CLINICAL PRACTICE GUIDELINE

# Adult Obesity (Age ≥ 18) Practice Guideline

## Assessment of Adult Patient to Evaluate for Obesity

Obtain height, weight, blood pressure (BP), body mass index (BMI) **(TABLE A)**

### Underweight
**BMI < 18.5kg/m²**

*Sanford Adult Obesity Guidelines* do not apply

### Normal Weight
**BMI 18.5-24.9kg/m²**

- Maintain weight trajectory and reassess annually
- Manage risk factors

### Overweight/Obese
**BMI ≥ 25kg/m²**

- If BMI > 30kg/m², then:
  - A. add obesity to problem list
  - B. add visit diagnosis if appropriate
  - C. document action plan
- Focus history and exam on risk factors, complications, and healthy behaviors/attitudes
- Assess for major and minor comorbid conditions **(TABLE B)**
- Review medications associated with weight gain **(TABLE C)**
- Screen patient with PHQ4; if positive, administer PHQ9 and/or GAD7 and refer to *Sanford Anxiety* or *Sanford Depression Practice Guidelines*

### Obtain Appropriate Laboratory Tests

- Evaluate for Metabolic Syndrome: A1C, TSH, Lipid Panel (review calculated ASCVD risk score)

### Assess Patient Readiness For Weight Loss

#### Patient Is Ready to Lose Weight

- Negotiate goals and management strategy to achieve weight loss **(TABLE D)**
- See BPA in One Chart
- Refer to risk appropriate resources as needed

#### Management Recommendations For Weight Loss

- Consider RN Health Coach, Behavioral Health Triage Therapists or other trained professional for motivational interviewing to focus on lifestyle changes **(TABLE E)**
- Consider referral to Registered Dietitian
- Consider approved weight loss medications when appropriate **(TABLE F)**

#### Patient Is Not Ready to Lose Weight

- Review goals, risk factors, and counsel regarding weight management
- See BPA in One Chart

#### Management Recommendations For Weight Loss

- Consider referral to RN Health Coach, Behavioral Health Triage Therapists or other trained professional for motivational interviewing to focus on lifestyle changes **(TABLE E)**
- Consider referral to Registered Dietitian

### Periodic Re-evaluation of Patient

- Measure height, weight, and calculate BMI
- Medicare allows for BMI ≥ than 30kg/m²
  - One face-to-face visit every week for the first month
  - One face-to-face visit every other week for months 2-6; and
  - One face-to-face visit every month for months 7-12; if the pt meets the 3kg(6.6lbs) weight loss requirement during the first 6 months



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| TABLE A: BMI Categories | |
|---|---|
| **BMI** | **Category** |
| Less than 18.5 | Underweight |
| 18.5-24.9 | Normal weight |
| 25-29.9 | Overweight |
| 30-34.9 | Obese-class I |
| 35-39.9 | Obese-class II |
| 40 or more | Extreme obesity-class III |

## TABLE B : Assess for and Categorize Minor and Major Comorbid Conditions

- It is important to assess for other conditions as treatment decisions and outcomes may be influenced by their presence.
- Waist circumference greater than or equal to 40 inches for males and greater than or equal to 35 inches for females is an additional risk factor for complications related to obesity.
- To rule out depression and eating disorders, brief screenings: PHQ-4 and *Starting The Conversation* **(APPENDIX A)** should be conducted if appropriate.
- Assessment should include a complete medical history including identifying medications that may induce weight gain or interfere with weight loss.
- Screening for sleep disorders should also be completed.

| Minor Comorbid Conditions | Major Comorbid Conditions |
|---|---|
| • Cigarette smoking<br>• Hypertension (BP greater than or equal to 140/90) or current use of antihypertensives<br>• LDL cholesterol >130 mg/dL<br>• HDL cholesterol <40 mg/dL for men; less than 50 mg/dL for women<br>• Prediabetes<br>• Family history of premature (age ≤ 45 years) coronary artery disease<br>• Age ≥ 55 years for males<br>• Age ≥ 65 years for females or menopausal females | • Waist circumference (males≥ 40 inches, females ≥ 35 inches)<br>• Established coronary artery disease (MI, angioplasty, CABG)<br>• Peripheral vascular disease<br>• Abdominal aortic aneurysm<br>• Symptomatic carotid artery disease<br>• Type 2 diabetes mellitus<br>• Obstructive sleep apnea |

## TABLE C: Drug Classes Associated with Weight Gain

- Diabetic (insulin, sulfonylureas, thiazolidinedione)
- Many selective serotonin reuptake inhibitors (SSRI), tricyclic antidepressants (TCA)
- Anti-psychotics
- Anti-epileptics
- Steroid hormones (progestins and glucocorticoids)

Consider alternative drugs not associated with weight gain:

- Metformin
- Bupriopion
- Topiramate
- Exenatide

**TABLE D: Treatment Grid and Overview of Management Recommendations (See BPA in One Chart)**

| Comorbid Condition | BMI | | | |
|---|---|---|---|---|
| | 25-30 | 30-35 | 35-40 | 40+ |
| 0 | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations |
| 1-2 Minor Comorbid Conditions | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations |
| Major Comorbid Conditions OR 3 Minor Comorbid Conditions | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>**The FDA approves drug therapy only for BMI >27** | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations | Counsel and educate:<br>• Nutritional/Physical activity changes<br>• Behavioral management<br>• Medication and surgical considerations |

**TABLE E: Management Recommendations**

**Nutrition (balanced healthy eating plan or lower calorie balanced eating plan)**

- Encourage at least five servings of fruit and vegetables per day, whole grains with fiber intake of 20-35 grams of fiber daily, less than or equal to 30% of calories from fat (7%-10% of calories from saturated fat, less than or equal to 1% from trans fat).
- For weight loss, encourage calorie reduction by evaluating portion sizes and journaling food intake.
- Provide tips for managing eating in social situations, dining out, take-out food and food label reading.
- Provide referral to a dietician, nutritionist or structured medically supervised weight loss program if available.
- Consider the use of meal replacements or very low calorie diet (VLCD) under medical supervision to help achieve weight loss in patients who are interested in such programs.

**Physical Activity**

- Minimally, all patients should be encouraged to do at least 10 minutes of physical activity above what they are already doing each day and gradually increase the amount of time, followed by an increase in intensity.
- Ideally, all patients should meet the current recommendations of 60 minutes of moderate-intensity activity on most days per week. This can by done in 10-minute increments.
- Patients with chronic activity limitations (e.g. arthritis, respiratory dysfunction, neuropathy, morbid obesity) should be evaluated and managed to establish or enhance patient mobility.
- Small bouts of physical activity, not generally considered exercise, such as taking the stairs, parking farther away, exercising while watching TV, standing rather than sitting and activity breaks from screens (TV, computer, other media) are also important for healthy body weight.

**Behavioral Management**

- Identify behaviors that may lead to increased weight gain; for example, stress, emotional eating, boredom and poor sleep.
- Help patients set specific, measurable, time-limited goals to decrease calorie intake and increased physical activity as appropriate.
- Suggest patients weigh themselves weekly and record the amount and type of food/beverages consumed and physical activity completed.
- Provide support and encourage patients to also seek support from family, friends and support groups in order to assist them with their eating, activity and weight goals.

**Medication**

- Evaluate for medications that may promote weight gain, and change when appropriate to a more weight-neutral alternative.
- Pharmacotherapy for weight loss should be included only in the context of a comprehensive treatment strategy that includes physical activity and nutritional support.

**Surgery**

- Bariatric surgery is indicated in carefully selected patients. Patients should be motivated, well informed in disease management, psychologically stable and accepting of operative risks.

## Clinical Pearls

- Weight loss of 5-10% can make a difference in achieving clinical goals
- Among patients who were overweight or obese, patient reports of being told by a physician that they were overweight were associated with more realistic perceptions of the patients' own weight, desire to lose weight, and recent attempts to lose weight (Post, et al., 2011, p.316) (Appendix A)

## References


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2. Brethauer, S., Kashyap, S., Schauer, P. *Cleveland Clinic Disease Management Project: Obesity*. Retrieved from http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/endocrinology/obesity/
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4. Paxton, A., Strycker, L., Toobert, D., Ammerman, A., Glasgow, R. (2011). Starting the conversation: Performance of a brief dietary assessment and intervention tool for health professionals. *American Journal of Preventive Medicine*, 40(1):67-71.
5. Post, R.E., Mainous, A.G., III, Gregorie, S.H., Knoll, M.E., Diaz, V.A., & Saxena, S.K. (2011). The influence of physician acknowledgment of patients' weight status on patient perceptions of overweight and obesity in the United States. *Archives of Internal Medicine, 171*(4), 316-321. doi:10.1001/archinternmed.2010.549.
6. American Association of Clinical Endocrinologists and American College of Endocrinology Clinical Practice Guidelines for Comprehensive Medical Care, 2016 AACE.

**APPENDIX A: Starting the Conversation**

## Starting The Conversation: Diet

(Scale developed by: the Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill, and North Carolina Prevention Partners)

Over the past few months:

| | | | | |
|---|---|---|---|---|
| 1. | How many times a week did you eat fast food meals or snacks? | Less than 1 time ☐ 0 | 1–3 times ☐ 1 | 4 or more times ☐ 2 |
| 2. | How many servings of fruit did you eat each day? | 5 or more ☐ 0 | 3–4 ☐ 1 | 2 or less ☐ 2 |
| 3. | How many servings of vegetables did you eat each day? | 5 or more ☐ 0 | 3–4 ☐ 1 | 2 or less ☐ 2 |
| 4. | How many regular sodas or glasses of sweet tea did you drink each day? | Less than 1 ☐ 0 | 1–2 ☐ 1 | 3 or more ☐ 2 |
| 5. | How many times a week did you eat beans (like pinto or black beans), chicken, or fish? | 3 or more times ☐ 0 | 1–2 times ☐ 1 | Less than 1 time ☐ 2 |
| 6. | How many times a week did you eat regular snack chips or crackers (not low-fat)? | 1 time or less ☐ 0 | 2–3 times ☐ 1 | 4 or more times ☐ 2 |
| 7. | How many times a week did you eat desserts and other sweets (not the low-fat kind)? | 1 time or less ☐ 0 | 2–3 times ☐ 1 | 4 or more times ☐ 2 |
| 8. | How much margarine, butter, or meat fat do you use to season vegetables or put on potatoes, bread, or corn? | Very little ☐ 0 | Some ☐ 1 | A lot ☐ 2 |

SUMMARY SCORE (sum of all items): _____

**Scoring the STC tools**

The scoring system for the STC tool is listed to the right of each answer (0-1-2). Answers in the far left column for any question is scored a 0, middle column is scored a 1, and right column is scored a 2. The higher the score, the more unhealthy the patient's diet or more sedentary life style.

The main purpose of the instrument is to guide counseling rather than use as a measurement tool. Providers and users of this tool could utilize a reduction in score to reinforce efforts in behavior change.

# Patient Engagement: BMI

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## Documentation requirements for patients with BMI>30

- Add specific level of Obesity to problem list (if >40 use Morbid Obesity) and document plan to address in note
- Reminder: smart sets are available to help with documentation and referrals

## Communication best practices

- Use **empathy,** keep it simple, and be direct (Dutton et al., 2010 & Pollak et al., 2007)
- Use terms such as "weight, excess weight, BMI, or "weight problem" rather than "obese" (Dutton et al, 2010, Kushner, 2001; Wadden & Didie, 2003)

## Getting ready for the conversation

- Physician empathy is positively correlated with patients' weight loss efforts (Pollack et al., 2007)
- Keep your own judgments and assumptions in check regarding patients who are overweight (Kushner, 2003; Wadden & Didie, 2003)

## The conversation

- How to *get it started:* **ask permission** (Kushner, 2001)
  - "I would like to talk with you about your weight, is that ok?"
  - If they decline, say "when you are ready, I'd like to talk with you about my concerns", then ask at future appointments
- *Share weight gain trajectory you've noticed and ask for their perspective:*

  "I've noticed that your weight is up from last year. What are your thoughts on this?"
  "When looking at your chart, I see that you have gained 5 pounds each year for the past 4 years.
  "I have some concerns about this that I would like to share, but first I would like to know how you feel about it"

## Scripting for assessment of patient knowledge and understanding

- *Connect to overall health:* "I have some information I would like to share with you but first I am curious about what you know regarding the risks of being overweight."
- *Fill in risks specific to the individual patient* "being overweight also affects (other specific medical problems)" and provide further education as needed (i.e., BMI in a medical context, etc.)

## Scripting for assessment of readiness for change

- "How concerned are you about your weight and how it affects your health?"
- "What step, if any, do you think you might want to make?"
- "On a scale of 1 to 10, how confident are you in taking control of your weight?"

# Patient Engagement: BMI

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## Connecting patients to resources

For many patients who want to lose weight, there is a **low probability of being successful on their own** (Baron, 2011). Once the patient is ready, link to other team members with expertise (i.e., RN Health Coach, Registered Dietician, etc.).

## Resources for Health Care Professionals

- See Obesity Clinical Practice Guidelines in One Chart.

  http://intrashare1:10001/public/sanfordconnect/CPG/default.aspx?RootFolder=%2fpublic%2fsanfordconnect%2fCPG%2fClincalPracticeGuidelines%2fChronic%20Disease&FolderCTID=&View=%7b5131BBA4%2dF8E6%2d459F%2d9038%2d0B28B982C38A%7d

- Training in Motivational Interviewing (M.1.) has helped many physicians develop tools to help engage their patients in making changes (Pollack et al., 2007; Rolnick et al., 2010)
  - Knowledge alone is not enough for many patients and advice giving can be ineffective
  - Assessing readiness to change and tailoring the interaction to support the patient's move to the next level of readiness is important
  - Motivational interviewing in Sanford Learn: cc-4011 (overview), sessions 1-5 (deeper dive): cc-3618, cc-3619, cc-3620, cc-3621, cc-3622

## References


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