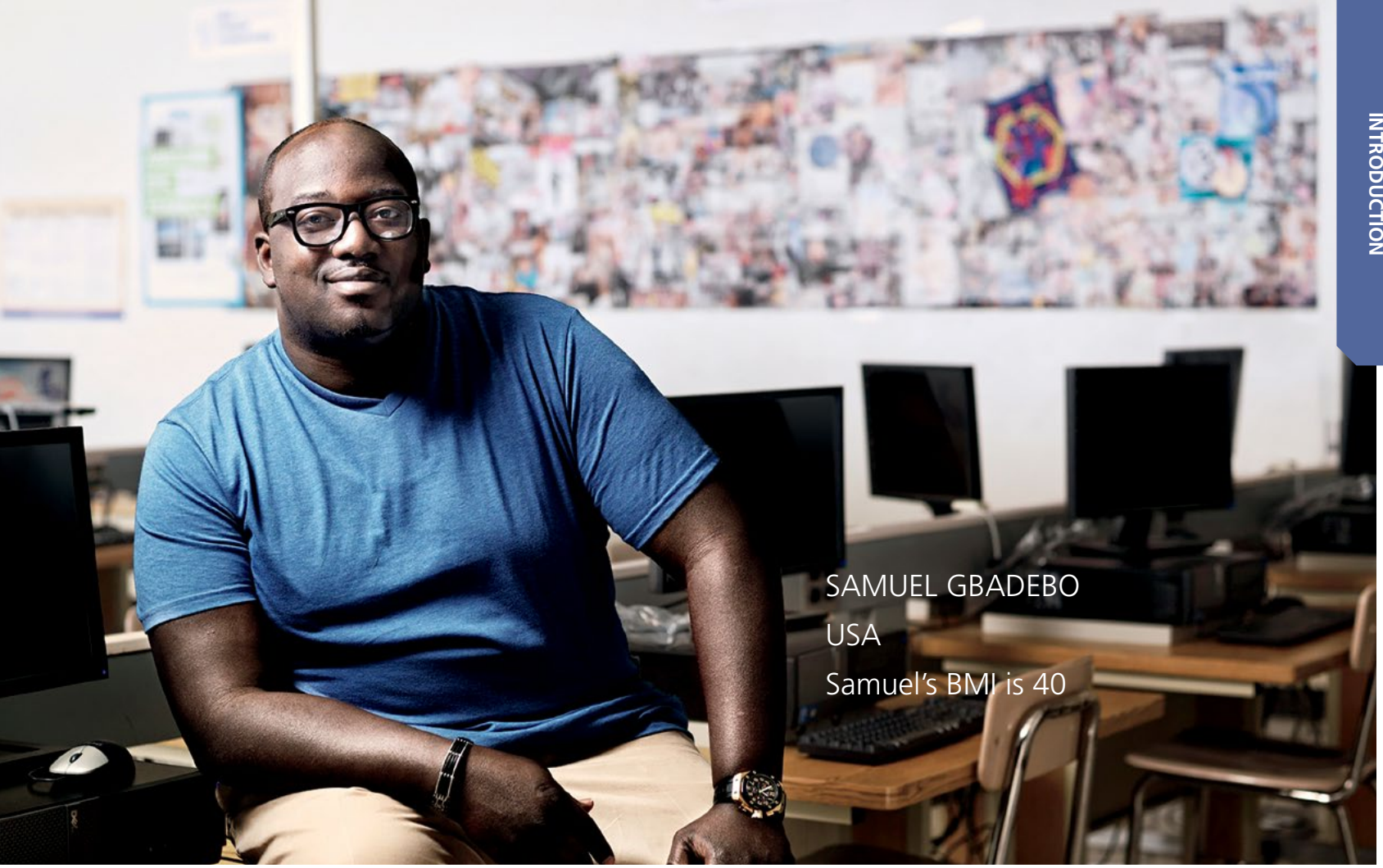

SAMUEL GBADEBO
USA
Samuel's BMI is 40

# Rethink Obesity® education

Useful techniques to enable effective conversations with patients.

**Rethink Obesity®**

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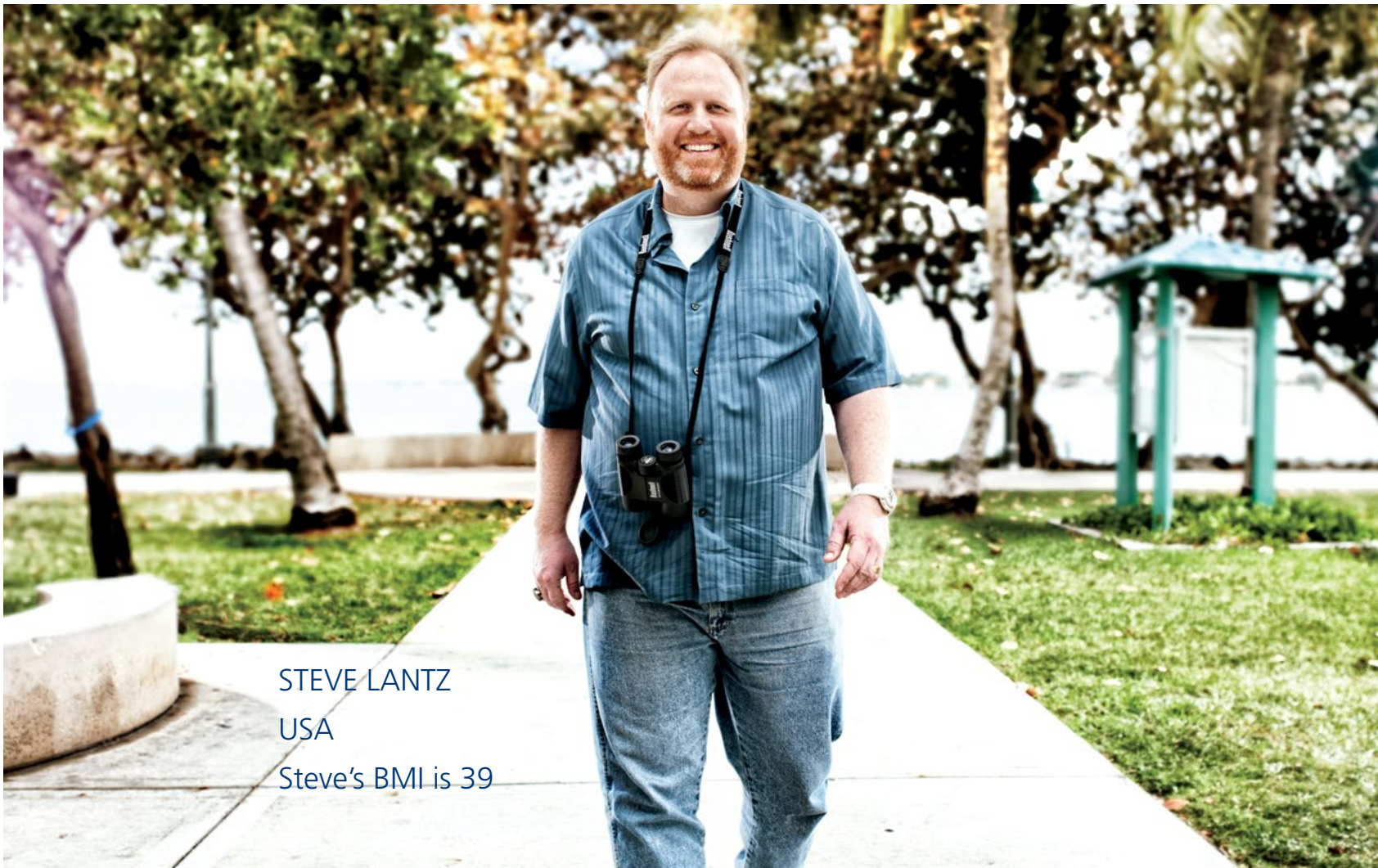
# Welcome and Introduction

Obesity is a complex, lifelong disease, influenced by environmental, genetic, physiological, and psychological factors, which should be treated by health care professionals.[1] As a health care professional, you are uniquely qualified to initiate and guide your patients through the process of weight loss, weight maintenance, and better health.

- Physician-initiated discussions and advice regarding weight loss encourage patients to change their behavior[2]
- Collaboration, counseling, and medical support from health care professionals helps patients achieve clinically significant and maintained weight loss[2]
- Achieving and maintaining weight loss requires long-term intervention[3]

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



STEVE LANTZ
USA
Steve's BMI is 39

## Content Overview

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

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

In addition, the current guidelines of obesity management set out by the American Association of Clinical Endocrinologists and the American College of Endocrinology (AACE/ACE) published in 2016 are provided for reference. 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 Rethink Obesity® Education

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.[4] The model was modified for obesity management for health care professionals 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.[5]

**The 5As of Obesity Management are as follows[6]:**

| | |
|---|---|
| **1. ASK** | • Ask for permission to discuss weight<br>• Explore readiness for change |
| **2. ASSESS** | • Assess obesity class and stage<br>• Assess for drivers, complications, and barriers |
| **3. ADVISE** | • Advise on obesity risks<br>• Explain benefits of modest weight loss<br>• Explain the need for a long-term strategy<br>• Discuss treatment options |
| **4. AGREE** | • Agree on realistic weight-loss expectations<br>• Focus on behavioural goals (SMART) and health outcomes<br>• Agree on treatment plan |
| **5. ASSIST** | • Address drivers and barriers<br>• Provide education and resources<br>• Refer to appropriate provider<br>• Arrange follow-up |

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

# Motivational Interviewing

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# Motivational Interviewing


## Summary

Motivational interviewing is an engagement strategy that aims to enhance self-efficacy and personal control for behavior change. As a method of communication, motivational interviewing is inherently collaborative, employing empathy and active listening to build trust and rapport between patients and health care professionals.[7]

Through the strategies of motivational interviewing, health care professionals can collaboratively explore patients' motivations for change and goal setting. The strategies of motivational interviewing include[7]:

- **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 *Rethink Your Obesity Discussions* guide model the motivational interviewing approach to help guide health care professionals in application with their patients.

## Defining Motivational Interviewing[7]

Motivational interviewing is a collaborative, goal-oriented approach of communication to elicit behavior 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[7]

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[7]

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**<br>**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**<br>**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**<br>**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**<br>**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.* |

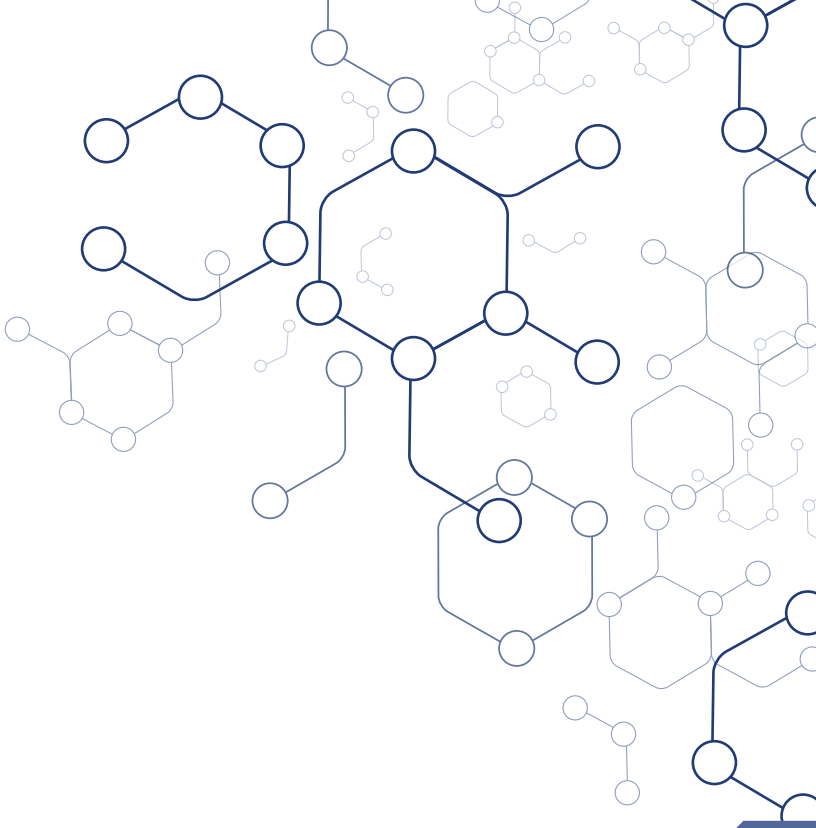
## Questions for Consideration

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?

MARY EDWARDS
USA
Mary's BMI is 44

For more information, resources, and tools, please visit **RethinkObesity.com**.



# Keys to Successful Conversations

SUCCESSFUL CONVERSATIONS

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# Keys to Successful Conversations


## Summary

Collaboration, counseling, and medical support from health care professionals may help patients achieve clinically significant and maintained weight loss.[2] Studies have shown that successful conversations between health care professionals and patients help patients to be more successful with their weight-loss goals.[2]

The weight discussion can be an uncomfortable one, which makes word choices especially important.[11] Consider using more descriptive terms like "healthy eating habits" and "physical activity routine" in place of terms like "diet" and "exercise." Other communication strategies like active listening, empathy, and encouragement can promote productive dialogue and healthy relationships with your patients.[8,9]

## Introduction

Studies link communication behaviors, such as empathy, encouragement, and psychosocial talk, with improved patient satisfaction and adherence.[8,9]

A successful conversation with patients about weight management has been shown to be 10% to 20% more effective in increasing motivation, encouraging action, and sustaining changes when compared with a didactic delivery of recommendations from a health care professional.[10]

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

## Preferable Terms and Phrases

Research has shown that choice of words plays an important role when discussing weight management.[11] 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 or excess weight rather than a discussion of obesity.
- **Activity** instead of exercise. Increasing activity levels can take many forms. A patient doesn't need to join a gym or begin running, which might be what they 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 chronic management required for long-term healthy weight.
- **Obesity and obese** are both clinical terms intended to describe a patient's condition, but can also sound judgmental or labeling in a different context. Referring to a patient as obese is something to avoid.

## Other Terms to Avoid[11]

- Excess fat
- Heaviness
- Large size
- Weight problem

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## Addressing Weight Bias

Research indicates that patients with excess weight feel stigmatized in many areas of their life, including health care settings.[12] 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[13]:

### 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

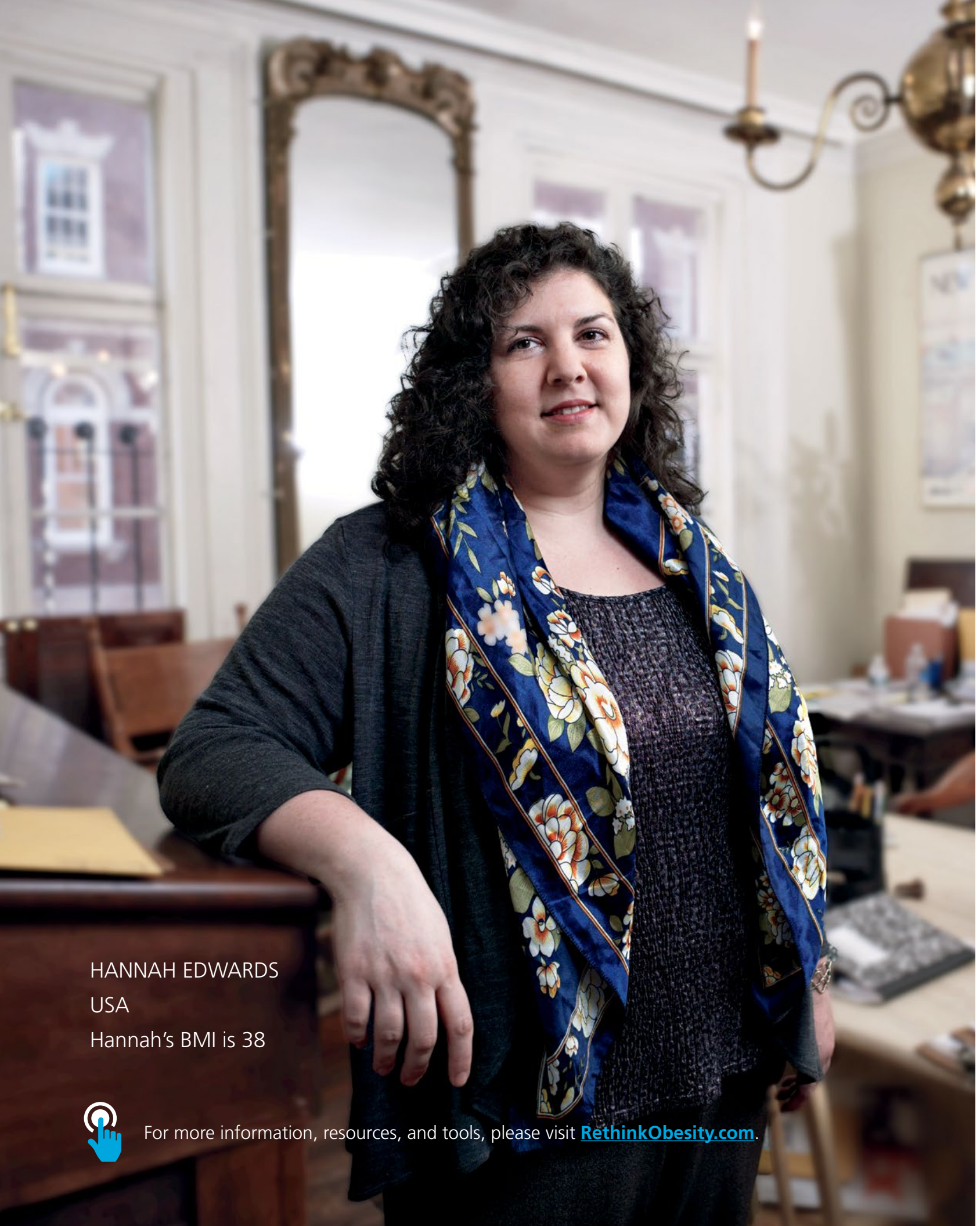
### Tools

- ☐ 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 health care professionals

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.[13]



HANNAH EDWARDS
USA
Hannah's BMI is 38

For more information, resources, and tools, please visit **RethinkObesity.com**.

## 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 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?

For more information, resources, and tools, please visit **RethinkObesity.com**.

# Behavioral Therapy



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# Behavioral Therapy


## Summary

Behavioral therapy is a treatment component in weight management that provides patients with skills that connect their thought processes to their current behaviors to better identify areas for change.[14]

Implementing behavioral therapy can increase motivation, empower patients, and promote self-care with the goal of increasing efficiency in patient appointments.[15]

There are several skills and strategies commonly associated with behavioral therapy including[14,15]:

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

## Introduction

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

Typically, health care professionals 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.[15] 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 *Rethink Your Obesity Discussions* guide.

## Goals of Behavioral Therapy for Weight Management

In a clinical setting, behavioral therapy can be successful when health care professionals achieve the following goals[15]:

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

## Defining Behavioral Therapy for Clinical Weight Management[15]

Behavioral therapy in weight management 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.

## 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 to your patients.

| Self-monitoring[14] | Example |
|---|---|
| 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. | *Daily food and activity tracking.* |

| Stress management[15] | Example |
|---|---|
| Identifying areas of habitual stress and typical responses with the goal of implementing healthy coping and stress reduction strategies. | *Relaxation techniques that don't involve eating or drinking, like meditation, or low-intensity activity.* |

| Stimulus control[14] | Example |
|---|---|
| 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. | *Listing common food cues and modifying the environment to reduce those cues, such as removing high-calorie foods from accessible areas.* |

| Behavioral substitution[14] | Example |
|---|---|
| Identifying cues to eat that are not related to hunger and substituting alternative behaviors for eating. | *Listing common food cues and substituting responses like cleaning or other low-intensity activities.* |

| Social support[15] | Example |
|---|---|
| Designating other helpers to appropriate support roles. | *Practicing assertiveness to ask for help or designating a walking partner.* |

| Problem-solving[14] | Example |
|---|---|
| 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. | *Most of the examples listed are examples of problem solving.* |

| Cognitive reframing[14] | Example |
|---|---|
| The ways that patients view themselves and their behaviors can influence their ability to initiate and sustain behavior changes. Reframing a negative attitude into a positive one encourages patients to focus on progress as a habit rather than on setbacks. | *If patients set 4 goals and achieve 3 of them, they should feel positive about the achievements and not consider the setback.* |

| Goal setting[14] | Example |
|---|---|
| Setting goals for behavioral weight management should focus on progress and achievement over time. | *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.* |

## Benefits of Behavioral Therapy[15]

Successful behavioral therapy sessions between health care professionals and patients can generate beneficial results, such as:

- **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:** Behavior 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

For more information, resources, and tools, please visit **RethinkObesity.com**.

# Treatment Overview

# Treatment Overview


## Summary

The 2016 AACE/ACE guidelines have been developed by obesity specialists to provide guidance and support to health care professionals diagnosing and managing overweight and obesity. They use BMI and obesity-related complications to stage and treat the disease. The AACE/ACE guidelines stress that obesity is a chronic disease and requires complications-specific staging and treatment.[1]

Regardless of your patient's obesity disease stage, healthy eating and physical activity should be included in any treatment plan.[1] Health care professionals 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 support practices for supporting healthy eating and physical activity.

## AACE/ACE Obesity Treatment Framework[1]

AACE/ACE has established an advanced framework for the diagnosis, treatment, and management of obesity. While anthropometric measures like BMI are used in the AACE/ACE 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. Go to **https://journals.aace.com/doi/pdf/10.4158/EP161365.GL** for the full version of the advanced framework.

While the AACE/ACE treatment overview is a great place to start, each weight management plan should be customized to individual patients according to the presence and severity of their obesity-related complications, as well as their individual goals and level of motivation.

# AACE/ACE guidelines for the Management and Treatment of Obesity[1]

## Diagnosis and Medical Management of Obesity

| DIAGNOSIS | | COMPLICATION-SPECIFIC STAGING AND TREATMENT | | |
|---|---|---|---|---|
| **Anthropometric Component (BMI kg/m²)** | **Clinical Component** | **Disease Stage** | **Chronic Disease Phase of Prevention** | **Suggested Therapy (based on clinical judgment)** |
| **<25**<br><23 in certain ethnicities<br>waist circumference below regional/ethnic cutoffs | | Normal weight<br>(no obesity) | Primary | • **Healthy lifestyle:** healthy meal plan/ physical activity |
| **25-29.9**<br>23-24.9 in certain ethnicities | Evaluate for presence or absence of adiposity-related complications and severity of complications<br>• Metabolic syndrome<br>• Prediabetes<br>• Type 2 diabetes<br>• Dyslipidemia<br>• Hypertension<br>• Cardiovascular disease<br>• Nonalcoholic fatty liver disease<br>• Polycystic ovary syndrome<br>• Female infertility<br>• Male hypogonadism<br>• Obstructive sleep apnea<br>• Asthma/reactive airway disease<br>• Osteoarthritis<br>• Urinary stress incontinence<br>• Gastroesophageal reflux disease<br>• Depression | Overweight<br>stage 0<br>(no complications) | Secondary | • **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions |
| **≥30**<br>≥25 in certain ethnicities | | Obesity stage 0<br>(no complications) | Secondary | • **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions<br>• **Weight-loss medications:** Consider after lifestyle therapy fails to prevent progressive weight gain. (BMI ≥27) |
| **≥25**<br>≥23 in certain ethnicities | | Obesity stage 1<br>(mild-moderate complications) | Tertiary | • **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions<br>• **Weight-loss medications:** Consider after lifestyle therapy fails to achieve therapeutic target or initiate concurrent with lifestyle therapy. (BMI ≥27) |
| **≥25**<br>≥23 in certain ethnicities | | Obesity stage 2<br>(at least 1 severe complication) | Tertiary | • **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions<br>• **Add weight-loss medications:** Initiate concurrent with lifestyle therapy. (BMI ≥27)<br>• **Consider bariatric surgery:** (BMI ≥35) |

a. All patients with BMI ≥25 have either overweight stage 0, obesity stage 0, obesity stage 1, or obesity stage 2, depending on the initial clinical evaluation for presence and severity of complications. These patients should be followed over time and evaluated for changes in both anthropometric and clinical diagnostic components. The diagnoses of overweight/obesity stage 0, obesity stage 1, and obesity stage 2 are not static, and disease progression may warrant more aggressive weight-loss therapy in the future. BMI values ≥25 have been clinically confirmed to represent excess adiposity after evaluation for muscularity, edema, sarcopenia, etc.

b. Stages are determined using criteria specific to each obesity-related complication; stage 0=no complication; stage 1=mild-to-moderate; stage 2=severe.

c. Treatment plans should be individualized; suggested interventions are appropriate for obtaining the sufficient degree of weight loss generally required to treat the obesity-related complication(s) at the specified stage of severity.

d. BMI ≥27 is consistent with the prescribing information mandated by the US Food and Drug Administration for weight-loss medications.

Reprinted with permission from American Association of Clinical Endocrinologists and American College of Endocrinology.[1]

## Obesity-related Complications That Can Be Improved by Weight Loss[1]

The AACE/ACE guidelines recommend treating obesity based on the presence and severity of obesity-related complications. Each stage of the disease corresponds to the severity level of 1 or more of these complications. Several of the complications below have a corresponding clinical marker that can be used in assessing the presence and severity of the complication. Using these clinical markers as well as information gathered from physical examinations and discussions with your patients, you can stage the disease.

- Metabolic syndrome
- Prediabetes
- Type 2 diabetes
- Dyslipidemia
- Hypertension
- Cardiovascular disease
- Nonalcoholic fatty liver disease (NAFLD)
- Polycystic ovary syndrome (PCOS)
- Female infertility
- Male hypogonadism
- Obstructive sleep apnea
- Asthma/reactive airway disease
- Osteoarthritis
- Urinary stress incontinence
- Gastroesophageal reflux disease (GERD)
- Depression

A full list of complications-specific criteria can be found at
**https://journals.aace.com/doi/pdf/10.4158/EP161365.GL**

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## 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 AACE/ACE. Even if more aggressive treatment options like surgery are decided upon, a healthy eating and physical activity plan needs to be initiated.[1]

Understanding your patients and 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.[16, 17]

- All-or-nothing mind-set
- Time
- Portion management
- Special events
- Diet and fitness myths
- Cost
- Access
- Unrealistic expectations
- Safety
- Self-consciousness
- Confusion
- Self-doubt

## Strategies for Improved Healthy Eating Habits

According to A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society (AHA/ACC/TOS), evidence suggests that no single dietary modification plan or strategy is more effective than another, provided the goal is to achieve a 500 to 750 daily calorie deficit.[18]

Consider some of the following strategies to achieve calorie deficits that patients can maintain over an extended period:

- Consistently eating 3 meals per day
- Practicing mindful eating
- Cooking meals at home
- Limiting frequency of fast food or carry-out meals
- Keeping track of daily foods and drinks (counting calories is optional)

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

## Best Practices for Supporting Healthy Eating and Physical Activity[19]

- **Start with the realistic steps:** By eliciting your patients' goals, you can help them to determine realistic and achievable targets. The steps should be measurable and build on each other over time
- **Not always about knowledge:** Focus on broad strategies and basic techniques for better nutrition and physical activity
- **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[3]
- **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
- **Revisit long-term goals:** Throughout the process, connect the patients' long-term goals to actions they can take

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 house work, or active play with children are all ways to increase activity levels.

For more information, resources, and tools, please visit **RethinkObesity.com**.

**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 (NHLBI) and stakeholder and professional organizations to develop clinical practice guidelines for assessment of cardiovascular 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.

**2013 TOS/AHA/ACC 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
https://www.ahajournals.org/doi/full/10.1161/01.cir.0000437739.71477.ee

**National Institute of Health Clinical guideline of the identification, evaluation, and treatment of overweight and obesity in adults**
https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf

**Edmonton Obesity Staging System (EOSS)**
http://www.drsharma.ca/setting-the-stage-for-edmonton-obesity-staging-system

**Obesity Medicine Association**
https://obesitymedicine.org/obesity-algorithm/

**US Preventive Services Task Force**
Final Recommendation Statement Obesity in Adults: Screening and Management
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/healthful-diet-and-physical-activity-for-cardiovascular-disease-prevention-in-adults-without-known-risk-factors-behavioral-counseling

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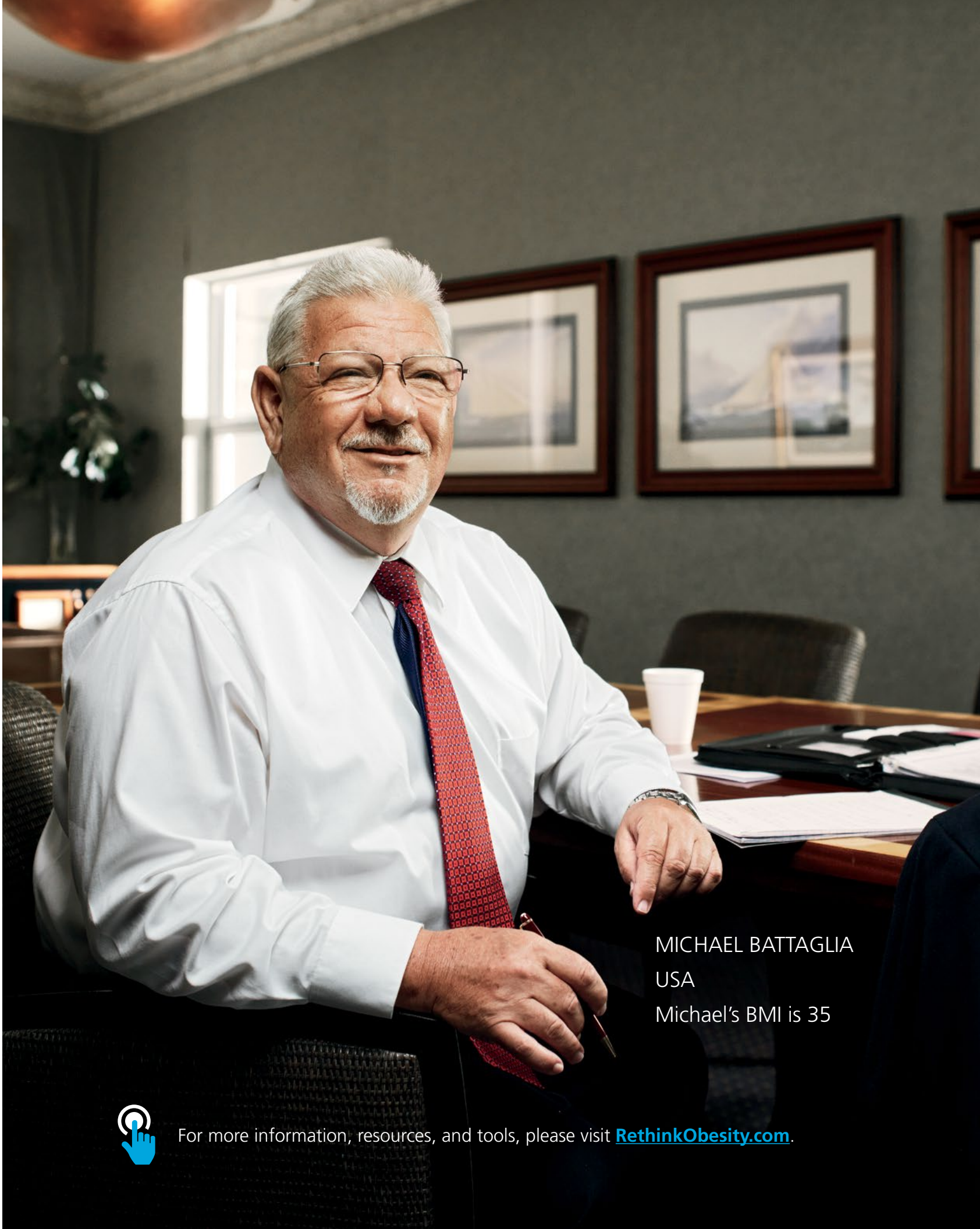

MICHAEL BATTAGLIA
USA
Michael's BMI is 35

For more information, resources, and tools, please visit **RethinkObesity.com**.

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