# Tools for Successful Weight Management in Primary Care

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**Abstract:** Obesity is one of the most pervasive and costly public health problems. Clinicians need effective tools to address weight management in primary care, including evaluation and communication methods, guideline-based weight management interventions and safe and effective weight loss medications and surgery. The objective of this Grand Rounds presentation is to provide practicing clinicians with the latest information regarding effective ways to care for and communicate with patients about weight loss; evidence-based guidelines for selecting weight management therapies and safety, efficacy and adverse effects of weight loss medications and surgery.

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Overweight, including obesity, is one of the most pervasive and costly public health problems. Two in 3 adults in the United States are overweight, including 1 in 3 who is obese.[1,2] Physicians now care for patients with many weight-related problems that could be improved by a modicum of weight loss; however, physicians need guidance regarding how to provide high-quality, effective weight management in primary care. The objective of this Grand Rounds presentation is to provide practicing clinicians with the latest information regarding effective ways to care for and communicate with patients about weight loss; evidence-based U.S. guidelines for selecting weight management therapies and safety, efficacy and adverse effects of weight loss medications and surgery using evidence-based recommendations from the Guidelines (2013) for Managing Overweight and Obesity in Adults,[3] recently released by the Obesity Society, American College of Cardiology and American Heart Association; National Heart, Lung and Blood Institute–sponsored obesity guidelines[4] and the 2008 Physical Activity Guidelines for Americans.[5]

## Assessment

### Identification

Identifying patients who are overweight is the 1st step in determining whether weight management is needed. Body mass index (BMI) is the recommended and most practical office-based tool to identify overweight and monitor patients over time.[3] Individuals with a BMI of 25 to <30 kg/m$^2$ are considered overweight, and those with a BMI ≥30 kg/m$^2$ obese. Most electronic medical records autocalculate BMI, and many plot weight trajectory, which can be used to engage patients when communicating about weight management. An additional tool is waist circumference, which is measured at the level of the iliac crest and indicates increased cardiovascular disease and health risks. Measuring waist circumference is particularly useful for patients who are overweight but otherwise "well." A waist circumference ≥88 cm (35 inches) for women and ≥102 cm (40 inches) for men reflects excessive abdominal fat and greater weight-related health risks than a patient with a normal waist circumference; weight management, therefore, may be particularly important for these high-risk patients.[3,6,7]

### Obesity-Focused History and Evaluation

After identifying patients who are overweight, an obesity-focused history is critical for developing a tailored weight management plan. Factors that affect weight management treatment decisions include life circumstances contributing to weight gain/loss (eg, receiving supplemental nutrition assistance, working night shifts, pregnancy or marital changes), physical and mental health issues, previous weight loss attempts, drug-induced weight gain, current dietary and activity habits and readiness to make lifestyle changes.[8] It is important to identify the presence and extent of alcohol or tobacco use and any disordered eating behaviors, such as binge eating, bulimia or night eating.[9] Identification of an alcohol addiction, active eating disorder or significant mental health issue may warrant referral to a mental health professional.[10]

To identify and communicate with patients regarding obesity-related health risks, clinicians can elicit an obesity-focused review of systems, physical examination, and laboratory

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evaluation. For example, a sleep history can help determine risk of sleep apnea and particularly should be sought in patients who have a history of atrial fibrillation, thrombosis, pulmonary hypertension or diastolic heart failure; an elevated blood pressure reading or acanthosis nigricans can be used to communicate risk of hypertension and diabetes and identifying and communicating with patients regarding early-stage diseases, such as prehypertension and prediabetes, can be used to partner with patients on preventing disease progression or medication initiation using a weight management intervention. Although there are no obesity-specific recommended laboratory screenings, current guidelines recommend universal lipid screening and screening for diabetes in overweight patients (and Asians with a BMI ≥23 kg/m$^2$).[11] Screening for fatty liver might also be considered, particularly when caring for male and Latino patients.[12] Because obesity increases the risk of postmenopausal breast and endometrial cancers, it is important to ensure women receive mammograms at recommended intervals and ask about postmenopausal vaginal bleeding, which might warrant referral to gynecology.[13,14] Considerations regarding the conduct of and challenges inherent in the physical examination of patients with obesity previously have been published.[15]

### Assessing Benefits of Weight Management

After identifying obesity-related health risks, clinicians and patients can determine potential benefits of weight management and develop non–weight-based goals for weight management intervention—discussing improvement in weight-related conditions can aid realistic goal setting that affects health, particularly because patients may have larger goals for weight loss than are attainable. A 5% to 10% weight reduction can improve quality of life, reduce pain and improve cardiovascular disease risk factors, such as blood pressure, cholesterol and blood sugar.[16] Dietary changes, even without weight loss, can prevent progression from prediabetes to diabetes,[16] and normalizing glucose regulation reduces cardiovascular risk.[17] A less-known weight-related complication that improves with weight loss is kidney disease. Being overweight or obese at the age of 17 years is associated with an 8-fold increased risk of developing end-stage renal disease.[18] A major cause is obesity-related glomerulopathy, which is independent of diabetes and hypertension and improves with weight loss.[19,20] A host of other conditions also improve with weight loss, including atrial fibrillation,[21] fatty liver disease,[22] polycystic ovarian syndrome,[23] urinary incontinence[24] and erectile dysfunction.[25] Thus, the benefits of weight loss underscore the critical importance of addressing weight management.

## Treatment

Tools physicians can use to help patients lose weight include the following: patient-centered communication, tailoring medications that affect weight, behavior modification, weight loss medications and surgery.

### Communicating With Patients About Weight Management

Physicians may be maximally effective in supporting weight management for a long term by using patient-centered terms to describe excess weight (so that patients do not feel judged[26]) and sharing decision making with patients. A patient-centered way to open a conversation about weight would be to frame the conversation around health, not size. For example, "I noted that your weight has been going up, and I'm concerned about the impact of this on your health." Shared decision making includes allowing patients to choose the behaviors, goals and treatments that they consider important.[27] Supporting patients in choosing and sustaining lifestyle changes is made easier by communication methods that facilitate conversations about change, including using patient-centered rather than doctor-centered communication (Table 1).[27,28] Fundamental to patient-centered communication is spending time relationship building, and there is evidence for its efficacy in weight management.[29–31] In this style of communication, physicians elicit patients' health needs, beliefs and expectations and engage patients in making decisions about their care.[27]

Motivational interviewing is one type of patient-centered communication that is used to address behavior change with an ambivalent patient.[28] For effective use of motivational interviewing, 4 skills are needed.[17] The 1st skill is engaging the patient in nonmedical conversation before eliciting their medical questions. The 2nd is focusing the visit on a specific change. For example, after asking about the patient's concerns, reflect back their concerns and then ask permission to address weight changes: "*I hear you're concerned about knee pain, correct? Let's talk about that; and, would it be okay to discuss your weight too? I noticed it's been going up. I'd like to hear your thoughts about why that might be.*" The 3rd skill is evoking from the patient their own good reasons to change. The physician listens for evidence of some intent to change and then responds with reflective-listening statements to evoke further discussion of behavior change. The 4th skill is planning change. If the patient is not ready to make changes, then the plan is to follow-up at the next visit. If the patient is ready, one might ask, "*If, as part of our plan to help your knee pain, you decide to work on getting to a healthier weight, what might be a first step*?" If a patient replies that they do not know, one might respond, "*May I offer some advice based on my experience? There are some options that you have. You could start tracking your diet and activity; try a weight-loss diet; or, if you already have tried these, there are weight-loss medicines or surgery. What makes the most sense to you*?" In other words, give

TABLE 1. Differences between patient-centered and doctor-centered communication during behavioral weight loss counseling

| Patient-centered communication | Doctor-centered communication |
|---|---|
| Physician: | Physician: |
| • Elicits patient's questions and answers them: "*What questions do you have before we begin*?" | • Asks medical questions before eliciting patient's questions |
| • Asks open-ended questions: "*How do you feel about your weight*?" | • Asks yes/no (closed) questions |
| • Asks patient's opinion: "*We've discussed some options to manage your weight, what seems doable to you*?" | • Gives unsolicited biomedical and behavioral advice |
| • Checks patient's understanding: "*What do you feel are the most important things we've talked about today*?" | • Assumes head nodding indicates understanding |
| • Gives statements of empathy and legitimization: "*You struggle to lose weight, but you keep trying because it's important for you to stay healthy.*" | • Gives directive statements (you should …) |
| • Gives patient time to respond | • Gives instruction with immediacy, not patience |





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