.
http://abom.org/

American College of Cardiology, The Obesity Society, and The American Heart Association: In collaboration with the National Heart, Lung, and Blood Institute and stakeholder and professional organizations, these groups developed clinical *Guidelines for the Management of Overweight and Obesity in Adults*.
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.full.pdf

American College of Physicians: This organization's practice assessment tool is a free quality improvement program that will assist providers in identifying, targeting, and implementing high value care in the treatment of patients with obesity.
http://www.acponline.org/running_practice/quality_improvement/practice_assessment/obesity.htm

Canadian Obesity Network: The Canadian Obesity Network's 5As of Obesity Management program is a step-by-step framework for busy non-specialists who manage obesity in their patients. It is an easy-to-use roadmap that ensures sensitive, realistic, measurable, and sustainable obesity management strategies that focus on improving health and well-being, rather than simply aiming for numbers on a scale.
http://www.obesitynetwork.ca/5As

Obesity Action Coalition: The *Understanding Your Weight-loss Options* brochure offers safe and effective information for individuals wanting to address their weight and improve their health. The brochure provides information on behavior and lifestyle changes, commercial weight-loss programs, medications for weight-loss, and bariatric surgery.
http://www.obesityaction.org/educational-resources/brochures-and-guides/understanding-your-weight-loss-options-brochure



Obesity Action Coalition and the American College of Physicians: *Excess Weight and Your Health—A Guide to Effective, Healthy Weight Loss* features a guidebook and video to support those wanting to learn more about their weight and how it impacts their health.
http://www.obesityaction.org/educational-resources/brochures-and-guides/excess-weight-and-your-health-a-guide-to-effective-healthy-weight-loss

Obesity Education Network: This website serves as an educational resource hub specifically for health care professionals. It supports providers by equipping them with the necessary tools to identify, diagnose, and manage patients with overweight or obesity.
http://www.obesityeducationnetwork.com/

Prepare Iowa: This course in Motivational Interviewing is designed to equip health care providers and staff with the knowledge and tools to optimize health outcomes for patients.
http://prepareiowa.trainingsource.org/training/courses/Motivational%20Interviewing%3A%20Supporting%20Patients%20in%20Health%20Behavior%20Change/detail

The Obesity Society: The *Treat Obesity Seriously* campaign offers tools and resources to educate policymakers and support health care providers.
http://treatobesityseriously.org/

University of Michigan Center for Health Communications Research: *BMi*^{2} is a DVD that offers additional practice in the core skills of Motivational Interviewing, with a particular focus on preventing and treating pediatric obesity, including nuances of working with parents of young children as well as working directly with older children.
http://chcr.umich.edu/project.php?id=1032

Rudd Center for Food Policy and Obesity: This resource provides examples of Motivational Interviewing techniques that can be used by providers to assess ambivalence and motivation for lifestyle changes in patients with overweight or obesity.
http://yaleruddcenter.org/resources/upload/docs/what/bias/healthcareproviders/MotivationalInterviewing.pdf

About the Strategies to Overcome and Prevent (STOP) Obesity Alliance

Strategies To Overcome and Prevent (STOP) Obesity Alliance is a diverse coalition of nearly 90 consumer, provider, government, labor, business, health insurer, and quality-of-care organizations working together to address how we perceive and approach obesity and weight-related health problems. Based at The Milken Institute School of Public Health at The George Washington University, the Alliance is directed by William H. Dietz, MD, PhD. Founding Director Christine Ferguson, JD, serves as the Alliance's Strategic Initiatives Advisor. Past Director Scott Kahan, MD, MPH, is the Alliance's Clinical Advisor. For more information on Alliance members or its leadership, visit www.stopobesityalliance.org.

The Alliance's work is grounded in a set of core principles that serve as the foundation for its research and recommendations:

Reducing Overweight and Obesity is About Improved Health, Not Appearance - The goal of improving health outcomes serves as the basis for addressing overweight and obesity.

The Work to End Obesity Cannot End with Personal Responsibility - Many factors contribute to obesity and overcoming them extends beyond individual will. The STOP Obesity Alliance is dedicated to negating the myth that overcoming obesity is solely a matter of personal responsibility and moving toward an understanding that overcoming obesity requires environments where people have opportunities to make good, healthful choices.

Prevention and Intervention Go Hand-in-Hand - In a time of limited resources, there are those who see the solution to obesity as an either/or proposition: prevention or intervention. STOP Obesity Alliance members approach the issue differently, grounding Alliance research and recommendations in the understanding that prevention and intervention strategies are both essential in effectively addressing obesity.

How to Connect With STOP Obesity Alliance

Visit our website
www.stopobesityalliance.org

E-mail us
obesity@gwu.edu

Follow us on Twitter
@STOPObesity

Like us on Facebook
www.facebook.com/stopobesityalliance

Sign-up for our monthly E-Newsletter
http://www.stopobesityalliance.org/newsroom/e-newsletter/

[1] Rose SA. Physician weight loss advice and patient weight loss behavior change: A literature review and meta-analysis of survey data. *International journal of obesity (2005)*. 2013;37(1):118; 118-128; 128.

[2] Bardia A, Holtan SG, Slezak JM, Thompson WG. Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clin Proc*. 2007;82(8):927-932.

[3] Moyer V. Screening for and management of obesity in adults: U.S. preventive services task force recommendation statement. *Ann Intern Med*. 2012;157:373-378.

[4] Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity 2009;17:941-64.

[5] ACPM. *COACHING AND COUNSELING PATIENTS A Resource from the American College of Preventive Medicine*. 1st ed. American College of Preventive Medicine.; 2009:24. Available at: http://www.acpm.org/?NurseCoachingClinRef. Accessed July 18, 2014.

[6] National center for health statistics, 2012.

[7] Jensen MD. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults. *J Am Coll Cardiol*. 2013.

[8] CDC. Losing weight. Healthy Weight Web site. http://www.cdc.gov/HEALTHYWEIGHT/LOSING_WEIGHT/INDEX.HTML. Updated 2014.

[9] Gunther S, Guo F, Sinfield P, Rogers S, Baker R. Barriers and enablers to managing obesity in general practice: A practical approach for use in implementation activities. *Quality in primary care*. 2012;20(2):93-103. Accessed 3 June 2014.

[10] STOP Obesity Alliance. Weight in America survey. *Harris Interactive*. 2010.

[11] Bardia A, Holtan SG, Slezak JM, Thompson WG. Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clin Proc*. 2007;82(8):927-932.

[12] Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity 2009;17:941-64.

[13] Brownell K, Kersh R, Ludwig D et al. Personal responsibility and obesity: a constructive approach to a controversial issue. *Health Affairs*. 2010;29(3):379--387

[14] Brownell K, Kersh R, Ludwig D et al. Personal responsibility and obesity: a constructive approach to a controversial issue. *Health Affairs*. 2010;29(3):379--387

[15] Kahan S, Cheskin LJ. Obesity and Eating Behaviors and Behavior Change. In: Kahan S, et al. Health Behavior Change in Populations. Johns Hopkins University Press, Baltimore, MD, 2014.

[16] Day F, Loos R. Developments in obesity genetics in the era of genome-wide association studies. *Journal of nutrigenetics and nutrigenomics*. 2011;4(4):222--238. Available at: http://www.karger.com/Article/FullText/332158.

[17] Gorkin D, Ren B. Genetics: Closing the distance on obesity culprits. *Nature*. 2014;507(7492):309--310. Available at: http://www.nature.com/nature/journal/v507/n7492/full/nature13212.html.

[18] Field AE. Relationship of a large weight loss to long-term weight change among young and middle-aged US women. *International journal of obesity and related metabolic disorders*. 2001;25(8)

[19] Foster GD, et al. Arch Intern Med. 2001 sep 24;161(17):2133-9.

[20] Puhl R. Motivating or stigmatizing? public perceptions of weight-related language used by health providers. *International journal of obesity (2005)*. 2013;37(4):612; 612-619; 619.

[21] Sutin AR, Terracciano A. *PLoS One*. 2013;8(7):e70048.

[22] Baier, E. Obese patients prompt hospitals to adopt new equipment, protocols. *MPR News*. 2011.

[23] Rudavsky, S. Hospitals super-sizing equipment for obese patients. *The Indianapolis Star*. 2013.

[24] Rice S. Hospitals retrofit to better care for growing number of morbidly obese patients. *Modern Healthcare*. 2014.

[25] Crook, K. Strategies for accommodating obese patients in acute care settings. *Hammes Company*. 2009.

[26] Finley, D. Accommodating dental patients who live large. *San Antonio Express News*. 2012.

[27] Haigh C. Health care community responding to obesity epidemic | Endocrine Today. *Healio.com*. 2009.

[28] Polley S. The Obesity Problem in U.S. Hospitals: Article - The Hospitalist. *The-hospitalist.org*. 2006.

[29] Ogden CL. Prevalence of childhood and adult obesity in the United States, 2011-2012. *JAMA : the journal of the American Medical Association*. 2014;311(8):806; 806-814; 814.

[30] Vallis M, Piccinini--Vallis H, Sharma A, Freedhoff Y. Modified 5 As Minimal intervention for obesity counseling in primary care. *Canadian Family Physician*. 2013;59(1):27--31

[31] CDC.gov Healthy Weight: Assessing Your Weight: BMI About Adult BMI. DNPAO. CDC. 2011.

[32] Post R, Mainous A, Gregorie S, Knoll M, Diaz V, Saxena S. The influence of physician acknowledgment of patients' weight status on patient perceptions of overweight and obesity in the United States. *Archives of internal medicine*. 2011;171(4):316--321

[33] Swift J, Choi E, Puhl R, Glazebrook C, Talking about obesity with clients: preferred terms and communications styles of UK pre-registration dieticians, doctors, and nurses. *Patient education and counseling.* 2013; 91(2):186-191.

[34] Christie D, Channon S. The potential for motivational interviewing to improve outcomes in the management of diabetes and obesity in pediatric and adult populations: a clinical review. *Diabetes, Obesity and Metabolism*. 2014;16(5):381--387

[35] ACPM. *COACHING AND COUNSELING PATIENTS A Resource from the American College of Preventive Medicine*. 1st ed. American College of Preventive Medicine.; 2009:24. Available at: http://c.ymcdn.com/sites/www.acpm.org/resource/resmgr/timetools-files/coachingclinicalreference.pdf. Accessed July 18, 2014.

[36] Miller W, Rollnick S. *Motivational interviewing.* Third ed. New York, NY: Guilford Press; 2012:482.

[37] Stewart E, Fox C. Encouraging Patients to Change Unhealthy Behaviors With Motivational Interviewing - Family Practice Management. *AAFP*. 2011. Available at: http://www.aafp.org/fpm/2011/0500/p21.html. Accessed July 20, 2014.

[38] Pollak KI. Physician communication techniques and weight loss in adults. *Am J Prev Med*. 2010;39(4):321; 321-328; 328.

[39] Schlair S. *How to deliver high quality obesity counseling in primary care using the 5As framework. Journal of clinical outcomes management. 2012; 19(5).*

[40] Wadden TA, Womble LG, Sarwer DB, Berkowitz RI, Clark VL, Foster GD. Great expectations: "I'm losing 25% of my weight no matter what you say". *J Consult Clin Psychol*. 2003;71(6):1084-1089

[41] Hall KD, Sacks G, Chandramohan D, et al. Quantification of the effect of energy imbalance on bodyweight. *The Lancet*. 378(9793):826-837.

[42] http://www.obesityaction.org/educational-resources/resource-articles-2/general-articles/set-a-smart-resolution-for-2013

[43] AHA/ACC/TOS. (2013) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.

[44] Rao M. Do healthier foods and diet patterns cost more than less healthy options? A systematic review and meta-analysis. *BMJ open*. 2013;3(12)

[45] Cawley J. The medical care costs of obesity: An instrumental variables approach. *J Health Econ*. 2012;31(1):219; 219-230; 230.

[46] USDA, Center for Nutrition Policy and Promotion. Eating healthy on a budget: the consumer economics perspective. Choosemyplate.gov. 2011.

[47] http://www.mayoclinic.org/healthy-living/stress-management/expert-answers/stress/faq-20058497

[48] Coris E. Cultural competency in obesity. College of Public Health Obesity Lecture Series. University of South Florida. 2003.

[49] Trigwell J, Watson P, Murphy R, Cable T, Stratton G. Addressing childhood obesity in black and racial minority (BRM) populations in liverpool.2011.

[50] Stevelos J, White W. Sexual abuse and obesity: What's the link. *Your Weight Matters Magazine*. 2010;6.

[51] Bleich SN, Gudzune KA, Bennett WL, Jarlenski MP, Cooper LA. How does physician BMI impact patient trust and perceived stigma? *Prev Med*. 2013;57(2):120-124.

Contact STOP with any questions at obesity@gwu.edu

www.stopobesityalliance.org