

# Tips and tools for effective obesity management

# Welcome and Introduction

Obesity is a complex, lifelong disease, influenced by environmental, genetic, physiological, and psychological factors, which should be treated by health care professionals (HCPs).<sup>1</sup> As an HCP, you are uniquely qualified to initiate and guide your patients through the process of chronic weight management—weight loss, weight maintenance, and better health.

- HCP-initiated discussions and advice regarding weight loss encourage patients to change their behavior.<sup>2</sup>
- Collaboration, counseling, and medical support from HCPs help patients achieve clinically significant and maintained weight loss.<sup>2</sup>
- Achieving and maintaining weight loss requires long-term intervention.<sup>3</sup>

Simply by recognizing the complexities of excess weight and the implications of addressing the condition, you are ready to help your patients to improve their weight, and as a result, their health.

## Content Overview

To facilitate a good discussion with your patients, it may be helpful to use techniques including motivational interviewing and behavioral therapy. The aim of this informational booklet is to present a foundation for these techniques that will hopefully enable you to have an effective consultation around weight with your patients.

Furthermore, this booklet is a background resource for the discussion guide *Changing the Obesity Discussion*, which provides specific talking points and questions that can be used directly in consultation with patients.

In addition, the guidelines for obesity management set out by the American Association of Clinical Endocrinologists (AACE) and published in 2014 are provided for reference, along with a more abridged summation of the Endocrine Society guidelines published in 2015. There are several guidelines for obesity management, so you may find another that better suits your practice, and to that end we have included Web addresses for other resources and guidelines.

### The following sections address these topics:

- Motivational Interviewing
- Keys to Successful Conversations
- Behavioral Therapy
- Treatment Overview

Recommended resources and additional information are provided throughout this booklet.

## Goals and Objectives of This Booklet

The aim of this resource is to enable you to:

- Utilize strategies and principles of **motivational interviewing**
- Have **successful conversations** with your patients
- Implement **behavioral therapy** in the time frame of existing appointments
- Gain a better **understanding of treatment guidelines**

## The 5As of Obesity Management

The 5As model was originally designed as a behavioral intervention strategy for smoking cessation in patient consultations.<sup>4</sup> The model was modified for obesity management for HCPs to use as a framework to guide a conversation. The 5As model has been associated with increased patient motivation and behavioral change when used by HCPs in weight-management consultations with patients.<sup>5</sup>

**The 5As of Obesity Management are as follows<sup>6</sup>:**

### 1. ASK

- Ask for permission to discuss weight
- Explore readiness for change

### 2. ASSESS

- Assess obesity class and stage
- Assess for drivers, complications, and barriers

### 3. ADVISE

- Advise on obesity risks
- Explain benefits of modest weight loss
- Explain need for long-term strategy
- Discuss treatment options

### 4. AGREE

- Agree on realistic weight-loss expectations
- Focus on behavioral goals (SMART) and health outcomes
- Agree on treatment plan

### 5. ASSIST

- Address drivers and barriers
- Provide education and resources
- Refer to appropriate provider
- Arrange follow-up

For more information on the 5As of Obesity Management, please visit [www.obesitynetwork.ca/5As](http://www.obesitynetwork.ca/5As). Additional links to guidelines can be found on page 31 of this booklet.

# Motivational Interviewing

# Motivational Interviewing

## Introduction

Motivational interviewing is an engagement strategy that aims to enhance self-efficacy and personal control for behavioral change. As a method of communication, motivational interviewing is inherently collaborative, employing empathy and active listening to build trust and rapport between patients and HCPs.<sup>7</sup>

Through the strategies of motivational interviewing, HCPs can collaboratively explore patients' motivations for change and goal setting. The strategies of motivational interviewing include<sup>7</sup>:

- **O**pen-ended questions
- **A**ffirmative statements
- **R**eflections
- **S**ummary statements

It can be helpful to use the acronym OARS to remember these strategies. The talking points and questions provided throughout the *Changing the Obesity Discussion* guide model the motivational interviewing approach to help guide HCPs in application with their patients.

## Defining Motivational Interviewing<sup>7</sup>

Motivational interviewing is a collaborative, goal-oriented approach of communication to elicit behavioral change in patients. The approach is designed to identify and resolve a patient’s ambivalence toward a specific goal by connecting necessary changes to incentives that reduce barriers for change.

## Principles of Motivational Interviewing<sup>7</sup>

There are 4 key principles that guide the practice of motivational interviewing in weight management with patients:

Expressing empathy	Supporting self-efficacy
This reassures your patients that you are listening to them and seeing their point of view on the problem. As a result, patients are more likely to honestly share their experiences and perspectives.	Motivational interviewing is based on patients’ existing capacity for change. By focusing on previous successes, they will feel capable of achieving and maintaining their desired change.
Rolling with resistance	Developing discrepancies
Resistance can occur when patients realize a need for change in their behavior patterns. It is best to sidestep or “roll with” any resistance and to avoid trying to fix or solve each problem.	Throughout discussions of weight management, you and your patients will begin to see the differences between where they are (current habits) and where they want to be (goals). Help patients realize these discrepancies and guide them to self-identify ways to bridge the gap.

## The OARS Motivational Interviewing Strategy<sup>7</sup>

The practice of motivational interviewing involves some specific skills and strategies to help patients reduce ambivalence and advance their readiness to make changes. One model for motivational interviewing is the **OARS strategy**, which is a simple way to generate the intended benefits of motivational interviewing.

### O Open-ended questions

Ask open-ended questions that encourage thought-provoking responses and engage a 2-way dialogue. This is an important first step to understanding a patient's barriers and expectations.

*How do you feel about your health right now?*

### A Affirmative statements

Recognize and support your patient's personal strengths, successes, and efforts to change. This will help promote a collaborative relationship.

*Your dedication to improving your health and losing weight is really noticeable. You've made a lot of improvements.*

### R Reflections

Use reflective listening and respond thoughtfully by paraphrasing. Confirm that the patient has been heard and validate his or her point of view.

*I get the feeling that there is a lot of pressure on you to lose weight, but you are not sure you can do it because of the difficulties you have had losing weight in the past.*

### S Summary statements

The statements that recount and clarify the patient's statements and identify specific points to act upon.

*So what I'm hearing is that you have struggled with weight for most of your adult life and are now starting to recognize how it is affecting your health and quality of life. Let's discuss some strategies to develop a plan to help you address your concerns.*





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## Questions for Consideration

Ask yourself a few questions before getting started:

- On a scale from 1 to 5, my current motivational interviewing skill level is \_\_\_\_\_  
(1 meaning very low skill level in motivational interviewing to 5 meaning very proficient in motivational interviewing).
  - How often do I currently use motivational interviewing with my patients?
  - How can I use motivational interviewing more frequently with my patients when discussing weight?
  - Does my staff know what motivational interviewing is and how to use it in patient interactions?
-



# Keys to Successful Conversations

# Keys to Successful Conversations

## Introduction

Collaboration, counseling, and medical support from HCPs may help patients achieve clinically significant and maintained weight loss.<sup>2</sup> Studies have shown that successful conversations between HCPs and patients help patients to be more successful with their weight-loss goals.<sup>2</sup>

The weight discussion can be an uncomfortable one, which makes word choices especially important.<sup>8</sup> Consider using more descriptive terms like “healthy eating habits” and “physical activity routine” in place of terms like “diet” and “exercise.” Other communication strategies, such as active listening, empathy, and encouragement, can promote productive dialogue and healthy relationships with your patients.<sup>9,10</sup>

## Be Encouraging and Empathetic

Studies link communication behavior such as empathy, encouragement, and psychosocial talk with improved patient satisfaction and adherence.<sup>9,10</sup>

A successful conversation with patients about weight management has been shown to be 10% to 20% more effective to increase motivation, encourage action, and sustain changes when compared with a didactic delivery of recommendations from an HCP.<sup>11</sup>

There are a few key messages to incorporate in your communications with patients about their weight.

## Know the Terms and Phrases to Use

Research has shown that word choice plays an important role when discussing weight management.<sup>8</sup> Certain words should be avoided and other words can have different implications in different contexts:

- **Weight or healthy weight** instead of fat or fatness. Patients may feel more comfortable having a discussion about weight rather than about obesity.
- **Activity** instead of exercise. Increasing activity levels can take many forms beyond joining a gym or running, which might be what patients think of when they hear, “You need to exercise more.”
- **Healthy eating plans, habits, and lifestyle** instead of diet, which can imply a short-term fix by cutting out foods. Plans, habits, and lifestyle can better indicate the healthy practice of chronic weight management.
- **Obesity and obese** are both clinical terms intended to describe a patient’s condition, but can also sound judgmental. Avoid referring to a patient as obese.

### Know the Terms to Avoid<sup>8</sup>

- |              |                  |
|--------------|------------------|
| • Fat        | • Heaviness      |
| • Fatness    | • Large size     |
| • Excess fat | • Weight problem |

## **Why We Should Recognize Weight Bias in the World of Health Care**

In the opinion of the Obesity Action Coalition (OAC), weight bias<sup>12</sup>:

- Is the last socially acceptable form of discrimination
- Keeps patients with obesity from seeking help, and some HCPs from offering it
- Hampers our nation's efforts to effectively combat the obesity epidemic
- Drives the current limits of access to treatment

## How You Can Address Weight Bias in a Health Care Setting

Research indicates that patients with excess weight feel stigmatized in many areas of their life, including health care settings.<sup>13</sup> The language you use and your environment are 2 key components to successful weight management. To promote successful interactions with your patients, it is important to consider the following checklist<sup>14</sup>:

### Equipment for waiting area

- ☐ Open-arm chairs that can support more than 300 pounds
- ☐ Firm sofas that can support more than 300 pounds
- ☐ Weight-sensitive reading materials

### Equipment for exam room

- ☐ Body weight scales with a capacity of more than 300 pounds
- ☐ Height meter
- ☐ Large gowns
- ☐ Step stools with handle bars
- ☐ Large adult and thigh blood pressure cuffs
- ☐ Tape measure
- ☐ Wide examination tables, preferably bolted to the floor
- ☐ Consider a hydraulic tilt, if possible

### Tools

- ☐ Body mass index (BMI) chart
- ☐ Self-administered medical questionnaire
- ☐ Eating pattern questionnaire
- ☐ Physical activity pattern questionnaire
- ☐ Graphing your weight gain chart
- ☐ Food and activity diaries
- ☐ Pedometers

### Procedures

- ☐ Treatment protocols
- ☐ Medication use
- ☐ Referrals to other HCPs

It is also recommended that scales be placed in a private area and that practice staff only discuss a patient's weight within a private exam room.<sup>14</sup>

## Questions for Consideration

Ask yourself a few questions to assess your attitude toward patients with excess weight:

- How do I feel when I work with patients of different body sizes and with excess weight?
- Do I make judgments about a person's character, intelligence, or abilities based solely on their weight or appearance?
- Consider your body language when discussing weight with your patients. Are your arms crossed over your chest? Do you make any empathetic gestures such as a tap on their shoulder or knee? Are you standing or sitting?
- When discussing weight with a patient, am I using person-centered language and avoiding labeling and judgmental terms?





# Behavioral Therapy

# Behavioral Therapy

## Introduction

Behavioral therapy is a treatment component in weight management that provides patients with skills that connect a patient's thought processes to their current behaviors to better identify areas for change.<sup>15</sup>

Implementing behavioral therapy can increase motivation, empower patients, and promote self-care, with the goal of increasing efficiency in patient appointments.<sup>16</sup>

There are several skills and strategies commonly associated with behavioral therapy, including<sup>15,16</sup>:

- Self-monitoring
- Stress management
- Stimulus control
- Behavioral substitution
- Social support
- Problem solving
- Cognitive reframing
- Goal setting

## Why Behavioral Therapy?

Obesity is a chronic disease influenced by physiological, psychological, environmental, and genetic factors, often requiring long-term management.<sup>1</sup> Weight loss is challenging for many patients, and behavioral therapy is an important component of the treatment of obesity.

Typically, HCPs cite time constraints and lack of training as barriers to initiating behavioral therapy. However, implementing behavioral therapy techniques can increase your patient's motivation and ability to engage in self-care, which may generate positive clinical results.<sup>16</sup> The strategies and skills for behavioral therapy provided throughout this resource are also embedded into many of the talking points and questions provided in the *Changing the Obesity Discussion* guide.

## What Is Behavioral Therapy for Clinical Weight Management?

It is a technique that enables an individual to recognize and understand the relationship between the stimuli (internal or external) that initiate behaviors associated with poor weight management.<sup>16</sup>

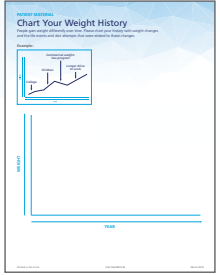
## What Are Its Goals?

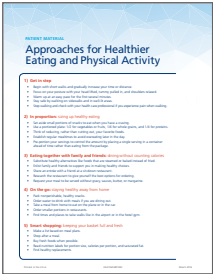
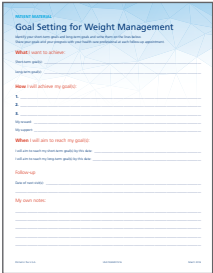
In a clinical setting, behavioral therapy can be successful when HCPs achieve the following goals<sup>16</sup>:

- Promote a patient's confidence in, and ability to engage in, active self-care
- Initiate behavioral changes that are productive for achieving the patient's stated goals
- Transfer behavioral skills to patients to ensure long-term behavioral change

## Strategies and Skills of Behavioral Therapy

To reach the potential benefits of behavioral therapy, it is important to pass along and build upon a skill set with your patients.

Self-monitoring <sup>15</sup>	Example
<p>The simple practice of recording the patient's eating and physical activity habits, as well as thoughts or feelings connected to those habits, enables patients to track progress toward goals and gain perspective over behavior patterns. Refer to the <i>Chart Your Weight History</i> handout as a patient resource enabling patients to chart their weight gains and losses along with accompanying life events.</p>	<p><i>Daily food and activity tracking.</i></p> 
Stress management <sup>15,16</sup>	Example
<p>Identifying areas of habitual stress and typical responses with the goal of implementing healthy coping and stress-reduction strategies.</p>	<p><i>Relaxation techniques that don't involve eating or drinking, like meditation or low-intensity activity.</i></p>
Stimulus control <sup>15</sup>	Example
<p>After patients learn to identify the stimuli in their common environments that prompt incidental behaviors, they can modify the environment to limit their exposure to those stimuli.</p>	<p><i>Listing common food cues and modifying the environment to reduce those cues, such as removing high-calorie foods from accessible areas.</i></p>
Behavioral substitution <sup>15</sup>	Example
<p>Identifying cues to eat that are not related to hunger and substituting alternative behaviors for eating. Valuable information from the OAC can be found at the following links:</p> <ul style="list-style-type: none"> <li>• <a href="http://www.obesityaction.org/understanding-obesity/obesity">http://www.obesityaction.org/understanding-obesity/obesity</a></li> <li>• <a href="http://www.obesityaction.org/obesity-treatments/behavior-modification-physical-activity">http://www.obesityaction.org/obesity-treatments/behavior-modification-physical-activity</a></li> </ul>	<p><i>Listing common food cues and substituting responses, such as cleaning or other low-intensity activities.</i></p>

<b>Social support<sup>16</sup></b>	<b>Example</b>
<p>Designating other helpers to appropriate support roles.</p>	<p><i>Practicing assertiveness to ask for help or designating a walking partner.</i></p>
<b>Problem solving<sup>15</sup></b>	<b>Example</b>
<p>These are skills that help patients to identify current problems or anticipate potential problems, devise and implement solutions, and assess the effectiveness of the solution. Refer to the <i>Approaches for Healthier Eating and Physical Activity</i> handout as a patient resource that contains tips for maintaining a healthier lifestyle.</p>	<p><i>Most of the examples listed are examples of problem solving.</i></p> 
<b>Cognitive reframing<sup>15</sup></b>	<b>Example</b>
<p>The ways that patients view themselves and their behaviors can influence their ability to initiate and sustain behavioral changes. Reframing a negative attitude into a positive one encourages patients to focus on progress as a habit rather than on setbacks.</p>	<p><i>If patients set 4 goals and achieve 3 of them, they should feel positive about the achievements and not consider the setback.</i></p>
<b>Goal setting<sup>15</sup></b>	<b>Example</b>
<p>Setting goals for behavioral weight management should focus on progress and achievement over time. More about discussing goals can be found in the section titled Setting Individual Goals in the <i>Obesity Discussions</i> guide. Refer to the <i>Goal Setting for Weight Management</i> handout as a patient resource to help patients list short- and long-term goals.</p>	<p><i>Setting a goal to cook most meals at home for 2 weeks with an incentive of dining out at the end of that time period.</i></p> 

## Benefits of Behavioral Therapy

Support from HCPs can help patients achieve clinically significant and maintained weight loss.<sup>2</sup> To that end, successful behavioral therapy sessions can generate beneficial results that include<sup>16</sup>:

- **Self- and situational awareness:** Through self-reflection and situational analysis, patients begin to recognize the disconnect between their automatic tendencies and their behavioral goals.
- **Gradual and sustainable changes:** Behavioral change can be an overwhelming and often time-consuming process. Behavioral therapy promotes a gradual process to build sustainable change.
- **Patient empowerment:** Behavioral therapy allows patients to come to their own conclusions and realizations about the stimulus-response relationships in their lives that are enabling detrimental behaviors. This, in turn, promotes accountability and autonomy.

More information on behavioral therapy can be found at:

<http://www.obesityaction.org/obesity-treatments/behavior-modification-physical-activity>



# Treatment Overview

# Treatment Overview

## Introduction

Multiple treatment guidelines have been developed by obesity specialists to provide guidance and support to HCPs diagnosing and managing overweight and obesity. They universally use BMI and obesity-related complications to diagnose and treat the disease. AACE guidelines, for instance, stress that obesity is a chronic disease that requires complications-specific staging and treatment.<sup>1</sup>

Regardless of your patient's obesity disease stage, healthy eating and physical activity should be included in any treatment plan.<sup>1</sup> HCPs play a significant role in guiding patients to incorporate healthy eating and physical activity habits into a lasting routine. Patients may run into some challenges as they begin and maintain their healthy eating and physical activity plans. Be sure to begin by discussing those challenges and managing their expectations for weight loss.

As you begin, encourage patients to start with realistic, measurable first steps and set reasonable expectations for safe and sustainable weight loss. Included in this guide are some best practices for supporting healthy eating and physical activity, including summations of the treatment guidelines offered by AACE, the Endocrine Society, and The Obesity Society (TOS).



# AACE Guidelines for the Management and Treatment of Obesity<sup>1</sup>

Diagnosis		Complications-specific Staging and Treatment	
STEP 1	STEP 2	STEP 3	STEP 4
Anthropometric Component—BMI <sup>a</sup>	Clinical Component	Complications-specific Staging <sup>b</sup>	Suggested Therapeutic Interventions
25.0-29.9	Presence or absence of obesity-related complications	Overweight	<ul style="list-style-type: none"> <li>• Healthy meal pattern and physical activity</li> <li>• Lifestyle modification/reduced-calorie meal plan</li> </ul>
≥30	<ul style="list-style-type: none"> <li>• Metabolic conditions                             <ul style="list-style-type: none"> <li>- Pre-diabetes</li> <li>- Metabolic syndrome</li> <li>- Type 2 diabetes</li> <li>- Hypertension</li> <li>- Dyslipidemia</li> <li>- NAFLD/NASH</li> </ul> </li> </ul>	Obesity Stage 0	<ul style="list-style-type: none"> <li>• Lifestyle modification/reduced-calorie meal plan/physical activity</li> <li>• Intensive behavioral and lifestyle therapy</li> </ul>
≥25	<ul style="list-style-type: none"> <li>• Sleep apnea</li> <li>• PCOS</li> </ul>	Obesity Stage 1 (1 or more mild-moderate complications)	<ul style="list-style-type: none"> <li>• Lifestyle modification/reduced-calorie meal plan/physical activity</li> <li>• Intensive behavioral and lifestyle therapy</li> <li>• Consider adding weight-loss medications to lifestyle therapy program if BMI ≥27.0</li> </ul>
≥25	<ul style="list-style-type: none"> <li>• Osteoarthritis</li> <li>• Stress incontinence</li> <li>• GERD</li> <li>• Disability/immobility</li> <li>• Psychological disorder or stigmatization</li> </ul>	Obesity Stage 2 (at least 1 severe complication)	<ul style="list-style-type: none"> <li>• Intensive behavioral and lifestyle therapy</li> <li>• Intensive behavioral and lifestyle therapy with medications if BMI ≥27.0</li> <li>• Consider bariatric surgery in patients with type 2 diabetes and BMI 35.0-39.9</li> <li>• Consider bariatric surgery in patients with BMI ≥40.0</li> </ul>

<sup>a</sup>Note: All patients with BMI ≥25 have either Overweight, Obesity Stage 0, Obesity Stage 1, or Obesity Stage 2, depending on the initial clinical evaluation for presence and severity of complications.

<sup>b</sup>Stages are determined using criteria specific to each obesity-related complication. Stage 0 = no complication; Stage 1 = mild to moderate; Stage 2 = severe.

GERD, gastroesophageal reflux disease; NAFLD, nonalcoholic fatty liver disease; NASH, nonalcoholic steatohepatitis; PCOS, polycystic ovary syndrome.

Reprinted from *Endocrine Practice*, Vol #20 (9), Author(s): Garvey WT et al, Title of Article: *2014 Advanced Framework for a New Diagnosis of Obesity as a Chronic Disease*, Table #5, Copyright: 9/2014, with permission from the American Association of Clinical Endocrinologists.

## AACE Obesity Treatment Framework<sup>1</sup>

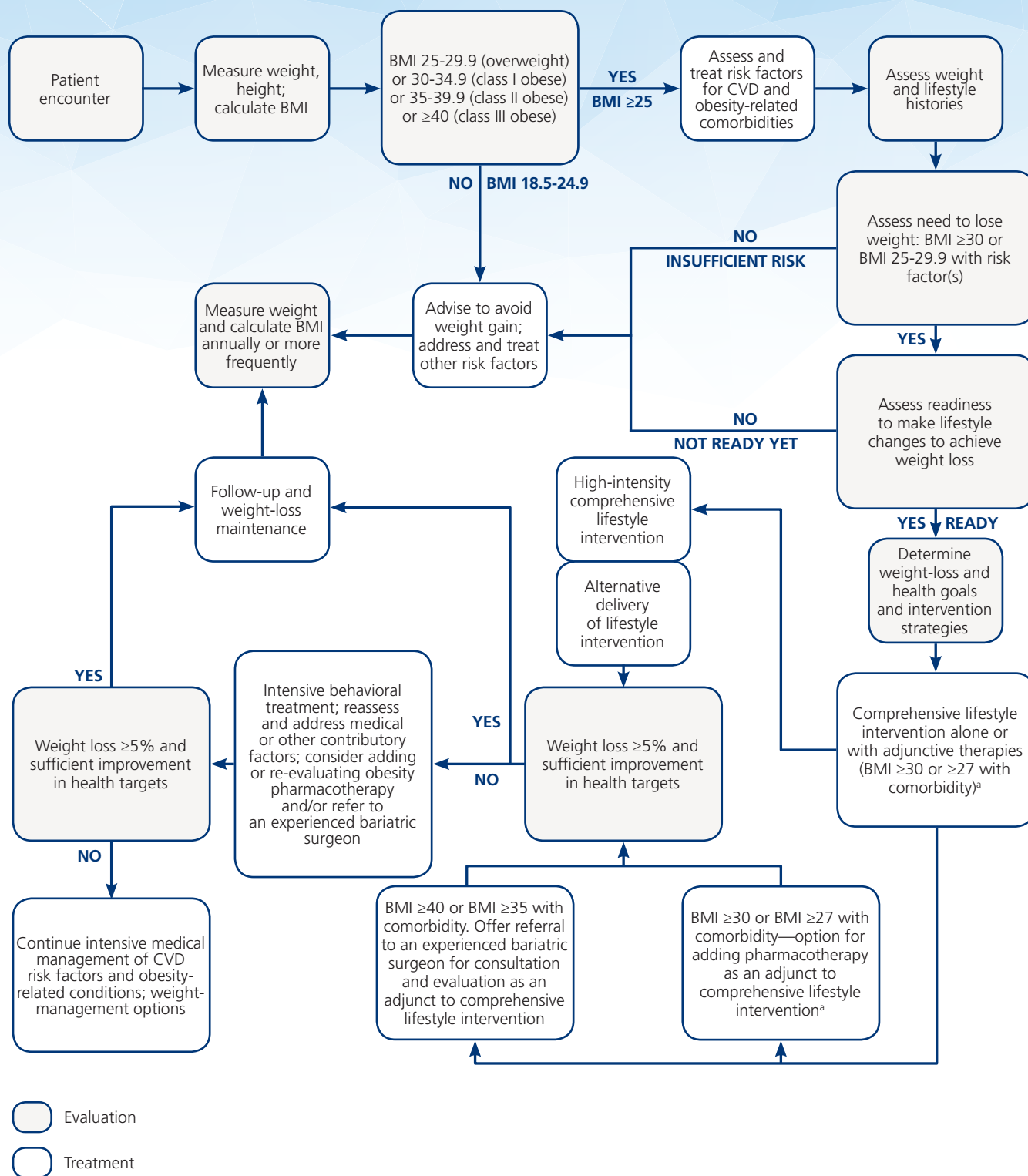
AACE has established an advanced framework for the diagnosis, treatment, and management of obesity. While anthropometric measures such as BMI are used in the AACE framework, the complete diagnosis considers the impact of weight on the patient's overall health by accounting for the presence and severity of specific obesity-related complications.

The staging of complications can be used to guide the selection of treatment modality and the intensity of weight-loss therapy. The range of possible treatment modalities includes:

- Healthy meal patterns and physical activity
- Intensive behavioral and lifestyle therapy
- Addition of weight-loss medications to a lifestyle therapy program
- Bariatric surgery

You can go to [www.aace.com/article/278](http://www.aace.com/article/278) for the full version of the advanced framework, and a full list of complications-specific criteria can be found at [www.aace.com/files/position-statements/framework-position-statement.pdf](http://www.aace.com/files/position-statements/framework-position-statement.pdf).

# AHA/ACC/TOS Treatment Algorithm for Patients With Overweight and Obesity<sup>17</sup>



<sup>a</sup>BMI cutpoint determined by the FDA and listed on the package inserts of FDA-approved obesity medications.

ACC, American College of Cardiology; AHA, American Heart Association; CVD, cardiovascular disease; FDA, US Food and Drug Administration.

Adapted from Jensen MD, Ryan DH, Apovian CM, et al; American College of Cardiology/American Heart Association Task Force on Practice Guidelines; The Obesity Society. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *J Am Coll Cardiol*. 2014;63(25 pt B):2985-3023.

## TOS Guidelines for the Management and Treatment of Obesity<sup>17</sup>

- Begin by determining a patient's BMI, presence of obesity-related conditions, and family history.
- All patients for whom weight loss is recommended should first be offered or referred to comprehensive lifestyle intervention, preferably with a trained interventionist or nutrition professional.
- If a patient has been unable to lose weight or sustain weight loss with this lifestyle intervention, and has a BMI  $\geq 30$  or  $\geq 27$  with a comorbidity, adjunctive therapies may be considered.
- For those patients who are motivated to lose weight, pharmacotherapy can be considered as an adjunct to continued comprehensive lifestyle intervention.
- Bariatric surgery may also be considered.

Finally, the guidelines state that obesity is a chronic condition that typically develops over a patient's lifetime, and that a weight-maintenance program with frequent contact can improve long-term success.

## The Endocrine Society Guidelines for the Pharmacological Management of Obesity<sup>18</sup>

The Endocrine Society guidelines recommend that diet, exercise, and behavioral modification be included in all obesity management approaches for BMI  $\geq 25$  kg/m<sup>2</sup>, and that other tools such as pharmacotherapy (BMI  $\geq 27$  kg/m<sup>2</sup> with comorbidity or BMI  $>30$  kg/m<sup>2</sup>) and bariatric surgery (BMI  $\geq 35$  kg/m<sup>2</sup> with comorbidity or BMI  $>40$  kg/m<sup>2</sup>) be used as adjuncts to behavioral modification to reduce food intake and increase physical activity when possible.

The guidelines state that patients who have a history of being unable to successfully lose weight and maintain weight loss and who meet label indications are candidates for weight-loss medications.

They recommend:

- Medication be continued if a patient's response to a weight-loss medication is deemed effective (weight loss  $\geq 5\%$  of body weight at 3 months) and safe
- Assessment of efficacy and safety at least monthly for the first 3 months
- Assessment at least every 3 months for as long as patient is prescribed medication

## Healthy Eating and Physical Activity Planning

Initiating healthier eating and activity habits is a fundamental step in weight management. Regardless of your patient's disease stage, healthy eating and physical activity plans are recommended by multiple treatment guidelines. Even if more aggressive treatment options like surgery are decided upon, a healthy eating and physical activity plan needs to be initiated.<sup>1</sup>

Understanding your patients, their unique perspectives, experiences, and feelings about their current eating and activity habits is essential. As you plan with your patient, be sure to discuss common challenges patients face when initiating a physical activity and healthy eating plan. You may want to refer back to their answers during your weight-history discussion about previous plans and activities they have tried.

## Common Patient Challenges to Healthy Eating and Physical Activity

As you create a plan for healthy eating and physical activity with your patient, it may be helpful to discuss common challenges patients often face<sup>19,20</sup>:

- All-or-nothing mind-set
- Time
- Portion management
- Special events
- Diet and fitness myths
- Cost
- Access (leading to frequent or binge eating)
- Unrealistic expectations
- Safety
- Self-consciousness
- Confusion
- Self-doubt
- Emotional difficulties

## Strategies for Improved Healthy Eating Habits

According to a report of the ACC/AHA Task Force on Practice Guidelines and TOS, evidence suggests that no single dietary modification plan or strategy is more effective than another, provided the goal is to achieve a daily 500- to 750-calorie deficit.<sup>17</sup>

Consider some of the following strategies to achieve calorie deficits that patients can maintain over an extended period<sup>17</sup>:

- Consistently eating 3 meals per day, and establishing regular mealtimes to avoid overeating later in the day
- Practicing mindful eating, and reducing amounts rather than cutting out favorite foods
- Cooking meals at home
- Using a portioned plate: 1/2 for fruits or vegetables, 1/4 for whole grains, and 1/4 for proteins
- Limiting frequency of fast food or carry-out meals
- Setting aside small portions of snacks to satisfy cravings
- Keeping track of daily foods and drinks (counting calories is optional)

If you feel that patients need more guidance, consider referring them to dietitians or nutritional counselors.

## Approaches for Increased Physical Activity

Because physical activity is so crucial to successful weight management, and yet can be a daunting prospect to some of your patients, here are some tips you can offer them:

- Begin with short walks and gradually increase your time and distance
- Warm up at an easy pace for the first several minutes
- Focus on your posture with your head lifted, tummy pulled in, and shoulders relaxed
- Stop walking and check with your health care provider if you experience pain when walking

## Best Practices for Supporting Healthy Eating and Physical Activity

- **Start with realistic steps:** By eliciting your patient's goals, you can help him/her to determine realistic and achievable targets. The steps should be measurable and build on each other over time.<sup>21</sup>
- **Not always about knowledge:** Focus on broad strategies and basic techniques for better nutrition and physical activity.<sup>21</sup>
- **Set expectations:** As a patient sets goals for change, make sure they are attainable and realistic. You should also discuss a healthy weight-loss rate, which for most is 1 to 2 pounds (0.5 to 1.0 kg) per week over the course of the first 6 months.<sup>3</sup>
- **Focus on progress:** Your patient will likely face a setback or 2 along the way. Instead of focusing on those setbacks, always discuss the progress your patient has made over time.<sup>21</sup>
- **Revisit long-term goals:** Throughout the process, connect the patient's long-term goals to actions they can take.<sup>21</sup>

As you discuss plans with your patients, be sure to point out that increasing activity levels is not simply getting exercise. Adding time spent walking, reducing time spent sitting, doing extra housework, or active play with children are all ways to increase activity levels.

**Examples of other guidelines for treatment and management can be found at the following websites:**

The ACC and AHA have collaborated with the National Heart, Lung, and Blood Institute and stakeholder and professional organizations to develop clinical practice guidelines for assessment of cardiovascular (CV) risk, lifestyle modifications to reduce CV risk, and management of blood cholesterol, overweight, and obesity in adults. The guidelines were approved for publication by the ACC, AHA, and TOS.

**AACE advanced framework for a new diagnosis of obesity as a chronic disease (2014)**

<https://www.aace.com/article/278>

**2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society**

[circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation](http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation)

**Pharmacological management of obesity: an Endocrine Society clinical practice guideline (2015)**

<http://press.endocrine.org/doi/full/10.1210/jc.2014-3415>

**National Institutes of Health: Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults**

[www.nhlbi.nih.gov/files/docs/guidelines/ob\\_gdlns.pdf](http://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf)

**Edmonton Obesity Staging System**

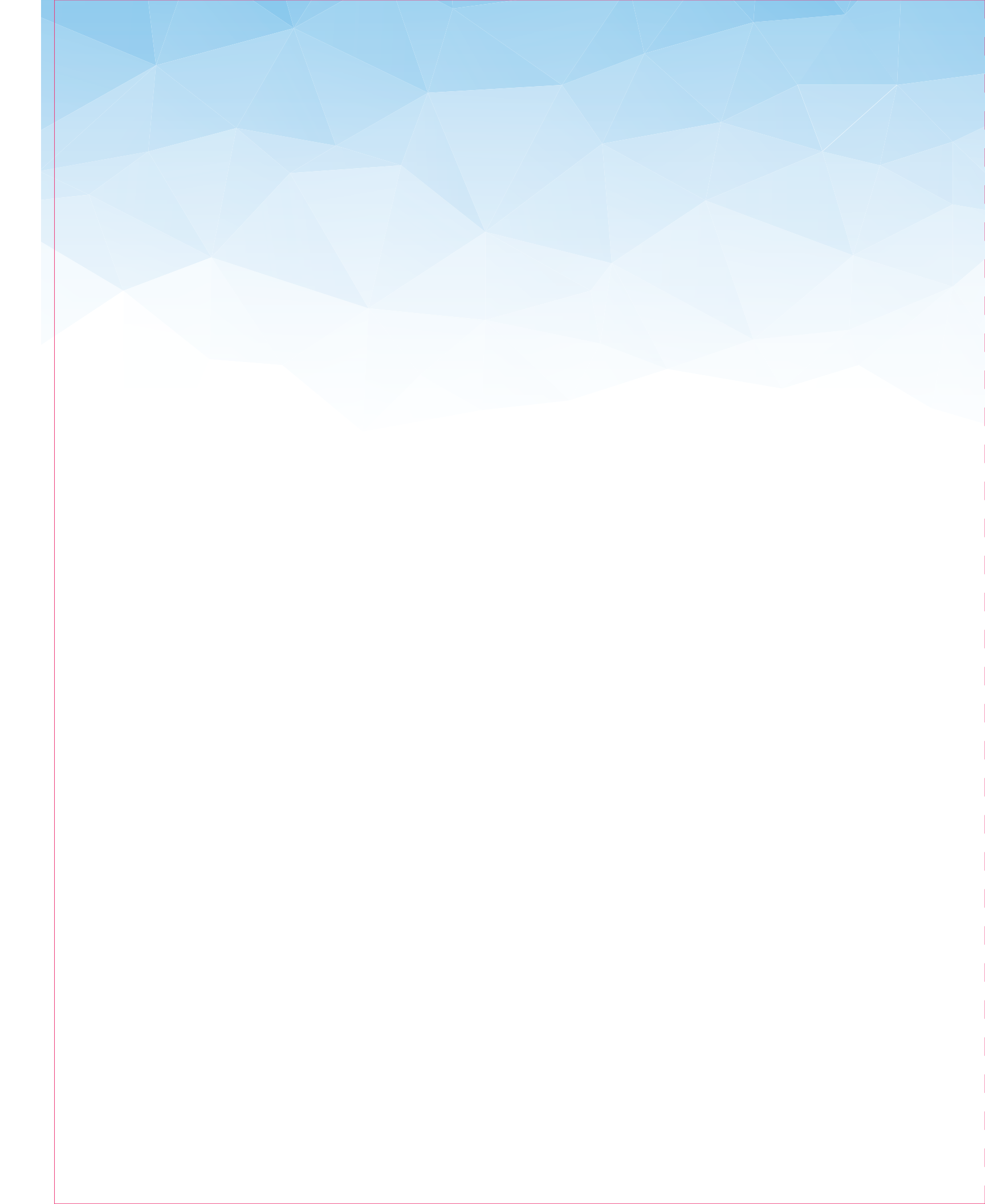
[www.drsharma.ca/edmonton-obesity-staging-system.html](http://www.drsharma.ca/edmonton-obesity-staging-system.html)

**Obesity Medicine Association: Obesity Algorithm®**

[www.asbp.org/obesityalgorithm.html](http://www.asbp.org/obesityalgorithm.html)

**US Preventative Services Task Force: Final recommendation statement: obesity in adults: screening and management**

[www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management](http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management)





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