Cardi-OH ECHO

Weight Management and Behavior Change: Cases and Discussions

January 27, 2022

Cardi-OH ECHO Team

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Spring 2022 Cardi-OH ECHO Participant Sites

CARDI·OH
Ohio Cardiovascular and Diabetes Health Collaborative

1	**Cleveland Clinic Lorain Family Health Center** Lorain, OH	**5** **Heart of Ohio Family Health** Whitehall, OH	**9** **Five Rivers Family Health Center** Dayton, OH

1 **Cleveland Clinic Lorain Family Health Center**
Lorain, OH

2 **Neighborhood Family Practice**
Cleveland, OH

3 **University Hospitals MacDonald Women's Hospital**
Cleveland, OH

4 **SRMC Internal Medicine Center**
Salem, OH

5 **Heart of Ohio Family Health**
Whitehall, OH

6 **Shrivers Pharmacy**
Athens, OH

7 **Crossroad Health Center**
Cincinnati, OH

8 **Crossroad Health Center**
Harrison, OH

9 **Five Rivers Family Health Center**
Dayton, OH

10 **University of Toledo Comprehensive Care Center**
Toledo, OH

11 **University of Toledo Comprehensive Medical Practice**
Toledo, OH

12 **University of Toledo Endocrinology**
Toledo, OH

Structure of ECHO Clinics

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 Tolerion, research support from Dexcom and Novo Nordisk and presentation honoraria from Medscape.
  - 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

Liz Beverly, PhD

Associate Professor

Heritage Faculty Endowed Fellowship in Behavioral Diabetes

OHF Ralph S. Licklider, DO, Research Endowment

Department of Primary Care

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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.

Diabetes Language Recommendations

Avoid	Recommend
Diabetic X	**Person with diabetes ✓**
Test X	**Monitor ✓**
Control X	**Manage ✓**
Unrealistic goals X	**High expectations for self-management ✓**
Suffering from diabetes X	**Living with diabetes ✓**
Good/bad/poor glycemic control X	**A1C, A1C levels, Glycemic targets ✓**
Compliance or adherence X	**Engagement, Medication-taking ✓**
Obese, morbidly obese, fat X	**Excess body weight, weight, BMI ✓**

Dickinson JK et al., Diabetes Care, 2017.

Weight Management Competencies in Primary Care

Goutham Rao, MD, FAHA

Chief Clinician Experience and Well-Being Officer, University Hospitals Health System

Jack H. Medalie Endowed Professor and Chairman

Department of Family Medicine and Community Health

Division Chief, Family Medicine, Rainbow Babies and Children's Hospital

Case Western Reserve University School of Medicine & University Hospitals Cleveland Medical Center

Learning Objectives

1. List and describe key competencies as set forth by the National Academy of Medicine. Explain why these competencies are important.

2. Describe a team-based model for implementation of weight management counseling in primary care.

3. List a minimum of 3 common barriers to implementation of weight management counseling in primary care settings.

Rationale

The Future of Obesity Treatment

Accessible, Inexpensive, and Technology Based?

A staggering 68% of US adults are either overweight or obese.[1] Current direct medical costs associated with treating obesity-related illness are roughly 5% to 10% of all US health care spending.[2] Effective solutions to this epidemic are scarce, expensive, or both. The mean cost of bariatric surgery is $27 905.[3] Few medications are cost significantly less than current alternatives. Technology can play a crucial role in providing low-cost, accessible weight management. Finally, participation should be sustainable, even if programs have only a modest effect on weight. Weight management is often a lifelong struggle, so it is essential that these pro-

Goutham Rao, MD
Katherine Kirley, MD

Rationale (continued)

- Criteria:
  - Convenience and accessibility
  - Cost
  - Ability to engage and re-engage patients over life course
- Trust and patients' wishes
- Built environment:
  - Defined as "the human-made space in which people live, work, and recreate on a day-to-day basis."

Organizations Engaged in the Development of Obesity Competencies

- Academy for Eating Disorders
- Academy of Nutrition and Dietetics
- Accreditation Council for Graduate Medical Education
- American Academy of Family Physicians
- American Association of Colleges of Nursing
- American Association of Colleges of Osteopathic Medicine
- American Association of Colleges of Pharmacy
- American Board of Obesity Medicine
- American Council of Academic Physician Therapy
- American Dental Education Association
- American Heart Association
- American Psychological Association
- National Association of Nurse Practitioner Faculties
- Physician Assistant Education Association
- The Obesity Society
- YMCA
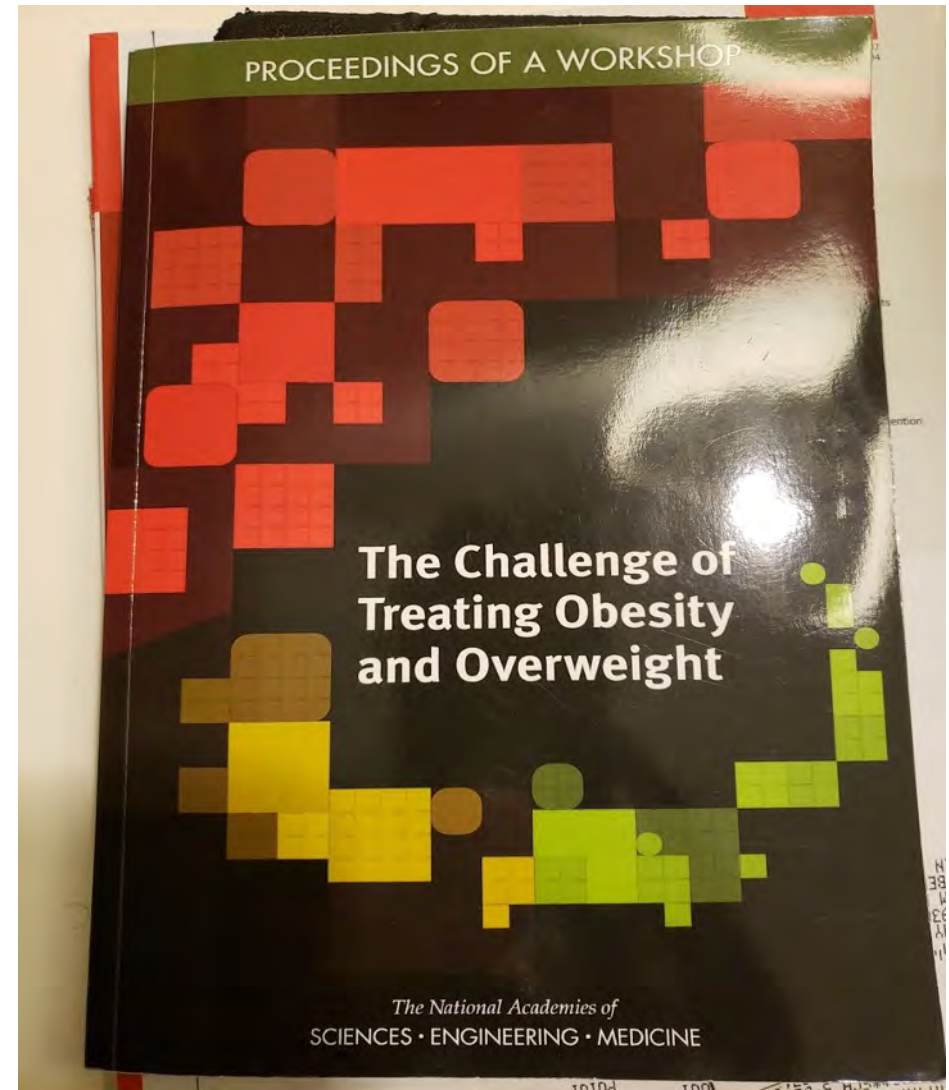
Core Obesity Knowledge

1) Framework of obesity as a medical condition

- 1.0 Demonstrate a working knowledge of obesity as a medical condition

- 1.1 Key measures and their limitations for the assessment of obesity and its comorbidities

  - E.g. Body mass index (BMI) is the most common anthropometric measure used for the identification of obesity, with a threshold value of $30kg/m^2$ separating obesity and overweight. It is important, however, for providers to understand the limitations of BMI for identification of obesity. In Asian populations, for example, lower thresholds are generally accepted as appropriate to identify individuals with excess body fat or obesity-related illnesses. It's also important for providers to understand the usefulness of other measures such as waist circumference.

Core Obesity Knowledge

2) Epidemiology and key drivers of the obesity epidemic

- 2.0 Demonstrate a working knowledge of the epidemiology of the obesity epidemic
  - E.g. The social, cultural, and other factors that have contributed to the obesity epidemic
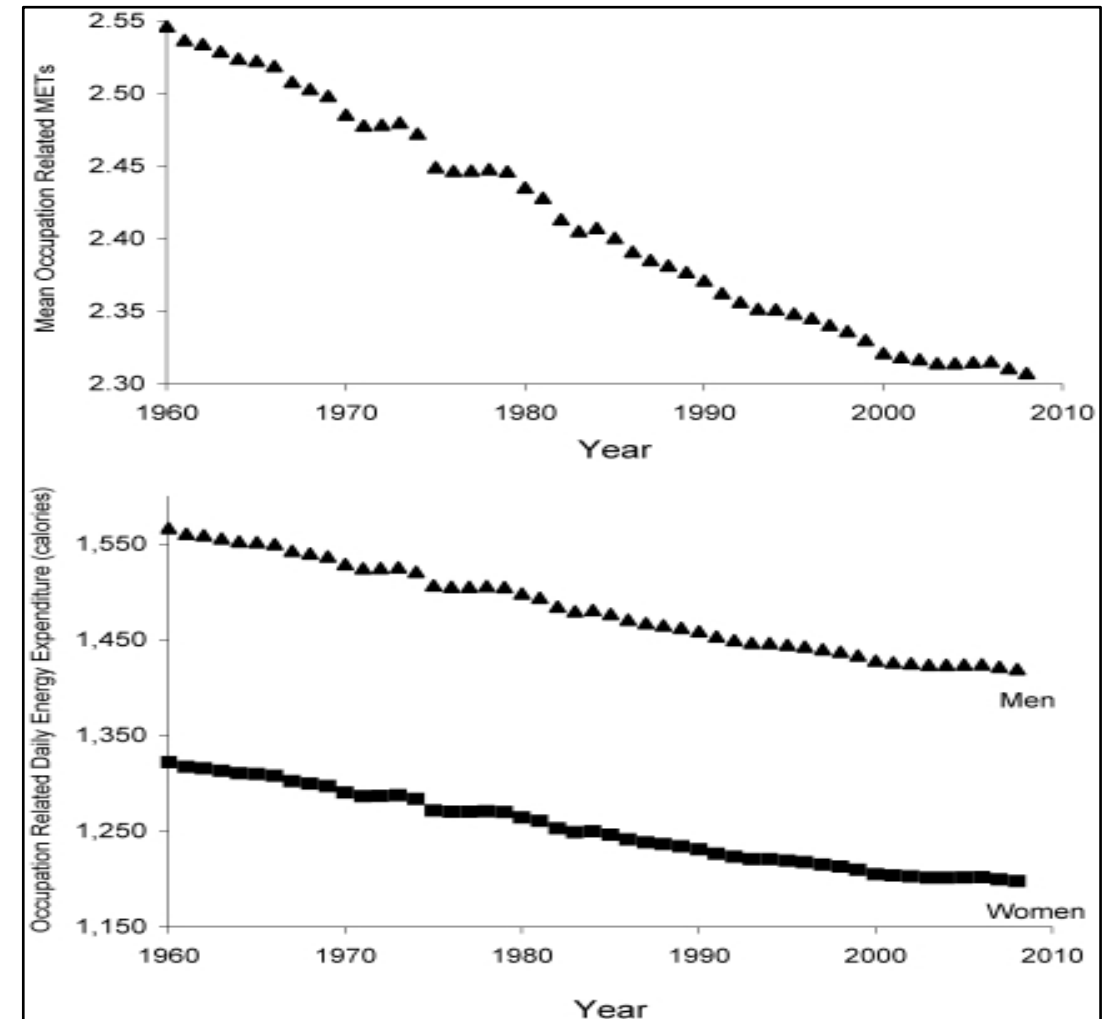
Core Obesity Knowledge

3) Disparities and inequities in obesity prevention and care

- 3.0 Describe the disparate burden of obesity and approaches to mitigate it
  - E.g. Explain the role of inequities associated with and/or determinants of obesity and its outcomes

Fast Food Consumption Among Adults in the United States, 2013–2016

NCHS Data Brief No. 322, October 2018

PDF Version (412 KB)

Cheryl D. Fryar, M.S.P.H., Jeffery P. Hughes, M.P.H., Kirsten A. Herrick, Ph.D., MSc., and Namanjeet Ahluwalia, Ph.D.

Key findings

Data from the National Health and Nutrition Examination Survey

- During 2013–2016, 36.6% of adults consumed fast food on a given day.
- The percentage of adults who consumed fast food decreased with age: 44.9% aged 20–39, 37.7% aged 40–59, and 24.1% aged 60 and over.
- A higher percentage of non-Hispanic black adults consumed fast food than non-Hispanic white, non-Hispanic Asian, and Hispanic adults.

On This Page

Key findings

What percentage of adults consumed fast food on a given day and did consumption differ by sex and age for 2013–2016?

Did the percentage of adults consuming fast food on a given day differ by race and Hispanic origin for 2013–2016?

Did the percentage of adults consuming fast food on a given day differ by family income level for 2013–2016?

Competencies for Interprofessional Obesity Care

4) Interprofessional obesity care

- 4.0 Describe the benefits of working interprofessionally to treat obesity that cannot be achieved by a single health professional
    - E.g. Summarize the value and rationale for including the skills of a diverse inter-professional team in treating obesity

5) Integration of clinical and community care for the prevention and treatment of obesity

- 5.0 Apply the skills necessary for effective interprofessional collaboration and integration of clinical and community care for obesity
    - E.g. Perform effectively in an interprofessional team
    - "I'd like to let you know that I've raised Mr. Webb's insulin dose as his diabetes was not well controlled. Please let me know if you plan to make any changes to his dietary plan."

Competencies for Patient Interactions

6) Discussions and language related to obesity

- 6.0 Use patient-centered communication when working with individuals with obesity and others

- 6.1 Discuss obesity in a non-judgmental manner using person-first language in all communications

- 6.3 Use person and family-centered communication

- Language to use/avoid: "overweight" rather than "fat"

- Asking permission: *"I am concerned about your weight and its impact upon your health. Would it be ok if we discussed this?"*

- Opening the door approach:
  - *"I want to let you know that I am concerned because your daughter's BMI percentile is 98."*
  - *"What does that mean doctor?"*
  - *"It means she is at a higher weight than the majority of girls her age. This puts her at risk for problems such as diabetes and high blood pressure. Is this something that concerns you as well? Is this something you would like to work on together?"*

Competencies for Patient Interactions

7) Recognition and mitigation of weight bias and stigma

- Story of Gina Score (1999)
  - *The horrifying, brutal events of Gina's death-the scared, overweight young girl was forced to run nearly three miles on her second day at the camp, was dragged along the dirt road, was accused of "faking" her symptoms as she began to foam at the mouth and hallucinate, and was left lying outside in the hot sun for hours without medical attention-touched South Dakotans, the country, and the world. -- Yankton Daily Press and Dakotan*

- 7.0 Employ strategies to minimize bias toward people with obesity

- 7.2.2 Recognize and mitigate the biases of others
  - E.g. Slender patient coping with several months with knee arthritis offered a steroid injection. **vs.** Patient with obesity with several months of knee arthritis given recommendation for acetaminophen and advised, *"You need to lose weight."*

Competencies for Patient Interactions

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8) Accommodating people with obesity

- 8.0 Implement a range of accommodations and safety measures specific to people with obesity
  - E.g. Privacy; WiFi scales

Strategies for Patient Care Related to Obesity

9) Provide evidence-based care/services for persons with obesity or at risk for obesity

- 9.2 Evaluate BMI and other anthropometric measures routinely
  - E.g. waist circumference (80 cm women (31.5"); 90-102 cm men (35" – 40")
- 9.6. Employ evidence-based individual and family behavioral change strategies such as motivational interviewing and cognitive behavioral therapy
  - E.g. Rolling with resistance
  - *"It's pretty simple – get to the grocery store once a week and give up fast food"* **vs.** *"You find it hard to make the time to shop and cook meals and find fast food a lot more convenient."*

Strategies for Patient Care Related to Obesity

10) Special concerns

- 10.0 Provide evidence-based care/services for persons with obesity comorbidities
  - E.g. Respond appropriately to patient with obesity co-morbidities based on scope of practice
  - "Thirty-four year-old Janet tells you during a routine checkup that feels tired much of the day, and despite going to bed at 10PM and getting up at 6AM, feels incompletely rested in the mornings. She tells you her husband also complains often that she snores. You suspect obstructive sleep apnea and order a sleep study."

Thank you!

Questions/Discussion