COPE WEBINAR SERIES FOR HEALTH PROFESSIONALS

May 20, 2020

Obesity Treatment, Beyond the Guidelines:
A Structured "A-B-C-D-E-F" Framework for Primary Care Practice

Moderator: Lisa Diewald, MS, RD, LDN
Program Manager
MacDonald Center for Obesity Prevention and Education
M. Louise Fitzpatrick College of Nursing

Nursing Education Continuing Education Programming Research

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OBJECTIVES

1. Discuss the factors contributing to limited attention to obesity counseling in clinical practice

2. Understand the value of a systematic approach to obesity management

3. Learn a practical, structured approach to addressing obesity in clinical practice

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CE DETAILS

Villanova University College of Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center Commission on Accreditation

Villanova University College of Nursing Continuing Education/COPE is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration

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CE CREDITS

- This webinar awards 1 contact hour for nurses and 1 CPEU for dietitians
- Suggested CDR Learning Need Codes: 5000, 5370, 6000, 9020
- Level 2
- CDR Performance Indicators: 6.2.5, 9.1.3, 9.1.4, 9.6.6

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Obesity Treatment, Beyond the Guidelines: A Structured "A-B-C-D-E-F" Framework for Primary Care Practice

Scott Kahan, MD, MPH
Director, National Center for Weight and Wellness
Medical Director, Strategies to Overcome and Prevent (STOP) Obesity Alliance

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DISCLOSURES

The planners and presenter of this program have no conflicts of interest to disclose.

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EVIDENCE-BASED OBESITY TREATMENT IN PRIMARY CARE: A PATIENT-CENTERED A-B-C-D-E-F FRAMEWORK

Scott Kahan, MD, MPH
National Center for Weight & Wellness
Johns Hopkins School of Public Health
kahan@nationalweight.org | @scottkahan

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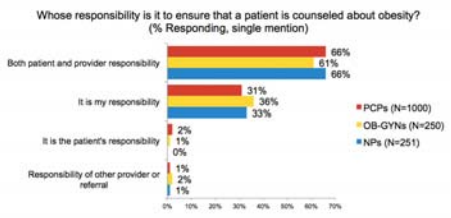
Which of these best characterizes your beliefs about obesity treatment?

A. Obesity is a medical condition; it is the healthcare provider's responsibility to ensure that patients are appropriately counseled and provided appropriate treatment for obesity, when indicated
B. Obesity is a personal issue; it is the patient's responsibility to ensure that he/she gets the help they need
C. Obesity is both a medical and personal issue; the responsibility for addressing obesity is shared between healthcare providers and patients
D. Obesity is an issue of personal responsibility and willpower; patients should take better care of themselves and not burden the healthcare provider or the healthcare system

10

An Obesity Paradox



Petrin C, Kahan S, et al. Obes Res Clin Pract, 2016.

11

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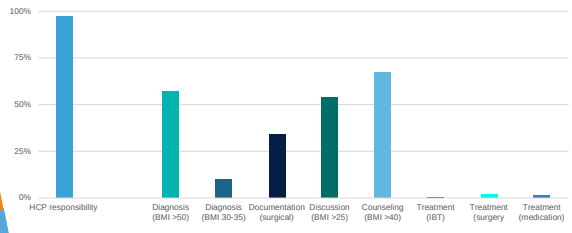
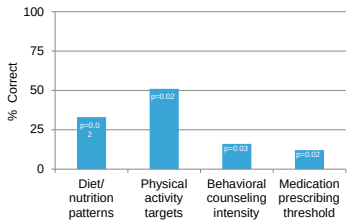


Kahan S. Mayo Clin Proc, 2018.

12

HCP Knowledge of Obesity Guideline Recommendations



Kahan S, et al. Obesity, 2018 . Kahan S, et al. ACPM Annual Meeting, 2017.

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Obesity Guidelines

ACC/AHA/TOS Obesity Guideline

ENDO Pharmacotherapy Guideline

AACE/ACE Obesity Guideline

Metabolic Surgery Guideline

OMA Obesity Algorithm

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An "ABCDEF" Approach to Weight Counseling

Obesity Treatment, Beyond the Guidelines
Practical Suggestions for Clinical Practice

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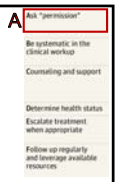
Kahan S, Manson JE. Obesity Treatment, Beyond the Guidelines. JAMA. 2019;321(14):1349-1350. doi:10.1001/jama.2019.2352

15

A: Ask "Permission"

"Over the last few years, your weight has been increasing, and I'm concerned that it may lead to diabetes and other health problems. Would it be okay if we started working on this together? "



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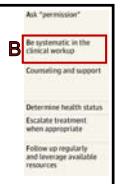
B: Be Systematic in the Clinical Workup

- "Just less and exercise more" isn't helpful



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Scott Kahan, MD, MPH - ABCDEF Approach to Obesity Management

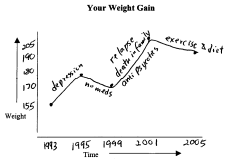
Elicit Weight History

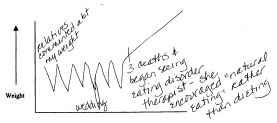
	Sample Questions
Onset	"When did you first notice your weight increasing?" "What was your lightest and heaviest weight as an adult? What did you weigh in high school, college, early 20s, 30s, 40s?"
Precipitating	"Have you noticed specific life events causing weight gain, e.g., stressful new job, marriage, divorce, children, smoking cessation, financial stress, depression, illness?"
Quality of life	"How does your weight affect your life?" "At what weight did you feel your best?"
Remedy	"What have you done or tried in the past to control your weight?"
Setting	"What was going on differently in your life during times when you felt in control of your weight, versus times when it is more challenging to manage?"
Temporal pattern	"What is the pattern of your weight gain, e.g., gradual, progressive gain, large, cyclic gain-loss ("yo-yo")?"

Kushner RF, Kahan S, et al. TOS Position Statement on Weight History-Taking in Clinical Practice. Obesity, 2019.

19

Elicit Weight History





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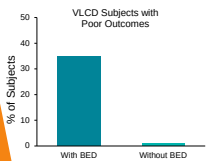
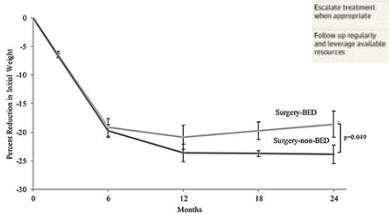
Weight History Informs Treatment





Chao AM, et al. Obesity 2016;24:2327-2333.
Yanovski SZ, et al. Obes Res 1994;2(3):205-12.

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Weight History Informs Treatment

	Notable Medications/Classes Associated With Weight Gain	Potential Alternatives
Diabetes medications	Insulin, sulfonylureas, TZDs	(Metformin), (GLP-1 agonists), (SGLT2 inhibitors), (pramlintide)
Hypertension medications	Beta-blockers	ACE inhibitors, CCAs, ARBs
Psychiatric medications	Antipsychotics, mirtazapine, TCAs, paroxetine	(Bupropion), nefazodone, fluoxetine
Birth control	Progestational steroids	Barrier methods, intrauterine devices

Apovian CM, et al. J Clin Endocrinol Metab. 2015;100:342-62.

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C: Counseling and Support

- Address weight loss expectations
- Counsel on benefits of modest weight loss
- Use evidence-based counseling strategies

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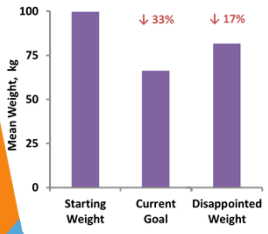
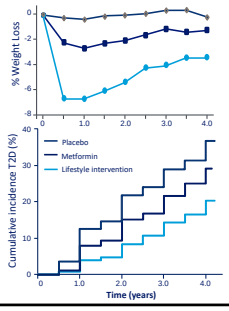
Address Weight Loss Expectations





Ask "permission"
Be systematic in the clinical workup
C
Counseling and support
Determine health status
Escalate treatment when appropriate
Follow up regularly and leverage available resources

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Modest Weight Loss Improves Health and Risks

Weight-related Condition	% Weight Loss for Therapeutic Benefit	References
Diabetes Prevention	3% to 10%	DPP (Lancet, 2009) SEQUEL (Garvey et al, 2013)
Hypertension	5% to >15%	Look AHEAD (Wing, 2011)
Dyslipidemia	3% to >15%	Look AHEAD (Wing, 2011)
HbA1c	3% to >15%	Look AHEAD (Wing, 2011)
NAFLD	10%	Asiry et al, 2007; Dixon et al, 2004; Anish et al, 2009
Sleep Apnea	10%	Sleep AHEAD (Foster, 2009) Winslow et al, 2012
Osteoarthritis	5-10%	Christensen et al, 2007; Felson et al, 1992; Aaboe et al, 2011
Stress Incontinence	5-10%	Burgio et al, 2007 Leslee et al, 2009
GERD	5-10% (women), 10% (men)	Singh et al, 2013 Tutuian R, 2011
PCOS	5-15% (>10% optimal)	Pandis D et al, 2008; Norman et al, 2002; Moran et al, 2013

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Guidelines For Intensive Behavioral Therapy

- Patients should receive a comprehensive behavior management program of at least 6 months (Level A)
- Gold standard is on-site, high-intensity (14+ sessions in 6 months), comprehensive intervention, delivered by trained interventionist (individual or group) and persisting for at least 1 year (Level A)
- Low intensity interventions may not be effective (Level A)
- Other approaches (web, phone) lead to less weight loss (Level B)

AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults. Circulation, 2013.

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Behavioral Therapy for Obesity

Counseling	• Regular, frequent interaction via group or individual contact
Diet	• Reduced energy intake, regardless of macronutrient composition
Physical activity	• 150 minutes/week of moderate activity • Strength training desirable
Behavioral strategies	• Structured curriculum of behavior change education, including identifying target behaviors and building skills to achieve target behaviors • Self-monitoring of food intake, physical activity, and/or weight • Goal setting, problem solving, stimulus control • Addressing barriers to change • Behavioral resources (e.g., portion-controlled meals) • Regular feedback and guidance from an interventionist • Weight maintenance strategies and relapse prevention

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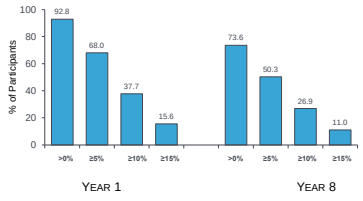
Behavioral Therapy in Obesity/Diabetes



Look AHEAD Research Group. Obesity. 2014;22(1):5-13.

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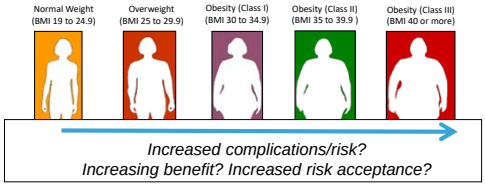
Scott Kahan, MD, MPH - ABCDEF Approach to Obesity Management

D: Determine Health Status



Kahan S, et al. Curr Obes Rep, 2013.

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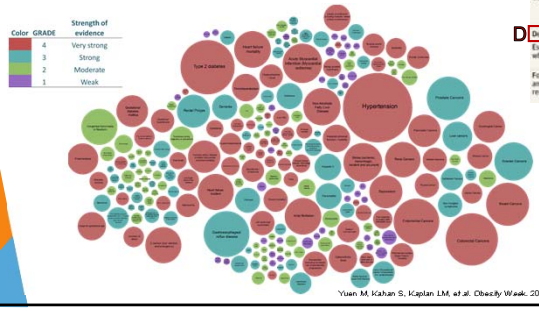

Yuan M, Kahan S, Kaplan LM, et al. Obesity Week. 2016. Poster T-P-3166.

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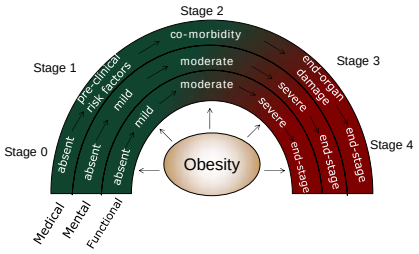
Assess Health Status via Staging



Sharma AM, Kushner RF. IJO 2009.

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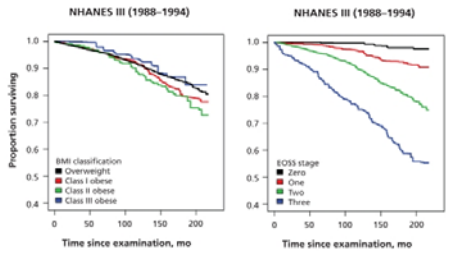
Staging Better Predicts Outcomes



Padwal R, et al. CMAJ 2011.

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2 Patients of Same Age and Weight/BMI

Stage 0

- Feels good
- Physically active
- No known RFs
- No functional limitations
- No mental health issues

Stage 2

- Hypertension
- Diabetes
- Sleep apnea
- Osteoarthritis
- Depression

Is aggressive treatment worth it?
Are less intensive options sufficient?
Is any treatment indicated?

Consider:
- Intensive counseling
- Referral
- Pharmacotherapy
- Bariatric surgery

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E: Escalate Treatment When Appropriate

- Specialist referral
- Medically-monitored structured diets
- Obesity pharmacotherapy
  - BMI >27 kg/m^2 with comorbidities
- Medical devices/endoscopic procedures
  - Generally BMI 30-40+ kg/m^2
- Bariatric surgery
  - BMI >35 kg/m^2 with comorbidities

Kahan S, Manson JE. Obesity Treatment, Beyond the Guidelines. JAMA. 2019;321(14):1349-1350. doi:10.1001/jama.2019.2352

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Medically-Monitored Structured Diet/Counseling

- Comprehensive, high-intensity, specialist-led, on-site lifestyle interventions
- May include a medically supervised low-calorie or very-low-calorie-diet utilizing meal replacement products (Level A)
- Average weight loss of 14-21 kg over 11-14 weeks (Level A)

AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults. Circulation, 2013.

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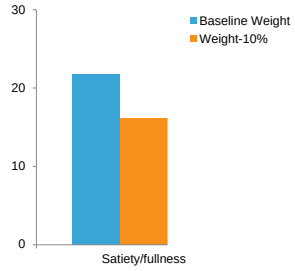
Effect of Weight Loss on Satiety



Kissileff HR, et al. Am J Clin Nutr, 2012.

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Obesity Pharmacotherapy

- 5 FDA-approved short-term medications
  - Phentermine and noradrenergics
- 4 FDA-approved long-term medications
  - Orlistat
  - Phentermine/topiramate ER
  - Naltrexone/Bupropion SR
  - Liraglutide 3.0 mg

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Obesity Pharmacotherapy

- Use pharmacotherapy as adjunct to diet, exercise, and behavioral counseling for adults… (Level 1 evidence)
  - with BMI 30+; or 27+ with comorbidity;
  - who are unable to lose and successfully maintain weight;
  - who meet label indications
- Assess efficacy/safety monthly for three months, then at least quarterly thereafter (Level 2)
- At three months, if ≥5% weight loss, continue; if not, discontinue and seek alternative approaches (Level 1)
- Use medications to promote long-term weight loss maintenance (Level 2)

Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab, 2015.

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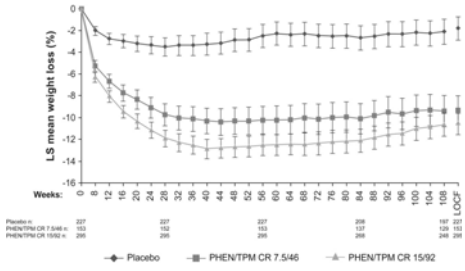
Obesity Pharmacotherapy



Garvey WT, et al. *Am J Clin Nutr*. 2012;95:297-308

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Pharmacotherapy Improves RFs and Prevents Comorbid Conditions

	Orlistat	Phentermine/ topiramate ER	Naltrexone/ bupropion SR	Liraglutide 3.0 mg
WC	↓	↓	↓	↓
BP	↓	↓	↑	↓
LDL	↓↓	↓	↓	↓
HDL	↑	↑	↑	↑
TG	↓↓	↓↓	↓↓	↓↓
HR	↓	-	↑	↑
A1C	↓	↓	↓	↓↓↓

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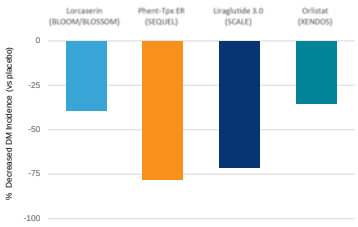
Pharmacotherapy Improves RFs and Prevents Comorbid Conditions



Kahan S, Fujioka K. Diab Spectr, 2018.

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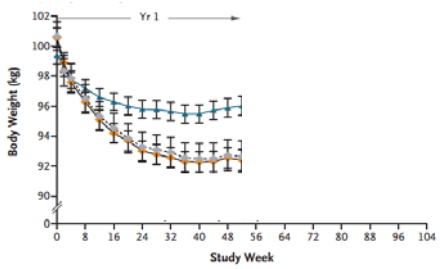
Short versus Long-Term Use



Smith SR, et al. *N Eng J Med*. 2010;363:245-256.

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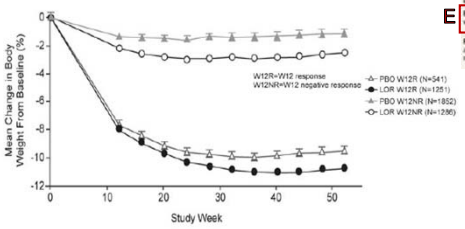
Outcomes by Responder Status



Smith SR, et al. *Obesity*. 2014;22:2137-2146.

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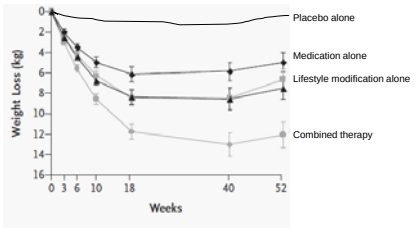
Combination Therapy



Adapted from Wadden, et al. *N Eng J Med*. 2005;353:2111-2120.

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Devices and Endoscopic Procedures

Gastric Band | **Gastric Balloons** | **Plenity Hydrogel** | **Endoscopic Sleeve Gastrectomy**

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Bariatric Surgery Procedures

Roux-en-Y Gastric Bypass

Sleeve Gastrectomy

E

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Guidelines For Bariatric Surgery

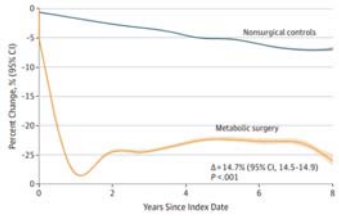
- Advise patients with BMI ≥40 (or ≥35 with comorbidity) that bariatric surgery may be an appropriate option to improve health (Grade A)
- Offer referral to an experienced bariatric surgeon for consultation and evaluation (Grade A)
- Insufficient evidence to recommend for or against surgery for BMI <35
- No clear guidance for medical devices

E

AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults. Circulation, 2013.

50

Bariatric Surgery Outcomes



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Aminian A, et al. JAMA 2019;322(13):1271-82.

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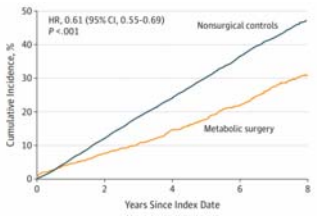
Bariatric Surgery Outcomes



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Aminian A, et al. JAMA 2019;322(13):1271-82.

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An "ABCDEF" Approach to Weight Counseling

Obesity Treatment, Beyond the Guidelines
Practical Suggestions for Clinical Practice

	Steps	What to Do
A	Ask "permission"	• Assess patient readiness to discuss weight issues. Consider begining the conversation with questions such as, "Your weight has been increasing over the years, which could lead to diabetes and other health problems. Would it be okay if we started working together on this?"
B	Be systematic in the clinical workup	• Elicit weight history, motivations, barriers, and social determinants. • Medications that may cause weight gain include some antidepressants, antipsychotics, insulin, sulfonylureas, steroids, and pain medications.
C	Counseling and support	• A wide range of dietary patterns can help weight management. • Physical activity, even just walking, is essential for health. • Use free online tools and resources, such as Dietary Guidelines for Americans, obesity treatment guidelines, and the Diabetes Prevention Program curriculum and handouts.
D	Determine health status	• Evaluate for weight-related health conditions (eg, diabetes, sleep apnea), physical limitations, and decreased quality of life.
E	Escalate treatment when appropriate	• Consider medication (BMI ≥27) or bariatric surgery (BMI ≥35) when weight-related health conditions are present. • Medication options for long-term use include orlistat, lorcaserin, phentermine/topiramate-extended release, naltrexone/bupropion-sustained release, and liraglutide.
F	Follow up regularly and leverage available resources	• Create a care team by identifying local obesity specialists (eg, obesity medicine physicians, registered dietitians), community programs (eg, YMCA-based diabetes prevention program), and other resources (eg, commercial weight-loss programs, health coaches, digital or telehealth platforms). • A few minutes at the end of an unrelated appointment can be used to check in on patients' progress and offer support. • Utilize medical assistants and other office staff to save time by assisting with patient education, monitoring, and coordinating care.

Kahan S, Manson JE. Obesity Treatment, Beyond the Guidelines. JAMA. 2019;321(14):1349-1350. doi:10.1001/jama.2019.2352

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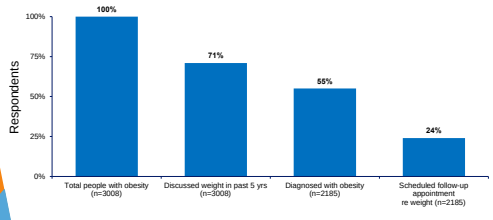
F: Follow Up Regularly, Leverage Resources



F

Kaplan LM, et al. Obesity, 2018.

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Scott Kahan, MD, MPH - ABCDEF Approach to Obesity Management

Follow up, Leverage Resources: *Don't Do It All At Once*

- Weight management is a chronic process
- Don't expect to impact long-term behavioral change during a single episode of care

Ask "permission"
Be systematic in the clinical workup
Counseling and support
Determine health status
Escalate treatment when appropriate
F Follow up regularly and leverage available resources

Kahan S, Manson JE. JAMA 2017.

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Follow up, Leverage Resources: *Don't Do It All On Your Own*

- Utilize a team-based approach
  - Clinical and non-clinical staff
  - Referrals and specialists
    - RDNs, Obesity Medicine physicians, CDEs, psychologists, etc
  - Community-based programs
    - Diabetes prevention programs, others
  - Online/virtual programs

Ask "permission"
Be systematic in the clinical workup
Counseling and support
Determine health status
Escalate treatment when appropriate
F Follow up regularly and leverage available resources

Kahan S, Manson JE. JAMA 2017.

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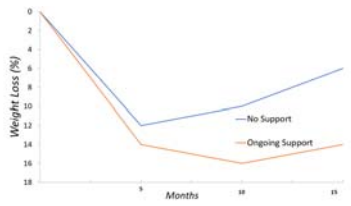
Long-Term Benefits (Generally) Require Continued Management



Perri M, et al. 1990.

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EVIDENCE-BASED OBESITY TREATMENT IN PRIMARY CARE: A PATIENT-CENTERED A-B-C-D-E-F FRAMEWORK

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QUESTIONS & ANSWERS

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Moderator: Lisa K. Diewald MS, RD, LDN
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