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

Scott Kahan MD, MPH

May 20th, 2020

Moderator: Lisa Diewald, MS, RD, LDN

Presenter: Scott Kahan MD, MPH

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00:00:01.620 --> 00:00:15.509
Villanova Webinar 1: Good afternoon. Welcome to COPE's May webinar for health professionals. In this period of social distancing, we're so grateful that you've chosen to attend what promises to be an informative and insightful virtual continuing education opportunity.

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00:00:16.680 --> 00:00:23.010
Villanova Webinar 1: We have 228 health professionals registered for the webinar today. And we're excited to get started.

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00:00:23.700 --> 00:00:36.540
Villanova Webinar 1: My name is Lisa Diewald. I am the Program Manager for the MacDonald Center for Obesity Prevention and Education at Villanova University's Fitzpatrick College of Nursing. I have the pleasure of being the moderator for today's program.

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Villanova Webinar 1: Despite the overwhelming prevalence of overweight and obesity in the US and globally, when we really take a hard look at it, obesity is really rarely discussed, assessed, or treated in clinical practice.

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Villanova Webinar 1: Time limitations, absence of formal training during clinical education, limited translation and communication of evidence based guidelines,

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Villanova Webinar 1: And perhaps a level of discomfort about bringing up the topic in an insensitive way

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Villanova Webinar 1: have all been implicated in this deficiency. We are so excited that this gap is being addressed on a national level and we're thrilled that Dr. Scott Kahan is here with us to walk us through a practical systematic approach

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Villanova Webinar 1: to incorporating evidence -based obesity management strategies into clinical practice.

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Villanova Webinar 1: Villanova University's M. Louise Fitzpatrick College of Nursing is home to the first College of Nursing in the country to have a center devoted exclusively to obesity prevention and education.

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Villanova Webinar 1: As the bottom of the slide illustrates, COPE's goals are to enhance nursing education and topics related to nutrition, obesity prevention, and health promotion strategies.

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00:01:46.770 --> 00:02:04.590
Villanova Webinar 1: Next, to provide continuing education programs such as this webinar on obesity and obesity related diseases for health professionals and educators, and finally to participate in research to expand and improve evidence-based approaches for obesity prevention and education in the community.

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00:02:10.470 --> 00:02:28.470
Villanova Webinar 1: Before we begin the presentation, I would just like to remind our listeners that PDFs of today's PowerPoint slides are posted on the homepage of cope. at villanova.edu/cope. After going to COPE's website, simply click on a webinar description page for this month's webinar.

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00:02:29.670 --> 00:02:37.290
Villanova Webinar 1: Please use the question and answer box on your screen to submit questions for our speaker. All questions will be answered

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Villanova Webinar 1: as time permits. The expected length of the webinar is one hour. The session, along with the audio transcripts, will be recorded and placed on the COPE website within the next week.

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00:02:50.700 --> 00:03:05.340
Villanova Webinar 1: If you use your phone to call into the webinar today and want the credit for attending the webinar, please take a moment afterwards to email us at cope@villanova.edu and provide your name, so that we can send you your CE certificate.

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00:03:07.560 --> 00:03:15.510
Villanova Webinar 1: The objectives for today's webinar are to discuss the factors contributing to limited attention to obesity counseling in clinical practice,

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Villanova Webinar 1: to understand the value of a systematic approach to obesity management and to learn a practical structured approach to addressing obesity in clinical practice.

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Villanova Webinar 1: Villanova University College of Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center Commission on Accreditation.

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Villanova Webinar 1: Villanova University College of Nursing Continuing Education/COPE is also a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration.

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Villanova Webinar 1: Our webinar this month awards one contact hour for nurses and one CPEU for dietitians and dT ours. The suggested CDR learning need codes are 5000 5370 6000 and 9020 and the CDR level of this webinar is two.

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00:04:10.380 --> 00:04:14.580
Villanova Webinar 1: Now I have the great privilege of introducing our speaker for today's webinar.

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Villanova Webinar 1: Scott Kahan MD, MPH is Director of the National Center for Weight and Wellness in Washington DC and Medical Director of the Strategies to Overcome and Prevent (STOP) Obesity Alliance at George Washington University.

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Villanova Webinar 1: He leads a multi-disciplinary obesity and chronic disease management staff, manages the care of patients with obesity and obesity related disorders,

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Villanova Webinar 1: and oversees the development and implementation of clinical programs for obesity prevention and treatment as well as clinical and health services research.

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00:04:51.630 --> 00:05:05.280
Villanova Webinar 1: In addition, he serves on the faculty of Johns Hopkins University Bloomberg School of Public Health and has authored numerous peer reviewed scientific articles and text focusing on obesity, preventive medicine, and public health.

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00:05:05.790 --> 00:05:13.980
Villanova Webinar 1: Dr. Kahan earned his MD from Medical College of Pennsylvania and completed residency training at Johns Hopkins University.

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Villanova Webinar 1: He is the recipient of many awards for his work, including clinician of the year from the Obesity Society and healthcare provider advocate of the year from the Obesity Action Coalition.

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00:05:26.820 --> 00:05:36.360
Villanova Webinar 1: While we're planning for Dr. Kahan's presentation to begin, I just wanted to mention that neither the presenter, nor the planners of this webinar, have any disclosures to report.

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00:05:36.990 --> 00:05:49.380
Villanova Webinar 1: Accredited status does not imply endorsement by Villanova University, COPE, or the American Nurses Credentialing Center of any commercial products or medical nutrition advice displayed in conjunction with an activity.

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00:05:49.890 --> 00:05:54.480
Villanova Webinar 1: And so with that, I welcome Dr. Kahan to our COPE webinar program and I will

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Villanova Webinar 1: turn over controls to him for his presentation, so welcome

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Villanova Webinar 1: Dr. Kahan. Glad to see you.

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Scott Kahan MD, MPH : Thank you, Lisa. Thanks everyone for joining us today. I hope everyone's staying safe and reasonably sane under these very unique conditions that we're all living under.

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00:06:18.270 --> 00:06:30.030
Scott Kahan MD, MPH : And I'm so glad to be here to be able to spend some time to talk about this important topic and also hopefully to have a bit of a discussion about it. We have the opportunity for questions and answers at the end.

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Scott Kahan MD, MPH : I'll try to leave as much time as possible. So let's see if we can get in here.

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Scott Kahan MD, MPH : There we go. And Lisa did a great job of introducing so I'm just going to dive right in here. And I'd love to start with asking you all a question.

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Scott Kahan MD, MPH : And so if you feel like it you can, in the chat section, put your answer to this question. So the question is, which of these best characterizes your beliefs about obesity treatment?

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00:07:02.370 --> 00:07:16.050
Scott Kahan MD, MPH : Is it A. obesity is a medical condition and it's the health care provider's responsibility to ensure that patients are appropriately counseled and appropriately provided treatment for obesity when indicated, or B.

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Scott Kahan MD, MPH : Obesity is a personal issue; It's the patient's responsibility to ensure that he or she gets the help they need.

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Scott Kahan MD, MPH : Or C. obesity is a medical and a personal issue; the responsibility for addressing obesity is shared between healthcare providers and patients.

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Scott Kahan MD, MPH : Or would you say 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.

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Scott Kahan MD, MPH : So let's see what you guys think about this.

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Scott Kahan MD, MPH : There's a bunch of answers already coming in. I'll keep you in suspense for just a few moments, but I'll say that there is quite consistent answers here.

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Scott Kahan MD, MPH : I'm seeing about 30 answers. And if they keep going and virtually every one is for C. Now that's what I expected, but believe it or not,

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Scott Kahan MD, MPH : just a few years ago when I'd asked this question, it was not a clear answer for everyone. There were a lot of people who said D. patients should just go and take care of themselves; Eat less exercise more, and don't burden the healthcare provider. There were some A's and B's and such.

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Scott Kahan MD, MPH : But increasingly, the answer to this question when I asked a range of different health care providers

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Scott Kahan MD, MPH : More and more consistently is C. That's what I would answer as well. It's a medical issue, it's a personal issue. And there's responsibility across the board

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Scott Kahan MD, MPH : for how to go about this in the most productive way possible. So I'm glad that we're all largely on the same page here but again, that's changed pretty quickly.

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Scott Kahan MD, MPH : Now, given that virtually everyone here agrees that it's both patient and provider responsibility most likely, look at some data that I'm going to show you here. So first of all,

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Scott Kahan MD, MPH : There's part of this study that we did a few years ago, one of the questions we asked to

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Scott Kahan MD, MPH : 1500 primary care providers; and that was split between internal medicine doctors, OBGYN and nurse practitioners

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Scott Kahan MD, MPH : when we asked, whose responsibility is it to ensure that a patient is counseled about obesity.

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Scott Kahan MD, MPH : You see there virtually everyone, about 65 to 70% agree it's both the patient and provider responsibility. Another 30 -35% of say it's my responsibility as a healthcare provider. So close to 100% agree that the health care provider, at least has part of the responsibility,

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Scott Kahan MD, MPH : if not all of the responsibility with respect to obesity counseling.

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Scott Kahan MD, MPH : Here's the problem. Despite that, and despite what we all answered, almost all of us answered in the chat box. Look at what actually happens. So on the left hand side here.

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Scott Kahan MD, MPH : This is from the last slide about 97-98% of the healthcare providers that we asked said

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Scott Kahan MD, MPH : that it's either their responsibility or combination of their responsibility and the patient's responsibility.

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Scott Kahan MD, MPH : But when we look at what healthcare providers are actually doing, very different story. Simple diagnosis of obesity happens in a minority of patients. When we look across the board.

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Scott Kahan MD, MPH : BMI greater than 30, much less than 25%. Even when we look in BMI greater than 50; So these are people who are 200 pounds overweight or so,

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Scott Kahan MD, MPH : It's still only about 50% that get a diagnosis of obesity. Typically in the healthcare system, when you don't have a diagnosis, often

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Scott Kahan MD, MPH : you don't get treatment. So, that is an important issue in terms of documentation in patients' charts. Again, very low, this data that I'm showing here.

62
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Scott Kahan MD, MPH : About 30 to 35% of people have documentation of obesity and this is among patients who are about to undergo bariatric surgery. So we're talking about patients with pretty severe obesity, when we look across the board and everyone that has

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Scott Kahan MD, MPH : some excess weight or BMI of 35 etc. it's much, much lower.

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Scott Kahan MD, MPH : What about discussion about obesity and counseling? So when you look at greater than a BMI of 25, it's only about 50% that get any degree of discussion, and that can be as little as a few seconds. When we look at actual

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Scott Kahan MD, MPH : counseling, it's not that much higher. It's only about two thirds of people. And here we're talking about again, severe obesity. When we look across the board, BMI of 25, BMI of 30 and greater, it's much lower than this.

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Scott Kahan MD, MPH : And then when we look at the actual treatment options beyond that intensive behavioral therapy, which is a structured and ongoing

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Scott Kahan MD, MPH : therapy process. Among Medicare patients, less than .5% actually get intensive behavioral therapy and this is covered by Medicare.

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Scott Kahan MD, MPH : When we look at bariatric surgery, only about 2% of eligible patients get bariatric surgery. When we look at FDA approved medications, only about 1 or 1.5% of people who are eligible for obesity medications are getting a prescription for them. So there's this

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Scott Kahan MD, MPH : Doctors overwhelmingly believe that they have a responsibility.

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Scott Kahan MD, MPH : to help their patients with obesity, but yet, for things as simple as making a diagnosis and having some discussion with patients;

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Scott Kahan MD, MPH : Two things like referring for bariatric surgery or considering FDA approved medications or the like, it's a minority of cases

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Scott Kahan MD, MPH : that have varying degrees of treatment. So this is a problem. There's a number of reasons for it. Certainly limited amounts of time in primary care is relevant.

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Scott Kahan MD, MPH : Lack of training of at least of primary care physicians is an issue. But one of the things that come up consistently is that most clinicians say they don't have

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Scott Kahan MD, MPH : effective guidelines to follow. Some say they don't even know that they have any obesity treatment guidelines available to them. Others say there are too many and they don't know how to

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Scott Kahan MD, MPH : cut through all that noise and still, others say that they've seen the guidelines, but they're just too complex and they can't really understand them and put them into practice.

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00:14:07.050 --> 00:14:18.540
Scott Kahan MD, MPH : That's understandable. We have a lot of guidelines out there. There is many, many more than just these, but these are the ones that are generally considered the most useful.

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Scott Kahan MD, MPH : These are put out by the Obesity society, The American College of Cardiology, and the American Heart Association very in depth high quality guidelines, but also very nuanced and

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Scott Kahan MD, MPH : and dense. So it's very hard to read through those. The Endocrine Society has a guideline focused on obesity pharmacotherapy medication use.

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Scott Kahan MD, MPH : The American College of Endocrinology and the American Association of Clinical Endocrinologists have another very dense evidence-based guideline. There's a very

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Scott Kahan MD, MPH : in-depth, dense metabolic surgery or bariatric surgery guideline. There's an obesity algorithm from The Obesity Medicine Association and many, many others, and so on the one hand, you can see lots of good options here.

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Scott Kahan MD, MPH : But it's easy to get caught up with, where do I go when; which do I read and

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Scott Kahan MD, MPH : have a hard time just cutting through all of those and knowing what to use. And although I don't have a slide of that, if I were to show you an example page from any of these,

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Scott Kahan MD, MPH : They're pretty dense and in-depth. So unless you have quite a bit of background in obesity science, it can be hard to decipher.

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Scott Kahan MD, MPH : So a few years ago, I was asked by the editors of JAMA along with a colleague of mine to put together, to distill these guidelines into a useful, usable practical

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Scott Kahan MD, MPH : resource for primary care physicians and other relevant clinicians to help them to better engage on the topic of obesity in their patients. And that led to this ABCDEF approach. We published it in JAMA

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Scott Kahan MD, MPH : about a year, year and a half ago now. And that's what I'm going to step you through over the course of the rest of this webinar.

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Scott Kahan MD, MPH : I'm gonna go slow. Let's see.

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Scott Kahan MD, MPH : There we go. Alright, so let's dive right in. First, we have A and that's Ask Permission and this may seem like a weird thing to say. We don't tell

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Scott Kahan MD, MPH : doctors or other clinicians that are seeing a patient with diabetes or cancer or the like. We don't ask them to ask permission before talking about diabetes with a patient, for example.

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Scott Kahan MD, MPH : But with obesity, this is a very different scenario. Many people, their weights, their appearance, their size or shape

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00:17:06.390 --> 00:17:22.890
Scott Kahan MD, MPH : is among the most sensitive things in their lives. And so, asking permission is an incredibly valuable way to break the ice on what can otherwise be a very sensitive and difficult discussion, both for the patient and the clinician.

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Scott Kahan MD, MPH : But something as simple as a question like this over the last few years, your weight has been increasing, and I'm concerned that it may lead to diabetes or other health problems. I have

94
00:17:33.930 --> 00:17:44.880
Scott Kahan MD, MPH : a good background in this, and I'd love to be here to help you and support you. Would it be okay if we could start working together on this? And in most cases, when asked in that way,

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Scott Kahan MD, MPH : patients will be eager to open up with their clinician and to talk about their way to get help with weight management and they'll be better off for it.

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00:17:59.130 --> 00:18:03.450
Scott Kahan MD, MPH : And so, asking permission is a really valuable strategy.

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Scott Kahan MD, MPH : The other thing that it can be really helpful for, especially in primary care is a lot of clinicians find it really hard to open up the discussion. They don't know if they're going to offend someone

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Scott Kahan MD, MPH : if they bring up their weight. They don't know how to do it in a way where they feel comfortable and

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Scott Kahan MD, MPH : feel like opening up the discussion. And so this is, it's almost like a cheat sheet. It's an easy way, again, to break the ice on an otherwise sensitive

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Scott Kahan MD, MPH : conversation. Now, in my experience, overwhelmingly when you ask a patient permission, they're eager to start talking about it and getting support. But sometimes, patients aren't ready.

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00:18:48.060 --> 00:18:56.700
Scott Kahan MD, MPH : And when it comes up in a clinical interaction, it may take them by surprise, and that they don't want to talk about it. And we should, of course,

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00:18:57.600 --> 00:19:03.960
Scott Kahan MD, MPH : go with their wishes on that. But even when a patient says that they don't want to talk about it, they don't want to work on it;

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00:19:04.710 --> 00:19:17.580
Scott Kahan MD, MPH : by bringing it up in a sensitive, thoughtful way like this, it sets the stage and the patient's mind that when the time comes, that you're someone that they can go to.

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Scott Kahan MD, MPH : You're someone that will treat them with respect and will be helpful for them in this challenging area. And so even if they're not interested,

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Scott Kahan MD, MPH : starting off by asking permission can do so much to advance the opportunity here that I think it's still a very valuable thing to do.

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Scott Kahan MD, MPH : So please keep that in mind. I'm glad that Ask starts with A. So I really do believe that this is the foremost strategy in starting the discussion with patients. So that's why we started in our ABCDEF

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00:20:01.350 --> 00:20:16.590
Scott Kahan MD, MPH : resource here. So now let's move on. Now we're at B. Be systematic in the clinical workup. So for primary care clinicians, what often happens with respect to weight

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00:20:17.250 --> 00:20:20.370
Scott Kahan MD, MPH : is either the clinician doesn't bring it up at all

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00:20:20.850 --> 00:20:33.630
Scott Kahan MD, MPH : or maybe bring it up, but in a way that often isn't very helpful at all. They might just say hey, you know you're really gaining some weight, you should just eat less and exercise more, and then you'll lose the weight and won't get the diabetes and so forth.

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Scott Kahan MD, MPH : But clearly just telling people to eat less and exercise more isn't likely going to be helpful. Most people know

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Scott Kahan MD, MPH : that eating well and exercising is relevant in terms of weight management.

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Scott Kahan MD, MPH : Most people also have experience to know that just simply trying to eat less and exercise more by itself is probably not going to be enough, particularly when you've been struggling with a lot of weight for much of your life.

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00:20:59.610 --> 00:21:08.790
Scott Kahan MD, MPH : People need help. They need support. They need guidance. They need help figuring out what's making it so hard for them to manage their weight or to keep off the weight.

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00:21:09.090 --> 00:21:22.230
Scott Kahan MD, MPH : And they need a systematic, thoughtful approach. So we should all stay away from these admonitions to just eat less, exercise more, and instead think about this in a more systematic and thoughtful way.

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00:21:22.740 --> 00:21:38.850
Scott Kahan MD, MPH : And so one of the ways of starting that and I think probably the most important way is to start by Eliciting a weight history. This is analogous to what we would do if we see a patient in the clinic coming in with a headache or coming in with

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00:21:39.870 --> 00:21:52.860
Scott Kahan MD, MPH : any other chief complaint. We want to best understand what's going on, what plays into it and then see how that information informs how we can go about helping them in a systematic way.

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00:21:53.520 --> 00:22:05.160
Scott Kahan MD, MPH : So in medical school, I learned this process, the O P Q R S T for structuring a weight history. And I think it's very relevant in terms of

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Scott Kahan MD, MPH : I'm sorry I we learned the O P Q R S T in terms of a medical history for any presenting issue. It's very relevant for a weight history as well.

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00:22:16.380 --> 00:22:27.900
Scott Kahan MD, MPH : And so the O stands for onset. So when did the obesity and weight gain start? When did the weight start going up? What was the lightest and heaviest weights that you've experienced as an adult?

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Scott Kahan MD, MPH : Were you heavy as a child or not and so on and so forth that gives a lot of insights into what may be playing into the weight.

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Scott Kahan MD, MPH : Precipitating factors are important. So what type of life events, for example, may have been associated with the weight gains

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Scott Kahan MD, MPH : Or reversals and weight losses could be stressful experiences could be big life changes like marriage, divorce graduation, a new stressful job and so on and so forth.

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Scott Kahan MD, MPH : Then Q is quality of life. How does your weight affect your life? What, weight did you feel your best? In many cases, particularly for people who are not coming into

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Scott Kahan MD, MPH : their primary care doctor, their dietitian or the like specifically for weight management,

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Scott Kahan MD, MPH : We're going to have to help them to get to a place where addressing their weight feels more meaningful to them. Typically

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Scott Kahan MD, MPH : doing it in ways that improve how they feel, how they can live their lives, how their quality of life is rather than just simply losing weight to see the scale but down.

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Scott Kahan MD, MPH : Typically those things are going to be much more meaningful and therefore be associated with more motivation for progress.

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Scott Kahan MD, MPH : Then R is remedy. So what have you done to for to control your weight? What sorts of diets have you tried? What sorts of resources have you tried?

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Scott Kahan MD, MPH : That often gives us a lot of insights, because some of those, we can just restart if it was helpful in the past. Others have those when we see that they have had a poor

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Scott Kahan MD, MPH : experience with this type of approach or that type of approach, that also gives us insight, perhaps into what we want to avoid or into learning more.

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Scott Kahan MD, MPH : S is for setting. So what was going on differently in your life when you feel more in control weight versus times more challenging?

132
00:24:25.590 --> 00:24:32.280
Scott Kahan MD, MPH : And T is temporal pattern. So what's the pattern of the weight gain? Have you just been gaining, gaining, gaining ever since you

133
00:24:32.790 --> 00:24:51.660
Scott Kahan MD, MPH : graduated from college for example. Has it been up and down and up and down, etc. So this is where I suggest every single clinicians. Start with their approach to weight counseling in your practice. Now I'll show you on the next slide here.

134
00:24:53.250 --> 00:24:55.740
Scott Kahan MD, MPH : This is an example of a weight life chart.

135
00:24:56.400 --> 00:25:05.640
Scott Kahan MD, MPH : I would imagine that most of you who spend a lot of time doing weight counseling probably have these available for patients to fill out. I find that incredibly valuable.

136
00:25:05.880 --> 00:25:13.260
Scott Kahan MD, MPH : So you can see on the Y axis here patients can graph their weight and on the X axis, they can graph the period of time.

137
00:25:13.740 --> 00:25:30.060
Scott Kahan MD, MPH : And by no means do they need to be precise around this. Even general curves are very helpful. So here you can see this person tended to gain weight as they develop depression. And then, especially as they're put on medications that tend to cause weight gain.

138
00:25:31.170 --> 00:25:42.630
Scott Kahan MD, MPH : So that gives us a lot of insight into what we can do, if they're still on the medication that cause weight gain, that might be something where we can work with their psychiatrists to switch to something that is more weight neutral.

139
00:25:43.800 --> 00:25:56.490
Scott Kahan MD, MPH : On the other hand, here is a person that's had this yo yo dieting history, probably a history of eating disorder than it particularly goes up when prior therapist asked her to

140
00:25:57.060 --> 00:26:08.250
Scott Kahan MD, MPH : encourage the natural eating, rather than diet. That may be very helpful, natural eating. Although, in my experience, when people are told to do natural eating or

141
00:26:08.760 --> 00:26:15.390
Scott Kahan MD, MPH : intuitive eating or the like, it's often not all that intuitive and often they don't get enough

142
00:26:16.080 --> 00:26:25.980
Scott Kahan MD, MPH : guidance in what to do. And so they often start to gain more weight and that may be fine if they get away from some of the challenges that they've had with dieting.

143
00:26:26.250 --> 00:26:36.600
Scott Kahan MD, MPH : That may end up being a better outcome, but my hope is that we can do both, not gain weight while also staying away from restrictive dieting.

144
00:26:37.350 --> 00:26:47.970
Scott Kahan MD, MPH : But the point here, big picture is that everybody has a different history. Everybody has a different pathway by which they gain weight and different factors

145
00:26:48.150 --> 00:26:57.360
Scott Kahan MD, MPH : and causes for the weight gain. And if we can start to visualize those, it gives us a lot of insight into how we can go about helping the patient.

146
00:26:59.250 --> 00:27:07.950
Scott Kahan MD, MPH : The other thing that a weight history gives us a lot of information about possible treatments. I can give you a lot of examples on this. I'll give you just two right here.

147
00:27:08.340 --> 00:27:19.320
Scott Kahan MD, MPH : The first is, if we have a history showing that a patient has binge eating disorder that gives us a lot of insight, because one, we want to treat the binge eating disorder.

148
00:27:19.620 --> 00:27:27.120
Scott Kahan MD, MPH : Because often, the binging disorder has more of an impact on quality of life than the excess weight does. But on top of that,

149
00:27:27.600 --> 00:27:40.740
Scott Kahan MD, MPH : we have lots of data showing that having binge eating disorder typically gets in the way of many weight treatments and many weight loss treatments. So here's an example in patients that undergo a medically monitored

150
00:27:41.580 --> 00:27:49.590
Scott Kahan MD, MPH : diet. Those that don't have binge eating disorder, almost all of them have at least decent outcomes, if not very good outcomes.

151
00:27:49.890 --> 00:27:57.840
Scott Kahan MD, MPH : Whereas in patients who have binge eating disorder; they are the ones that tend to have poor outcomes. Not all of them but a good number of them.

152
00:27:58.140 --> 00:28:07.110
Scott Kahan MD, MPH : And so if we knew before the fact that the patient has binge eating disorder, then of course we would go away from a treatment like this, and instead treat the binge eating disorder.

153
00:28:07.470 --> 00:28:12.990
Scott Kahan MD, MPH : Here's another example with bariatric surgery. While the overwhelming proportion of people who have

154
00:28:13.440 --> 00:28:26.250
Scott Kahan MD, MPH : surgery will lose weight, big difference between people who have binge eating disorder prior to the surgery versus who don't. People with binge eating disorder tend to lose less weight and tend to have more of a likelihood of regain.

155
00:28:28.020 --> 00:28:36.990
Scott Kahan MD, MPH : And so that's one example of why it's so important to learn more about the patient before just diving into dietary counseling

156
00:28:37.440 --> 00:28:40.800
Scott Kahan MD, MPH : or other types of counseling. It doesn't necessarily mean by the way

157
00:28:41.220 --> 00:28:51.960
Scott Kahan MD, MPH : that patients with a history of binge eating disorder can't get bariatric surgery or do other treatments. Although, we want to make sure that the binge eating disorder is treated before we consider those things, if at all.

158
00:28:52.530 --> 00:29:03.780
Scott Kahan MD, MPH : Another example I had mentioned briefly earlier is using the weight history to identify if a patient is on a medication that can cause weight gain.

159
00:29:04.050 --> 00:29:16.710
Scott Kahan MD, MPH : And there are many of them out there. And in general, the medications that can cause weight gain are otherwise very good medications. But they have this potential side effect of weight gain. Many diabetes medications can cause it.

160
00:29:17.400 --> 00:29:27.690
Scott Kahan MD, MPH : Some hypertension medications. Many psychiatric medications and progesterone birth control pills, particularly injectable progesterone

161
00:29:28.440 --> 00:29:40.620
Scott Kahan MD, MPH : birth control treatments. So, sometimes we just don't have an opportunity to change if they need to be on that medication and that is what it is. But far more often, we are able to address that

162
00:29:40.980 --> 00:29:48.630
Scott Kahan MD, MPH : by changing to a medication that will do the same thing in terms of the benefit, but won't have the same risks of weight gain.

163
00:29:48.930 --> 00:30:01.980
Scott Kahan MD, MPH : And so you can see some examples here for alternative diabetes medications, hypertension medications, and so on and so forth. The ones that have a parenthesis around it actually suggest that some weight loss would be

164
00:30:02.400 --> 00:30:08.940
Scott Kahan MD, MPH : expected. The ones that don't have the parenthesis are just weight neutral, we wouldn't expect weight gain or weight loss.

165
00:30:09.360 --> 00:30:23.250
Scott Kahan MD, MPH : So again, without a weight history, no way to know if the patient is on these medications. But, when we get that information, it gives us a lot of leverage to help the patient. So these are just two examples of many, many other

166
00:30:23.730 --> 00:30:28.950
Scott Kahan MD, MPH : important information that will come out of a weight history, but really good places to start.

167
00:30:32.670 --> 00:30:35.370
Scott Kahan MD, MPH : So then we get to C, counseling and support.

168
00:30:36.420 --> 00:30:49.080
Scott Kahan MD, MPH : So the first thing I recommend with counseling is to address weight loss expectations. Then we want to counsel on the benefits of modest weight loss and we of course want to use evidence-based counseling strategies.

169
00:30:49.590 --> 00:30:55.590
Scott Kahan MD, MPH : So there's overwhelming evidence showing that people who want to lose weight, almost always have

170
00:30:56.160 --> 00:31:06.030
Scott Kahan MD, MPH : way out of proportion expectations for what is reasonable for weight loss. So this is one study that was published some time ago.

171
00:31:06.540 --> 00:31:17.400
Scott Kahan MD, MPH : You see here the starting weight, their goal weight and this was just a basic behavioral weight loss plan. Their goal weight was 33% weight loss.

172
00:31:18.150 --> 00:31:21.000
Scott Kahan MD, MPH : You don't even get that with most bariatric surgery.

173
00:31:21.690 --> 00:31:27.960
Scott Kahan MD, MPH : And yet, just from doing some basic counseling, people were expecting to lose 33% weight loss.

174
00:31:28.200 --> 00:31:44.400
Scott Kahan MD, MPH : And then when we asked what their disappointed weight was, it was still 17% weight loss. So even with the least aggressive bariatric surgery, that's lap band, you get less than 17% . We have great medications for obesity management which I'll show you that in a minute.

175
00:31:45.570 --> 00:31:58.710
Scott Kahan MD, MPH : You don't get near 17% and even with expert counseling by a dietitian or others, you don't, on average, get anywhere near 17% and yet they would be disappointed with 17%.

176
00:31:59.820 --> 00:32:15.000
Scott Kahan MD, MPH : So we're setting people up for failure and for frustration. If we don't help to better align their expectations with reality from the get go. It's not an easy thing to do, but it's an important thing to do.

177
00:32:16.350 --> 00:32:26.670
Scott Kahan MD, MPH : Now the good news is much smaller weight losses lead to substantial improvements in health in most people. So here's one example from the diabetes prevention program.

178
00:32:27.210 --> 00:32:35.850
Scott Kahan MD, MPH : This was a randomized control trial for patients with obesity and prediabetes. They were randomized either essentially just a placebo

179
00:32:36.180 --> 00:32:46.830
Scott Kahan MD, MPH : or metformin, which usually leads to a little bit of weight loss or moderate counseling with a goal weight loss of 7% of goal of 500 calories lower

180
00:32:47.340 --> 00:33:01.800
Scott Kahan MD, MPH : intake and a goal of essentially 20 minutes of walking a day. You can see people lost exactly that 7% and they kept much of it off over the next several years . And look what happens in terms of diabetes outcomes, which was the primary goal of that trial.

181
00:33:02.670 --> 00:33:11.430
Scott Kahan MD, MPH : And people who were on the placebo. They had a steady rate of developing diabetes and people in the metformin group here,

182
00:33:11.910 --> 00:33:23.700
Scott Kahan MD, MPH : they had a 30% lower likelihood of getting diabetes. That's what metformin does. But in people in the basic lifestyle intervention, 60% lower likelihood of developing diabetes.

183
00:33:23.940 --> 00:33:30.150
Scott Kahan MD, MPH : And that's from just 7% weight loss, even if half of it is regained over the next few years.

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00:33:30.780 --> 00:33:38.460
Scott Kahan MD, MPH : So we want to address these expectations in part because very modest weight loss is easier to wrap your head around.

185
00:33:39.120 --> 00:33:50.280
Scott Kahan MD, MPH : And still does very, very impressive things in terms of health. Here's just a little bit more, we see across the board so many weight related conditions that are improved

186
00:33:50.520 --> 00:34:07.800
Scott Kahan MD, MPH : by as little as 3%, maybe 5%, maybe seven or 10% weight loss. You don't necessarily need to get down to a BMI of 25. You don't necessarily need to lose 50 or 100 pounds, like most people think they do. Small weight losses leads to a lot of benefits.

187
00:34:09.150 --> 00:34:20.070
Scott Kahan MD, MPH : So the guidelines for intensive behavioral therapy in primary care is at least six month programs that ideally should be a comprehensive behavioral counseling.

188
00:34:20.520 --> 00:34:34.530
Scott Kahan MD, MPH : The gold standard is onsite high-intensity comprehensive intervention. The high-intensity refers to the frequency of interaction, at least 14 sessions over six months, and it could be individual or by group.

189
00:34:35.550 --> 00:34:44.370
Scott Kahan MD, MPH : Low-intensity intervention. So just seeing someone once every couple months, probably doesn't work well for most people. That's what the evidence shows.

190
00:34:44.880 --> 00:34:56.910
Scott Kahan MD, MPH : And then web and phone approaches do tend to work well, usually a little bit less well but still effective for most people, which is certainly good nowadays when of course most things are virtual.

191
00:34:59.040 --> 00:35:14.040
Scott Kahan MD, MPH : Behavioral therapy should include regular frequent interaction reduced energy intake, regardless of macro nutrient composition. So patient preference in terms of what type of dietary approach they want to do is largely the primary

192
00:35:15.690 --> 00:35:23.580
Scott Kahan MD, MPH : driver there. Whether you count calories or not, reducing energy intake is at the core of losing weight.

193
00:35:24.420 --> 00:35:33.090
Scott Kahan MD, MPH : Physical activity is important, particularly with strength training. Then we should be guiding patients through a structured curriculum of behavior change education.

194
00:35:33.330 --> 00:35:40.530
Scott Kahan MD, MPH : That includes identifying the target behaviors and helping support them as they build the skills to achieve those target behaviors.

195
00:35:40.800 --> 00:35:50.670
Scott Kahan MD, MPH : And then to continue to maintain the weight loss. So self-monitoring and goal setting, problem solving, and so on and so forth. These are all important behavioral strategies.

196
00:35:52.290 --> 00:36:01.770
Scott Kahan MD, MPH : And behavioral therapy works very well among patients with diabetes and obesity with the type of behavioral therapy that I showed in the last few slides.

197
00:36:02.250 --> 00:36:09.120
Scott Kahan MD, MPH : We get very good weight loss over a year but also even eight or more years down the line to the point where

198
00:36:09.660 --> 00:36:22.290
Scott Kahan MD, MPH : three out of four people who are keeping off at least some weight over the course of the years. Half keeping off at least 5% and about a quarter keeping off at least 10%

199
00:36:22.860 --> 00:36:35.100
Scott Kahan MD, MPH : maybe even 15%. This is where we start to see bariatric surgery levels of weight loss across the board. And in this study people have improved A1C in diabetes,

200
00:36:35.610 --> 00:36:46.080
Scott Kahan MD, MPH : improved lipids waist circumference, blood pressure, and so forth. And in the group that lost at least 10%, they also had a decreased risk of heart attacks and strokes.

201
00:36:48.390 --> 00:36:59.640
Scott Kahan MD, MPH : So then we get to D, determine health status. So, there tends to be this assumption that people who are heavier are sicker

202
00:37:00.180 --> 00:37:03.810
Scott Kahan MD, MPH : and have more complications from their weight

203
00:37:04.290 --> 00:37:14.610
Scott Kahan MD, MPH : and that they would get more benefit from losing weight, and that they would have more of a risk acceptance. In other words, they're willing to do more aggressive treatments, because they have more weight to lose.

204
00:37:14.940 --> 00:37:24.870
Scott Kahan MD, MPH : But when we look at that in studies, it's not actually true. Many people who are heavier aren't necessarily less healthy than people who are only a little heavy and vice versa.

205
00:37:25.320 --> 00:37:34.650
Scott Kahan MD, MPH : And so it puts us in a bit of a difficult situation. In general, we want to be thinking about health status as a function of actual health.

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00:37:35.010 --> 00:37:41.940
Scott Kahan MD, MPH : So when somebody comes in, who's heavy, whether they're 20 pounds or 50 pounds overweight, we want to look at the weight related health

207
00:37:42.420 --> 00:37:53.070
Scott Kahan MD, MPH : conditions that they may have. And there are many. We have a beeper out showing that there's 236 diseases associated with obesity. This is from a figure

208
00:37:54.000 --> 00:38:02.490
Scott Kahan MD, MPH : Many of the ones that you know about hypertension, diabetes, but many, many others, hard to even see. There's so many here, 24 different cancers,

209
00:38:03.030 --> 00:38:12.180
Scott Kahan MD, MPH : diseases of every part of the body. So that's how we want to appreciate what their health status is and that informs how aggressive our treatment should be.

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00:38:12.810 --> 00:38:22.290
Scott Kahan MD, MPH : And we have very good data that when we do that, it leads to better outcomes. So this could essentially be thought of as staging, just like we stage a cancer

211
00:38:22.470 --> 00:38:30.900
Scott Kahan MD, MPH : to see how aggressive this and therefore how aggressive our treatment is. We can do the same thing with weight independent of what someone's BMI or weight is.

212
00:38:31.200 --> 00:38:40.170
Scott Kahan MD, MPH : If we look across stage zero to four. Stage zero is they're perfectly healthy, even if they're 50 or 100 pounds overweight.

213
00:38:40.530 --> 00:38:52.110
Scott Kahan MD, MPH : They're healthy medically. They don't have diabetes or the like. They don't have mental health problems associated with their weight. And functionally, they feel good. They're not limited by their weight, don't have lots of arthritis or the like.

214
00:38:52.560 --> 00:39:02.700
Scott Kahan MD, MPH : Stage one, they have a little bit of mild things. Stage two: this is where they start to get diabetes and such. And then stage three and stage four: they have very serious weight related health problems.

215
00:39:03.210 --> 00:39:10.050
Scott Kahan MD, MPH : So when we look across people's outcomes, this is over 200 months or so. So over that 15 years

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00:39:10.530 --> 00:39:22.650
Scott Kahan MD, MPH : When we stratify by weight or weight class, look what happens. So at baseline, whether someone is only a few pounds overweight or 100 pounds overweight,

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00:39:22.920 --> 00:39:38.100
Scott Kahan MD, MPH : that doesn't help us predict how their long term health will be in terms of survival. So when you look 15 years out, there's virtually no statistical difference between people who were very heavy at the beginning and

218
00:39:38.490 --> 00:39:48.450
Scott Kahan MD, MPH : only slightly heavy at the beginning, in terms of their likelihood of dying or 15 years but when we look at the beginning at their stage. In other words, how sick they are

219
00:39:48.900 --> 00:40:04.170
Scott Kahan MD, MPH : at the beginning, big difference here. People who are healthy, so stage zero and at a baseline, even if they were 100 pounds overweight, they are doing very well 15 years later. People who are very sick at a baseline.

220
00:40:04.650 --> 00:40:10.920
Scott Kahan MD, MPH : half of them almost are dead 15 years later. So this is a very valuable strategy.

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00:40:11.460 --> 00:40:17.910
Scott Kahan MD, MPH : Here's how it plays out. So two patients are the same age, the same weight. They're the same degree overweight.

222
00:40:18.240 --> 00:40:30.960
Scott Kahan MD, MPH : But one of them stage zero, feels good physically active, no risk factors know depression etc. versus the other one has diabetes and hypertension, sleep apnea, arthritis and so forth.

223
00:40:31.380 --> 00:40:38.430
Scott Kahan MD, MPH : Very different approach in how I would go about addressing this. In someone who's healthy, even if they're 100 pounds overweight,

224
00:40:38.880 --> 00:40:46.380
Scott Kahan MD, MPH : I don't know that aggressive treatment for weight loss is worth it. I think that there are probably less intensive options that may be good enough.

225
00:40:46.680 --> 00:40:56.310
Scott Kahan MD, MPH : And maybe no treatment at all is worth it if they're healthy like this. Why even go down the path of recommending weight loss. Perhaps that's something you have to consider.

226
00:40:57.060 --> 00:41:06.180
Scott Kahan MD, MPH : For patients with stage zero, even though they're the same degree overweight, I would consider much more intensive counseling, likely referral to a specialist.

227
00:41:07.560 --> 00:41:13.380
Scott Kahan MD, MPH : Very possibly obesity from pharmacotherapy that's FDA approved medications. Very possibly bariatric surgery.

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00:41:14.640 --> 00:41:18.330
Scott Kahan MD, MPH : So that's why we want to determine the health status to better stratify patients.

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00:41:18.600 --> 00:41:24.540
Scott Kahan MD, MPH : And then for those that need more intensive treatment that's when we consider escalating treatment.

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00:41:24.780 --> 00:41:40.800
Scott Kahan MD, MPH : Now that can be referring to a specialist like a dietitian or an obesity medicine specialist like myself or a comprehensive weight program for the like. It could be medically monitor structured diets, pharmacotherapy medical devices, or bariatric surgery.

231
00:41:42.300 --> 00:41:56.430
Scott Kahan MD, MPH : So for medically monitored structured diets. This is what used to be called Liquid Diets I don't use these very much for a number of reasons. We could talk about that in the question section if you want. But nonetheless, they're known to be helpful, particularly for patients with diabetes.

232
00:41:57.510 --> 00:42:03.660
Scott Kahan MD, MPH : Medically supervised low calorie meal replacement diets tend to lead to a lot of weight loss in the beginning.

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00:42:04.710 --> 00:42:16.290
Scott Kahan MD, MPH : Quite a lot. And if they don't have follow up, people tend to regain their weight. But, with good smart follow up and ongoing counseling frequently, most of the weight loss is kept off.

234
00:42:17.610 --> 00:42:20.130
Scott Kahan MD, MPH : And I'm not going to go into too much depth there.

235
00:42:22.080 --> 00:42:33.810
Scott Kahan MD, MPH : Then we'll get to medications. The whole concept around medications is that once people lose weight, their metabolism tends to go down, their appetite tends to go up and satiety tends to go down.

236
00:42:34.050 --> 00:42:49.890
Scott Kahan MD, MPH : And that's one of the reasons that they tend to have a hard time sticking to diets. In theory, when we use a medication, that then brings their satiety to baseline so that it's not so hard to keep with a structured weight approach.

237
00:42:50.700 --> 00:43:03.690
Scott Kahan MD, MPH : So there are a number of medications we have. A number of them are very old short term medications. They're only usually used for a few weeks and then we have four long term approved medication that can be used for the long term.

238
00:43:04.740 --> 00:43:11.100
Scott Kahan MD, MPH : I'm not going to go into data into detail about the different medications. It's just beyond the scope of this talk. But again,

239
00:43:12.840 --> 00:43:18.600
Scott Kahan MD, MPH : perhaps we could talk about in question section, also happy to field any questions by email if you'd like to reach out afterwards.

240
00:43:18.990 --> 00:43:33.030
Scott Kahan MD, MPH : But conceptually, here's what we know about the pharmacotherapy. First of all, it's approved for BMI greater than 30 or BMI greater than 27 with at least one weight-related comorbidity like high blood pressure, diabetes, or the like.

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00:43:33.510 --> 00:43:43.140
Scott Kahan MD, MPH : In people who are unable to lose and successfully maintain weight loss with non-medication options, and of course, if they meet the label indications.

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00:43:43.650 --> 00:43:48.480
Scott Kahan MD, MPH : We should follow them up regularly to make sure that they're getting a benefit and safe.

243
00:43:48.960 --> 00:44:02.670
Scott Kahan MD, MPH : And then if they don't lose at least 5% within three months, typically, we're going to stop the medication and look for other options. If they keep losing weight, then typically we keep them on the medication and it can be helpful for long term weight loss.

244
00:44:03.060 --> 00:44:12.090
Scott Kahan MD, MPH : Typically this is what we see. Patients who just get some basic counseling with a placebo, lose a little bit of weight. Patients who get the same counseling with the medication usually lose a lot.

245
00:44:14.070 --> 00:44:20.160
Scott Kahan MD, MPH : And we see improvements across the board in the range of risk factors from blood pressure, lipids and

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00:44:20.610 --> 00:44:25.500
Scott Kahan MD, MPH : I've seen it control all of these going the right direction, except for a couple. So, for example,

247
00:44:25.950 --> 00:44:41.820
Scott Kahan MD, MPH : a couple of the medications can raise heart rate a little bit. It's rarely significant, but you gotta pay attention to this one as well, Liraglutide. And then in one of them blood pressure, can go up a little bit. It's rarely more than one or two millimeters mercury.

248
00:44:43.290 --> 00:44:54.000
Scott Kahan MD, MPH : And across the board in particular, they decrease the risk of developing diabetes by 30, 40, 50, 60% or more, potentially, as well as a number of other risk factors.

249
00:44:55.200 --> 00:45:01.110
Scott Kahan MD, MPH : Now in order to get long term benefits, typically, you need to use the medication long term.

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00:45:01.770 --> 00:45:09.960
Scott Kahan MD, MPH : So just like a blood pressure medication, if you stop the blood pressure after the blood pressure goes down, then typically people will regain the weight and that's what we see here.

251
00:45:10.200 --> 00:45:24.150
Scott Kahan MD, MPH : After a year, people who are on the medication in this curve were re-randomized either to stay on the medication or switch to a placebo. And when they switch to the placebo and stop the medication, they tended to regain.

252
00:45:24.960 --> 00:45:33.030
Scott Kahan MD, MPH : So these are just like blood pressure medications or diabetes. They don't have to stand up long-term. But, for many people, if they stop it, they will regain.

253
00:45:35.010 --> 00:45:45.060
Scott Kahan MD, MPH : The good news is we know early, whether they're going to get benefit from the medication and therefore would benefit from staying on within three months with most of the medications.

254
00:45:45.660 --> 00:45:58.110
Scott Kahan MD, MPH : You either don't get much benefit and therefore you can stop the medication because you're just not going to get any benefit going forward. But if you get a good benefit of the first three months, most likely will keep losing weight and keep it off if you keep doing medication.

255
00:45:59.910 --> 00:46:14.850
Scott Kahan MD, MPH : And then whenever possible, we want to combine medication and counseling. You get some weight loss with the medication alone, you get weight loss with counseling alone, but you get much more with the combined. So whenever indicated, we want to do the two together.

256
00:46:16.410 --> 00:46:18.240
Scott Kahan MD, MPH : Then there are some medical devices.

257
00:46:18.720 --> 00:46:30.090
Scott Kahan MD, MPH : These are not yet part of the standard of care. In most cases, we just don't have long enough data. And so they're not typically covered by insurance, either. So I'm going to leave these for now.

258
00:46:30.840 --> 00:46:41.820
Scott Kahan MD, MPH : We're leaving just bariatric surgery left. So although there are several different bariatric surgical procedures, by far and away more than 95% of procedures in the US

259
00:46:42.540 --> 00:46:59.850
Scott Kahan MD, MPH : today are either Roux-en-Y Gastric Bypass or Sleeve Gastrectomy. In sleeve gastrectomy, a good part of the stomach is taken out of circulation. In gastric bypass, a larger part of the stomach is taken out and then part of the intestines rerouted as well.

260
00:47:01.530 --> 00:47:17.970
Scott Kahan MD, MPH : Here's the guidelines for bariatric surgery. Patients with a BMI greater than 40 or greater than 35 with at least one weight-related comorbidity may be eligible for bariatric surgery. If they have diabetes, then there's even more of a recommendation to consider it.

261
00:47:19.710 --> 00:47:35.910
Scott Kahan MD, MPH : Refer to an experienced bariatric surgery surgeon for consultation and evaluation. It's still back and forth on whether a BMI less than 35 would be valuable for surgery in patients with uncontrolled diabetes probably down to a BMI of 30 is warranted.

262
00:47:37.140 --> 00:47:50.010
Scott Kahan MD, MPH : For others it's unclear. And as I said, no clear guidance yet for medical devices. Bariatric surgery has very good outcomes. In terms of weight loss, you see, you see a lot of weight loss early.

263
00:47:50.820 --> 00:48:05.970
Scott Kahan MD, MPH : And although there's usually some regain, on average people keep off for years, most of that weight. And certainly there are some cases, 2 or 3% of people, they either don't lose a lot of weight, where they start to regain. It's really noticeable. It's unfortunate.

264
00:48:07.440 --> 00:48:16.740
Scott Kahan MD, MPH : It's pretty heartbreaking. But that's a very small proportion of people so very much surgery, very good outcomes. We also see very good outcomes of course in risk factors like

265
00:48:16.980 --> 00:48:26.670
Scott Kahan MD, MPH : blood pressure and lipids and diabetes and we even have very good data suggesting improvement in cardiovascular outcomes and premature death.

266
00:48:28.560 --> 00:48:41.880
Scott Kahan MD, MPH : So that brings us to the last letter F for follow up regularly and leverage available resources. Unfortunately, at least in primary care, typically what happens if a doctor even brings up

267
00:48:42.420 --> 00:48:52.110
Scott Kahan MD, MPH : weight and weight loss with a patient, they bring it up. They tell them to lose weight and then that's basically it. What rarely happens is long-term follow up.

268
00:48:52.830 --> 00:49:02.100
Scott Kahan MD, MPH : Long-term support and utilization of available resources. So just 24% of people in this study had scheduled follow up after

269
00:49:02.490 --> 00:49:05.160
Scott Kahan MD, MPH : the doctor initially brought up weight with the patient.

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00:49:05.490 --> 00:49:13.320
Scott Kahan MD, MPH : And that that makes no sense. Imagine if a patient with diabetes. The doctor tells the patient that it's important to get the diabetes under control.

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00:49:13.440 --> 00:49:21.810
Scott Kahan MD, MPH : Maybe gives them the medication or gives some counseling and how to improve their blood sugar and then never follows up with them. Never schedules ongoing counseling.

272
00:49:22.680 --> 00:49:32.400
Scott Kahan MD, MPH : Not very common that we see that in diabetes, but it's very common in the world of obesity. So we want to try to avoid that. Two really important things to keep in mind here.

273
00:49:33.090 --> 00:49:37.380
Scott Kahan MD, MPH : You don't have to do it all at once. And you don't have to do it all yourself.

274
00:49:37.680 --> 00:49:52.110
Scott Kahan MD, MPH : So weight management is a long-term chronic management process. We shouldn't expect to have a long-term impact on patients by just a single episode of care, no matter how good you are at counseling, no matter what you do.

275
00:49:52.590 --> 00:49:59.490
Scott Kahan MD, MPH : Typically long-term interaction, support and guidance is going to be necessary and valuable.

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00:50:00.090 --> 00:50:15.990
Scott Kahan MD, MPH : And then don't do it all on your own. If you're a dietitian, you may end up doing lots of it on your own, but that's your job. That's what you do, day in, day out. If you're a primary care physician, if you're a nurse practitioner, if you're a psychologist, etc.

277
00:50:17.040 --> 00:50:24.030
Scott Kahan MD, MPH : Typically, we don't have the time to do it all on our own, because we have a lot of other things to do in addition to weight counseling.

278
00:50:24.360 --> 00:50:30.750
Scott Kahan MD, MPH : Luckily, there's lots of resources that we can use. We can try to have a team-based approach. And for some of us,

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00:50:31.410 --> 00:50:47.070
Scott Kahan MD, MPH : I work in a multidisciplinary clinic. So I have the team right there. But even if you don't, most of us, if not all of us in our communities. We can put together a team of sorts. So there's dietitians in our community and psychologists and

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00:50:47.460 --> 00:51:00.450
Scott Kahan MD, MPH : endocrinologists and CDEs and so on and so forth. And so whether we're referring out to the specialists, we're coordinating or otherwise, often there's lots of support for patients if we go out of our way to find that.

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00:51:01.230 --> 00:51:09.450
Scott Kahan MD, MPH : Our clinical staff in our office can also be helpful as well as our non-clinical staff, so even a medical assistant, even a front desk

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00:51:10.410 --> 00:51:21.750
Scott Kahan MD, MPH : administrative staff can be helpful for different parts of this whether collecting historical data or like there are some very good community-based programs now like the diabetes prevention program

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00:51:22.320 --> 00:51:33.060
Scott Kahan MD, MPH : which is covered by Medicare. And now, of course, and we'll see more and more there are online virtual programs to refer to when needed. So that will help us to extend our reach significantly.

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00:51:33.960 --> 00:51:39.780
Scott Kahan MD, MPH : And just one last slide. Very good data showing that no matter how much weight you lose,

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00:51:40.350 --> 00:51:54.390
Scott Kahan MD, MPH : If you have ongoing support and counseling and guidance and such, people tend to continue losing weight in many cases and do a much better job at keeping it off, compared to when there's no support. They tend to regain the weight. Long-term

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00:51:54.810 --> 00:52:01.620
Scott Kahan MD, MPH : approach is going to be necessary for the vast majority of patients, given this as a long-term chronic management issue.

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00:52:02.340 --> 00:52:15.630
Scott Kahan MD, MPH : So I will stop there. That's the A B C D E F approach. It was published in JAMA that's available. I'll make sure that we post it to the website as well. So in addition to the slides, you'll have that. And again,

288
00:52:16.050 --> 00:52:32.070
Scott Kahan MD, MPH : we have time for questions now, but I'm also available and very happy, you see my email here, don't hesitate to reach out and help in any way I can. So with that, there have been a few questions that came in during the course of this webinar.

289
00:52:33.090 --> 00:52:49.590
Scott Kahan MD, MPH : And I'll start with those. But we still have a few more minutes. So please feel free to put additional questions in the question and answer box here. So the first question that came up, is Why don't physicians just refer their registered dietitians? A good question.

290
00:52:50.730 --> 00:52:58.710
Scott Kahan MD, MPH : Part of the answer to that question is, well, I don't know, but I really wish that they would, because we have these great resources out there, a whole

291
00:52:59.100 --> 00:53:06.150
Scott Kahan MD, MPH : population of very well trained registered dietitians. And everybody would be better off, I think,

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00:53:06.660 --> 00:53:14.370
Scott Kahan MD, MPH : if there was more and more frequent referral to expert registered dietitians. At the same time, the other

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00:53:14.880 --> 00:53:23.850
Scott Kahan MD, MPH : the one pushback that I would have with this question, the way it was framed is why don't physicians just refer to registered dietitians.

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00:53:24.120 --> 00:53:36.240
Scott Kahan MD, MPH : And the way that I interpret that question is, well, why should physicians or nurse practitioners or the like. Why should they even do anything having to do with weight. Just refer them to the dietitians and dietitians will take care of it.

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00:53:37.530 --> 00:53:47.310
Scott Kahan MD, MPH : I don't think that's a very productive thing. Registered dietitians are a very important part of the approach here, but they may not be sufficient on their own.

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00:53:47.580 --> 00:53:57.120
Scott Kahan MD, MPH : Not everybody needs for example, dietetic counseling. They need other types of counseling, they may need psychology counseling, they may need exercise counseling.

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00:53:57.690 --> 00:54:10.020
Scott Kahan MD, MPH : Moreover, medications, particularly those with more severe obesity and more severe health problems associated with the obesity may need an escalation of treatment beyond just counseling.

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00:54:10.470 --> 00:54:19.980
Scott Kahan MD, MPH : That would have to be done by a nurse practitioner or a physician or an endocrinologist or the like. And so

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00:54:21.360 --> 00:54:26.070
Scott Kahan MD, MPH : While some patients may get enough benefit from dietetic counseling,

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00:54:26.760 --> 00:54:44.010
Scott Kahan MD, MPH : in many cases, we're going to need more than just that. And also, as dietitians will tell you, unfortunately, it's as silly as it can get. But often dietitian counseling is not covered by insurance in Medicare, for example. It's only if you have diabetes or kidney disease typically.

301
00:54:45.660 --> 00:54:47.490
Scott Kahan MD, MPH : Next question that came up

302
00:54:50.640 --> 00:55:03.150
Scott Kahan MD, MPH : How can you keep patients motivated over time? So there's a lot of ways of going about this, but I think the most basic is to continue working with them over time.

303
00:55:03.840 --> 00:55:18.480
Scott Kahan MD, MPH : Motivation will wax and wane for anyone. But when they have a partner in their care, when they have ongoing support and guidance, it helps them when their motivation is down to be there with them to help them recover it.

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00:55:19.440 --> 00:55:28.230
Scott Kahan MD, MPH : And helps also to predict and even before their motivation is waning often as clinicians, we can appreciate that

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00:55:28.800 --> 00:55:39.570
Scott Kahan MD, MPH : and then help them to prevent that. The other thing that's very important in terms of long-term motivation is to help people find their intrinsic motivation.

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00:55:39.960 --> 00:55:44.970
Scott Kahan MD, MPH : So compared with external motivation, which is things like losing weight.

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00:55:45.330 --> 00:55:50.070
Scott Kahan MD, MPH : It's for an outside reason losing weight, just to see the number go down on the scale or just to make their

308
00:55:50.310 --> 00:56:01.320
Scott Kahan MD, MPH : primary care doctor happy. Their doctor sort of yelled at them that they need to lose weight and then they're going to lose weight to make them happy. Those are not very lasting motivations

309
00:56:03.210 --> 00:56:11.580
Scott Kahan MD, MPH : As opposed to having intrinsic motivations. So intrinsic motivations come from within. Those are things like

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00:56:12.360 --> 00:56:22.170
Scott Kahan MD, MPH : being motivated by something that you genuinely enjoy. So for example, if you tell me to go to the gym. I don't really like it very much, and I may or may not consistently do it.

311
00:56:22.410 --> 00:56:31.890
Scott Kahan MD, MPH : If you tell me to go outside and play sports, well I love that. And so I'm not doing that to lose weight. I'm doing that, but it's fun. And that's going to be very sustainable.

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00:56:32.280 --> 00:56:41.250
Scott Kahan MD, MPH : Also things that are consistent with our genuine values are what's meaningful to us

313
00:56:41.820 --> 00:56:59.340
Scott Kahan MD, MPH : is important for motivation. So for example, if as a clinician, you believe in a vegan diet and you tell all your patients to do the diet. Some of them it may help, many of them it's not going to help because it's not very meaningful to them.

314
00:57:01.440 --> 00:57:12.930
Scott Kahan MD, MPH : But when you look at people who start a vegetarian or vegan diet because it's consistent with our animal rights values or their religious values or their

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00:57:13.560 --> 00:57:23.160
Scott Kahan MD, MPH : environmental values, those are things that are deeply meaningful for people. And so people who start a vegetarian diet for that reason,

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00:57:23.430 --> 00:57:27.870
Scott Kahan MD, MPH : often they have no problems sticking to it or much less difficulty sticking to it.

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00:57:28.140 --> 00:57:39.600
Scott Kahan MD, MPH : Because they're so motivated and that motivation when its associated with those meaningful things, that tends not to wane in the same way, over time. So that's the way that I would start to think about

318
00:57:40.110 --> 00:57:49.860
Scott Kahan MD, MPH : long-term motivation. Let's see what other questions are here. Will a recording and slides materials be available? Yes. They're available on the Villanova website.

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00:57:50.310 --> 00:57:51.510
Scott Kahan MD, MPH : We'll make sure to put that

320
00:57:51.510 --> 00:57:55.560
Scott Kahan MD, MPH : up there. Again, it's villanova.edu/cope.

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00:57:59.100 --> 00:58:04.680
Scott Kahan MD, MPH : Not a question. Very nice job good coverage. Wow. Thank you. I appreciate that.

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00:58:06.090 --> 00:58:10.410
Scott Kahan MD, MPH : And it looks like we have one more minute here. Let's see if we can get one more question.

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00:58:11.520 --> 00:58:26.700
Scott Kahan MD, MPH : As a dietitian, I have patients that have had much success losing weight with diet modification in conjunction with prescribed phendimetrazine from their doctor. However, when the medication is discontinued, most, patients regain a lot of the weight.

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00:58:29.040 --> 00:58:38.400
Scott Kahan MD, MPH : Then if the same patients begin adding the medication, again, their weight largely reduces again. What are your thoughts on using phendimetrazine in conjunction with diet modifications, long-term?

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00:58:38.760 --> 00:58:43.650
Scott Kahan MD, MPH : Okay, phendimetrazine is one of the short-term approved medications.

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00:58:44.370 --> 00:58:53.970
Scott Kahan MD, MPH : It's not actually used very often. Phendramine is used much more frequently. That is also a short-term medication. So these are only approved for short-term use, that's up to 12 weeks.

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00:58:54.210 --> 00:59:03.870
Scott Kahan MD, MPH : Now technically they can be used off label. Beyond that, but they tell you that if you continue those medications they tend to work less well over time. Patients build

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00:59:04.800 --> 00:59:13.050
Scott Kahan MD, MPH : a tolerance to them. So although you could use it long-term, they tend to not be as effective long-term and they're also not studied well long-term.

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00:59:13.710 --> 00:59:22.110
Scott Kahan MD, MPH : The longer-term medications. The ones that are approved for long-term use, those are much more valuable longer term, and those are the ones that I would recommend

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00:59:22.710 --> 00:59:37.020
Scott Kahan MD, MPH : using for long term use. And maybe I could just pull them up here. Looks like I can't go back, but those are Phentermine-Topiramate extended release. So that's a combination of phentermine and topiramate. That's called Qsymia.

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00:59:37.590 --> 00:59:42.300
Scott Kahan MD, MPH : Liraglutide three milligrams. That's called Saxenda. Orlistat or

332
00:59:44.130 --> 00:59:53.100
Scott Kahan MD, MPH : Xenical that's also allied over the counter at a lower dose. Then there is Contrave which is a combination of naltrexone and bupropion.

333
00:59:53.400 --> 01:00:03.690
Scott Kahan MD, MPH : Those are the ones that are approved long-term. And so that's what I would be thinking about. But at the core of that question was a really important point, like I mentioned before.

334
01:00:04.290 --> 01:00:17.370
Scott Kahan MD, MPH : In general, just like with the blood pressure medication, if you stop the medication and someone who needs it. They're likely not going to get that benefit anymore. And so, continuing it as long as it's approved for long-term use and working well and

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01:00:17.850 --> 01:00:22.500
Scott Kahan MD, MPH : being well tolerated; that is likely going to be a better way of going about this for patients.

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01:00:23.430 --> 01:00:30.540
Scott Kahan MD, MPH : So I want to respect your time. I am going to stop there. There were a couple of questions that just came up.

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01:00:30.840 --> 01:00:44.610
Scott Kahan MD, MPH : I'm sorry that we don't have time. But again, my email is right here. Please, don't hesitate to email me with those questions, I will respond and don't hesitate even a month or a year down the line, feel free to keep my email, and I'm happy to help in any way that I can.

338
01:00:45.630 --> 01:00:47.040
Scott Kahan MD, MPH : So thank you all for your time.

339
01:00:47.070 --> 01:00:47.430
Villanova Webinar 1: Thank you.

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01:00:47.910 --> 01:00:51.750
Scott Kahan MD, MPH : Thank you for the positive feedback as well and please stay safe and good luck with it.

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01:00:52.830 --> 01:01:00.870
Villanova Webinar 1: Thank you so much Dr. Kahan. We really learned a lot. I think working together, dietitians and physicians can really make

342
01:01:02.550 --> 01:01:08.730
Villanova Webinar 1: some headway, along with other professionals. I just wanted to just real quick mention that

343
01:01:09.450 --> 01:01:18.360
Villanova Webinar 1: everyone who has completed the webinar will be emailed an evaluation within a week. The email will be sent to the email address you used to register for the webinar.

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01:01:18.600 --> 01:01:26.850
Villanova Webinar 1: Evaluation will expire in three weeks. So please complete it as soon as you can so that you can get your CEU certificate emailed to you.

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01:01:28.440 --> 01:01:29.580
Villanova Webinar 1: And our next

346
01:01:30.750 --> 01:01:36.600
Villanova Webinar 1: webinar addresses Early life risk factors for obesity and children with autism spectrum disorder.

347
01:01:37.290 --> 01:01:44.040
Villanova Webinar 1: The date has been announced. It is actually July 8 so put that on your calendar. We look forward to that

348
01:01:44.610 --> 01:01:59.370
Villanova Webinar 1: presentation. And finally COPE offers an online catalog of webinars and presentations. So if you missed a webinar and you'd like to earn a CE credit, you can look in the enduring continuing education catalog that is right there on the

349
01:02:00.450 --> 01:02:09.300
Villanova Webinar 1: website and search the catalog and see what interests you. Okay. And with that, thank you, Dr. Kahan. I really appreciate your

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01:02:10.350 --> 01:02:27.240
Villanova Webinar 1: your approach. I think we've all learned. I actually made tons of notes for my own private practice that I can use. And I'm sure others did as well. So thank you so much. Good luck with your work and thank you everyone for listening. Take care and stay safe.

351
01:02:28.710 --> 01:02:29.100
Villanova Webinar 1: Bye bye.