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REVIEW

# Practical Strategies for Engaging Individuals With Obesity in Primary Care

Scott I. Kahan, MD, MPH

## Abstract

Although widely recognized as a chronic disease that requires long-term, structured, and multidisciplinary management, obesity remains largely underdiagnosed and undertreated. The prevalence of obesity continues to increase dramatically, with the highest rates seen in the United States. Despite the availability of several clinical practice guidelines, published studies suggest that health care professionals (HCPs) infrequently and inconsistently follow guideline recommendations. Barriers to HCP participation in obesity management are likely to inhibit obesity counseling in primary care. Improving HCP obesity-related practices and counseling is important. This article discusses current practices, barriers to effective obesity management, and recommendations to improve HCP obesity management and counseling, based on findings from a PubMed search and clinical experience. The aim of the article is to share best-practice strategies for engaging patients.

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From Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, and George Washington University School of Medicine and Health Sciences, Washington, DC.

The past half-century has seen a staggering increase in global obesity rates, with 266 million men and 375 million women now exceeding the weight threshold for obesity (defined by a body mass index [BMI; calculated as weight in kilograms divided by height in meters squared] of ≥30 kg/m$^2$).[1] The prevalence of obesity (BMI, 30-40 kg/m$^2$) and severe obesity (BMI, ≥40 kg/m$^2$) is approximately 37.7% and 7.7%, respectively,[2] representing an approximate increase of 10% in the prevalence of obesity in the United States since 2005−2006 and an increase in excess of 600% in the prevalence of severe obesity since the mid-1980s.[2,3] In addition to being a public health epidemic affecting large populations, obesity is a complex and multifaceted clinical condition. Several global organizations and regulatory bodies explicitly recognize obesity as a chronic disease, including the World Health Organization, the US Food and Drug Administration, the US National Institutes of Health, and, most recently, the American Medical Association.[4-8] Obesity is associated with almost 200 metabolic, mechanical, and mental comorbid conditions,[9] the prevalence of which increase as BMI rises.[10] People with obesity have an increased risk of development of cardiovascular disease and type 2 diabetes[11] and a reduced health-related quality of life.[12] The financial costs of obesity are substantial, both to affected individuals and society at large.[13]

As with other chronic conditions, successful management is not necessarily defined by achieving a "cure." Long-term weight loss is generally accepted as maintaining weight loss of 5% to 10% for 1 or more years and is associated with improvements in major risk factors.[14-21] Conventional wisdom and older research suggest that long-term weight loss success is elusive[22,23]; however, recent studies have shown impressive outcomes for behavioral weight loss interventions, particularly when provided by trained interventionists. The Look AHEAD study evaluated weight loss achieved with behavioral weight loss counseling in 5145 people with overweight or obesity and type 2 diabetes.[24] Patients receiving behavioral counseling lost more than 8% of body weight during the first year and, at year 8, 50.0% of intervention patients maintained a 5% or more loss, 26.9% maintained a greater than 10% loss, and 11.0% maintained a more than 15% loss of initial body weight. Systematic reviews of behavioral weight loss counseling conducted by the US Preventive Services Task Force (USPSTF) and the National Heart, Lung, and Blood Institute (NHLBI) Obesity Expert Panel found similarly

**ARTICLE HIGHLIGHTS**

- Evidence indicates that health care professional (HCP)—patient engagement on the topic of obesity is often suboptimal.
- Lack of HCP—patient engagement can adversely affect the diagnosis and management of obesity.
- Barriers perceived by HCPs and patients influence their level of engagement.
- Several strategies may help to address the barriers and enable effective HCP—patient engagement.
- The health benefits that patients derive from being engaged with their HCP are clearly evident.

impressive outcomes, which has led to policy changes encouraging behavioral counseling in primary care.[20,25] Primary care physicians (PCPs) are in the unique position of engaging people with obesity and ensuring that they receive appropriate counseling. Nonetheless, whereas most people with obesity have tried—often repeatedly—to lose weight,[26] few receive formal guidance and counseling from their health care professional (HCP).[27] Based on relevant articles from a PubMed search performed in June 2017 and my own clinical experience, this article discusses current obesity-related practices of HCPs in the United States and the availability of specialist training for US HCPs and provides practical recommendations for improving how HCPs engage with patients to support long-term weight management.

## CURRENT GUIDELINES AND PRACTICE

### The Importance of Screening and Diagnosis

Screening and diagnosis are fundamental steps in addressing medical conditions. In a study of 7790 National Health and Nutrition Examination Survey (NHANES) participants, those whose weight problem was diagnosed and who were advised of their weight status by their HCP had 6.1-fold (BMI, >25 kg/m$^2$) or 8.3-fold (BMI, >30 kg/m$^2$) increased odds of correctly perceiving their weight status.[28] Moreover, participants had 2.5-fold (BMI, >25 kg/m$^2$) or 2.2-fold (BMI, >30 kg/m$^2$) increased odds of attempting to lose weight. Among 9827 patients in a large primary care database, formal diagnosis of obesity was associated with 2.4-fold increased odds of having an obesity management plan in place.[29] An NHANES analysis of 5054 participants revealed 1.9-fold (BMI, >25 kg/m$^2$) and 1.8-fold (BMI, >30 kg/m$^2$) increased odds of losing weight (defined as reported >5% weight loss) if their HCP had diagnosed and communicated that they were overweight.[30]

### Current Guidelines for Screening and Diagnosis

The USPSTF recommends that clinicians screen all adults for obesity and offer referral for intensive multicomponent behavioral interventions to patients with a BMI of 30 kg/m$^2$ or higher.[31] The NHLBI obesity guidelines, disseminated by the American Heart Association/American College of Cardiology/The Obesity Society, recommend that weight should be measured and BMI calculated at least every year in all people who need to lose weight.[32] Body mass index screening and follow-up is a clinical quality measure now included in the Physician Quality Reporting System[33] and carried out by the Centers for Medicare and Medicaid Services.[34] Moreover, negative payment adjustments are levied to HCPs and group practices who do not satisfactorily report data on quality measures for Medicare Part B Physician Fee Schedule-covered professional services.[34]

### Current Practice for Screening and Diagnosis

Despite several guidelines, practice recommendations, and incentives, these measures are not consistently followed in primary care settings.[35] According to retrospective analyses of patient records, up to 90% of people with obesity (BMI, ≥30 to ≤35 kg/m$^2$) have not received a formal diagnosis from their physician.[36] Although rates of diagnosis increase in patients in higher weight classes, they remain suboptimal across all weights.[35]

### The Importance of Obesity Counseling

Counseling delivered by HCPs substantially affects weight loss behaviors. A cross-sectional analysis of 810 British adults with a BMI of less than 25 kg/m$^2$ revealed that an HCP recommendation to lose weight was associated with 3.7-fold increased odds of wanting to weigh less and 3.5-fold increased odds of attempting to


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