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Ohio Cardiovascular and Diabetes Health Collaborative

In partnership with:

Cardi-OH ECHO

Weight Management and Behavior Change: Cases and Discussions

February 3, 2022

Cardi-OH ECHO Team and Presenters

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Structure of ECHO Clinics

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Duration	Item
5 minutes	Introductions and announcements
10 minutes	Didactic presentation, followed by Q&A
40 minutes (20 minutes per case)	Patient case study presentations and discussions
5 minutes	Reminders and Post-Clinic Survey

Disclosure Statements

- The following planners, speakers, and/or content experts of the CME activity have financial relationships with commercial interests to disclose:
  - Marilee Clemons reports advising at Novo Nordisk.
  - Kathleen Dungan, MD, MPH reports receiving consulting fees from Eli Lilly, Boehringer Ingelheim, and Dexcom, research support from Sanofi, Dexcom, Abbott and Viacyte and presentation honoraria from Medscape, UpToDate, and Elsevier.
  - Adam T. Perzynski, PhD reports being co-founder of Global Health Metrics LLC, a Cleveland-based software company and royalty agreements for book authorship with Springer Nature publishing and Taylor Francis publishing.
  - Goutham Rao, MD serves on the Scientific Advisory Board of Dannon-WhiteWave (White Plains, NY), a division of Groupe Danone, S.A., Paris, France.
  - Christopher A. Taylor, PhD, RDN, LD, FAND reports funding for his role as a researcher and presenter for Abbott Nutrition and funding for research studies with the National Cattleman's Beef Association and the American Dairy Association Mideast.
  - These financial relationships are outside the presented work.
- All other planners, speakers, and/or content experts of the CME activity have no financial relationships with commercial interests to disclose.

Person-Centered Language Recommendations

The ADA and the APA recommend language that emphasizes inclusivity and respect:

- **Gender**: Gender is a social construct and social identity; use term "gender" when referring to people as a social group. Sex refers to biological sex assignment; use term "sex" when referring to the biological distinction.
- **Race**: Race is a social construct that is broadly used to categorize people based on physical characteristics, behavioral patterns, and geographic location. Race is not a proxy for biology or genetics. Examining health access, quality, and outcome data by race and ethnicity allows the healthcare system to assist in addressing the factors contributing to inequity and ensure that the health system serves the needs of all individuals.
- **Sexual Orientation**: Use the term "sexual orientation" rather than "sexual preference" or "sexual identity." People choose partners regardless of their sexual orientation; however, sexual orientation is not a choice.
- **Disability**: The nature of a disability should be indicated when it is relevant. Disability language should maintain the integrity of the individual. Language should convey the expressed preference of the person with the disability.
- **Socioeconomic Status**: When reporting SES, provide detailed information about a person's income, education, and occupation/employment. Avoid using pejorative and generalizing terms, such as "the homeless" or "inner-city."

Flanagin A et al., 2021, JAMA; Dickinson JK et al., Diabetes Care, 2017; American Psychological Association, 2021; ODM, 2021.

Key Principles of Weight Management Communication

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Learning Objectives

1. Describe the "Opening the Door" approach to beginning weight management discussions.
2. List a minimum of 3 preferred terms to use when discussing weight management.
3. List a minimum of 3 additional key communication tasks essential to effective weight management counseling.

New and Emerging Weight Management Strategies for Busy Ambulatory Settings

A Scientific Statement From the American Heart Association

Endorsed by the Society of Behavioral Medicine

Goutham Rao, MD, Chair; Lora E. Burke, PhD, MPH, FAHA; Bonnie J. Spring, PhD; Linda J. Ewing, PhD; Melanie Turk, PhD, RN; Alice H. Lichtenstein, DSc, FAHA; Marc-Andre Cornier, MD; J. David Spence, MD, FAHA; Michael Coons, PhD; on behalf of the American Heart Association Obesity Committee of the Council on Nutrition, Physical Activity and Metabolism, Council on Clinical Cardiology, Council on Cardiovascular Nursing, Council on the Kidney in Cardiovascular Disease, and Stroke Council

Recent data from the Centers for Disease Control and Prevention show that a staggering 68% of American adults are either overweight or obese, and 34% are obese.[1] Although there is evidence that its prevalence is stabilizing, obesity remains an extremely serious public health problem. It is a major risk factor for a wide range of medical (eg, type 2 diabetes mellitus), social (eg, discrimination in employment and education settings), and psychological (eg, depression) conditions.[2]

Although the effectiveness of different obesity treatments has been evaluated systematically,[3] rational, safe, and effective treatments from which the majority of overweight and obese patients can benefit remain elusive. New medications are emerging, but their impact on weight loss has been modest, and their long-term adverse effects are uncertain.[4] Bariatric surgery is effective but expensive and is appropriate only for a small proportion of patients in whom the benefits outweigh the risks. Effective and safe commercial and noncommercial behavior modification programs are scarce. Changes in public policy and the "built environment"[5] may curb obesity, but such changes take a long time to bring about, and the magnitude of their impact has yet to be established clearly. A recent review, for example, concluded that soft drink taxes have only a small impact on a population's average body mass index (BMI).[6]

It is widely acknowledged that no single strategy will solve the obesity problem and that effective public health initiatives to prevent and treat obesity will require the involvement of multiple stakeholders, including patients, employers, health plans, governments at all levels, the food and beverage industries, and healthcare providers.[7,8] Among these healthcare providers are those who deliver care in busy ambulatory settings, including primary care physicians, nurse practitioners, nurses, registered dietitians, and others. Screening and counseling for obesity in such settings is widely recommended.[9,10] Unfortunately, there is ample evidence that physicians and other healthcare professionals are poorly equipped to tackle the problem. A survey conducted in 2006 revealed, for example, that only 65% of obese patients were advised to lose weight by their physicians.[11] A lack of knowledge, skills, and practical tools have all been identified repeatedly as barriers to the identification and management of obesity by healthcare professionals.[12–14]

The purpose of this statement is to provide an overview of new and emerging tools and strategies for discussing weight and assisting overweight and obese patients. Only tools and

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This statement was approved by the American Heart Association Science Advisory and Coordinating Committee on June 13, 2011. A copy of the document is available at http://my.americanheart.org/statements by selecting either the "By Topic" link or the "By Publication Date" link. To purchase additional reprints, call 843-216-2533 or e-mail kelle.ramsay@wolterskluwer.com.

The American Heart Association requests that this document be cited as follows: Rao G, Burke LE, Spring BJ, Ewing LJ, Turk M, Lichtenstein AH, Cornier M-A, Spence JD, Coons M; on behalf of the American Heart Association Obesity Committee of the Council on Nutrition, Physical Activity and Metabolism, Council on Clinical Cardiology, Council on Cardiovascular Nursing, Council on the Kidney in Cardiovascular Disease, and Stroke Council. New and emerging weight management strategies for busy ambulatory settings: a scientific statement from the American Heart Association. *Circulation*. 2011;124:1182–1203.

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(*Circulation*. 2011;124:1182-1203.)

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Terminology

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- Obese
- Fat/fatness
- Adiposity
- Heavy
- Weight

Additional Core Principles

- Empathy
  - Shared experience
- Collaborative
- Structure
  - Time
- Recognition of successes
- Medicalization
- Reflection on recommendations

Case Scenario

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- Robert is a forty-eight-year man with obesity who brings his 15-year-old daughter Lauren in for a school physical. Lauren’s height is 5’6” and weight is 190lbs, BMI = 30.7kg/m^2, BMI% =97. She has been generally healthy and reports no problems at school or at home. Her physical examination is unremarkable except for having obesity. Her BMI% has been consistently in the obese range for the past 7 years. Both her parents and her younger brother have obesity.

Options for Opening the Discussion

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- *"We need to talk about Lauren's weight."*
- *"It should come as no surprise to you Lauren, that your weight puts you in the obese category. Let's discuss this."*
- *"Lauren, how interested are you in losing weight?"*
- *"Robert, Lauren is very heavy for her age. This is something she needs to work on."*

A Prescriptive Approach

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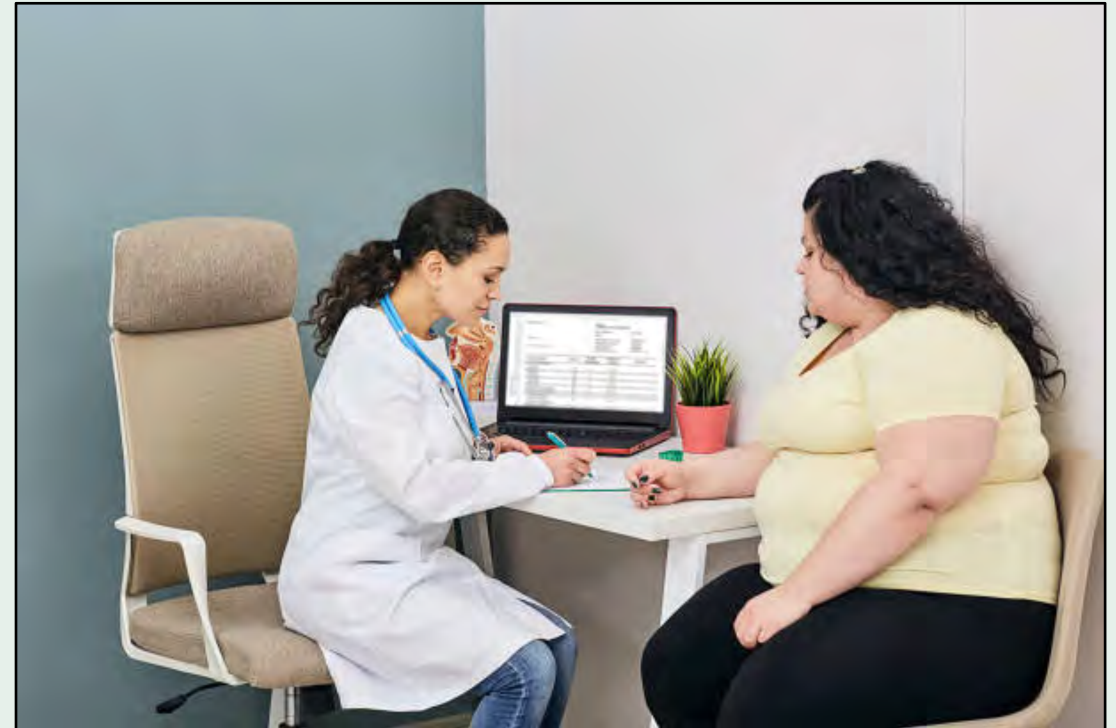
- “I am concerned about your weight.” [sincere expression of concern]
- “It puts you at risk for diabetes, hypertension, heart disease….etc..” [medicalizes the issue]
- “Is this something that concerns you as well?” [solicits interest]
- “Is this something that we can work on together?” [collaboration]
- Responses (100%) = yes



Don’ts

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- Never emphasize cosmetic benefits of weight loss:
  - ***“You would look and feel better.”***
- What if you as a health care professional have obesity?
- What if you as a health care professional are noticeably thin?
- Downplaying the issue:
  - ***“True, your BMI is over 30, but you’re very active, and have a large frame.”***

Thank you!

Questions/Discussion