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REVIEW

Practical Strategies for Engaging Individuals With Obesity in Primary Care

Scott I. Kahan, MD, MPH

Abstract

Although widely recognized as a chronic disease that requires long-term, structured, and multidisciplinary management, obesity remains largely underdiagnosed and undertreated. The prevalence of obesity continues to increase dramatically, with the highest rates seen in the United States. Despite the availability of several clinical practice guidelines, published studies suggest that health care professionals (HCPs) infrequently and inconsistently follow guideline recommendations. Barriers to HCP participation in obesity management are likely to inhibit obesity counseling in primary care. Improving HCP obesity-related practices and counseling is important. This article discusses current practices, barriers to effective obesity management, and recommendations to improve HCP obesity management and counseling, based on findings from a PubMed search and clinical experience. The aim of the article is to share best-practice strategies for engaging patients.

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From Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, and George Washington University School of Medicine and Health Sciences, Washington, DC.

The past half-century has seen a staggering increase in global obesity rates, with 266 million men and 375 million women now exceeding the weight threshold for obesity (defined by a body mass index [BMI; calculated as weight in kilograms divided by height in meters squared] of ≥30 kg/m^2).[1] The prevalence of obesity (BMI, 30-40 kg/m^2) and severe obesity (BMI, ≥40 kg/m^2) is approximately 37.7% and 7.7%, respectively,[2] representing an approximate increase of 10% in the prevalence of obesity in the United States since 2005–2006 and an increase in excess of 600% in the prevalence of severe obesity since the mid-1980s.[2,3] In addition to being a public health epidemic affecting large populations, obesity is a complex and multifaceted clinical condition. Several global organizations and regulatory bodies explicitly recognize obesity as a chronic disease, including the World Health Organization, the US Food and Drug Administration, the US National Institutes of Health, and, most recently, the American Medical Association.[4-8] Obesity is associated with almost 200 metabolic, mechanical, and mental comorbid conditions,[9] the prevalence of which increase as BMI rises.[10] People with obesity have an increased risk of development of cardiovascular disease and type 2 diabetes[11] and a reduced health-related quality of life.[12] The financial costs of obesity are substantial, both to affected individuals and society at large.[13]

As with other chronic conditions, successful management is not necessarily defined by achieving a "cure." Long-term weight loss is generally accepted as maintaining weight loss of 5% to 10% for 1 or more years and is associated with improvements in major risk factors.[14-21] Conventional wisdom and older research suggest that long-term weight loss success is elusive[22,23]; however, recent studies have shown impressive outcomes for behavioral weight loss interventions, particularly when provided by trained interventionists. The Look AHEAD study evaluated weight loss achieved with behavioral weight loss counseling in 5145 people with overweight or obesity and type 2 diabetes.[24] Patients receiving behavioral counseling lost more than 8% of body weight during the first year and, at year 8, 50.0% of intervention patients maintained a 5% or more loss, 26.9% maintained a greater than 10% loss, and 11.0% maintained a more than 15% loss of initial body weight. Systematic reviews of behavioral weight loss counseling conducted by the US Preventive Services Task Force (USPSTF) and the National Heart, Lung, and Blood Institute (NHLBI) Obesity Expert Panel found similarly

ARTICLE HIGHLIGHTS

- Evidence indicates that health care professional (HCP)—patient engagement on the topic of obesity is often suboptimal.
- Lack of HCP—patient engagement can adversely affect the diagnosis and management of obesity.
- Barriers perceived by HCPs and patients influence their level of engagement.
- Several strategies may help to address the barriers and enable effective HCP—patient engagement.
- The health benefits that patients derive from being engaged with their HCP are clearly evident.

impressive outcomes, which has led to policy changes encouraging behavioral counseling in primary care.[20,25] Primary care physicians (PCPs) are in the unique position of engaging people with obesity and ensuring that they receive appropriate counseling. Nonetheless, whereas most people with obesity have tried—often repeatedly—to lose weight,[26] few receive formal guidance and counseling from their health care professional (HCP).[27] Based on relevant articles from a PubMed search performed in June 2017 and my own clinical experience, this article discusses current obesity-related practices of HCPs in the United States and the availability of specialist training for US HCPs and provides practical recommendations for improving how HCPs engage with patients to support long-term weight management.

CURRENT GUIDELINES AND PRACTICE

The Importance of Screening and Diagnosis

Screening and diagnosis are fundamental steps in addressing medical conditions. In a study of 7790 National Health and Nutrition Examination Survey (NHANES) participants, those whose weight problem was diagnosed and who were advised of their weight status by their HCP had 6.1-fold (BMI, >25 kg/m^2) or 8.3-fold (BMI, >30 kg/m^2) increased odds of correctly perceiving their weight status.[28] Moreover, participants had 2.5-fold (BMI, >25 kg/m^2) or 2.2-fold (BMI, >30 kg/m^2) increased odds of attempting to lose weight. Among 9827 patients in a large primary care database, formal diagnosis of obesity was associated with 2.4-fold increased odds of having an obesity management plan in place.[29] An NHANES analysis of 5054 participants revealed 1.9-fold (BMI, >25 kg/m^2) and 1.8-fold (BMI, >30 kg/m^2) increased odds of losing weight (defined as reported >5% weight loss) if their HCP had diagnosed and communicated that they were overweight.[30]

Current Guidelines for Screening and Diagnosis

The USPSTF recommends that clinicians screen all adults for obesity and offer referral for intensive multicomponent behavioral interventions to patients with a BMI of 30 kg/m^2 or higher.[31] The NHLBI obesity guidelines, disseminated by the American Heart Association/American College of Cardiology/The Obesity Society, recommend that weight should be measured and BMI calculated at least every year in all people who need to lose weight.[32] Body mass index screening and follow-up is a clinical quality measure now included in the Physician Quality Reporting System[33] and carried out by the Centers for Medicare and Medicaid Services.[34] Moreover, negative payment adjustments are levied to HCPs and group practices who do not satisfactorily report data on quality measures for Medicare Part B Physician Fee Schedule-covered professional services.[34]

Current Practice for Screening and Diagnosis

Despite several guidelines, practice recommendations, and incentives, these measures are not consistently followed in primary care settings.[35] According to retrospective analyses of patient records, up to 90% of people with obesity (BMI, ≥30 to ≤35 kg/m^2) have not received a formal diagnosis from their physician.[36] Although rates of diagnosis increase in patients in higher weight classes, they remain suboptimal across all weights.[35]

The Importance of Obesity Counseling

Counseling delivered by HCPs substantially affects weight loss behaviors. A cross-sectional analysis of 810 British adults with a BMI of less than 25 kg/m^2 revealed that an HCP recommendation to lose weight was associated with 3.7-fold increased odds of wanting to weigh less and 3.5-fold increased odds of attempting to

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lose weight.[37] A 2013 meta-analysis of 32 published studies on the impact of HCP weight loss counseling on actual changes in patient behavior found that patients are nearly 4 times more likely to attempt weight loss when their HCP provides weight loss advice.[38]

Current Guidelines for Obesity Counseling

All relevant guidelines, including the USPSTF and the NHLBI-led American Heart Association/American College of Cardiology/The Obesity Society recommendations, highlight intensive behavioral counseling for patients with a BMI of 30 kg/m^2 or higher.[2,20,32] Counseling should be intensive initially (usually defined by weekly or biweekly interactions) followed by monthly interactions (after 6 months), should be multicomponent, and should involve guidance for long-term maintenance. Beginning in 2011, Medicare began coverage for intensive obesity counseling in primary care, consisting of weekly obesity counseling visits for 1 month, followed by biweekly visits for months 2 through 6, followed by monthly visits thereafter.[39]

Current Practice for Obesity Counseling

Despite these guidelines and coverage, only a minority of HCPs engage in weight loss counseling with their patients. In 2008, a survey of more than 1200 PCPs sampled from the American Medical Association Masterfile found that less than 50% of PCPs reported always providing advice on diet, exercise, or weight control.[40] A cross-sectional study of 21,220 US adult outpatient visits with 954 PCPs between 2007 and 2008 (taken from the National Ambulatory Medical Care Survey [NAMCS] data from 32,500 adult primary care visits to PCPs) revealed that 58% of PCPs performed no weight counseling during clinic appointments.[41] Only 85 physicians in the NAMCS survey (8.9%) provided the majority of the weight counseling, suggesting that the vast majority of PCPs perform little or no weight counseling.[41] The NAMCS survey data for 2012 show that just 4.9% of adult office visits in the previous year were for obesity, despite obesity prevalence approaching 40% in the US.[42]

Some studies suggest that the rates of weight loss counseling in primary care may actually be declining. Among 10,113 primary care visits in 2003—2004, fewer than 5.8% included weight loss counseling, which represented a 30% decline from 1995 through 1996.[43] Data from the NAMCS survey revealed that weight loss counseling declined from 7.8% of visits in 1995—1996 to 6.2% of visits in 2007—2008, despite the increasing prevalence of obesity. A study that evaluated secular trends in the diagnosis and treatment of obesity among an NHANES sample of 31,039 nonpregnant adults found no change in the odds of receiving a diagnosis of obesity from a physician or physician-directed weight loss from 1994 through 2008, despite a large increase (from 56.1% to 69.1%) in the prevalence of overweight in US adults during that period.[44] Furthermore, several studies report minimal knowledge of, and adherence to, published guidelines for obesity counseling and treatment among PCPs.[45,46]

In terms of the patient perspective on current practice for obesity counseling, a 2014 study of 1002 male firefighters reported that 69% of participants overall and 48% of participants with obesity reported never having received weight loss advice from their HCPs.[47] Although the likelihood of receiving weight loss advice increased with age and severity of obesity, data from the same study suggest that just 68.1% of firefighters with class II/III obesity received weight loss advice from their HCP.[47] Among 2725 US adults with a mean BMI of 37.1 kg/m^2, almost one-quarter responded that they had never discussed their weight with their PCP, and nearly two-thirds reported that they wished their physician would discuss weight or offer weight management counseling to them.[48] Furthermore, this problem is not limited to the US health care system. For example, the aforementioned 2013 cross-sectional analysis of 810 British adults with a BMI higher than 25 kg/m^2 reported that just 17% and 42% of people with overweight or obesity, respectively, recalled ever receiving advice to lose weight from their HCP.[37]

Perceived Barriers

Health care professionals perceive several barriers that prevent them from fully aligning their clinical practice with current guideline recommendations. Lack of training in obesity is a key barrier. Just 25% of medical schools

TABLE. Considerations for the Clinic Environment

Furniture	• Wide-base, higher-weight-capacity chairs (preferably armless) in both the waiting and patient areas • Provide specialized bariatric chairs, where possible • Pedestal toilets, rather than wall-mounted • Wheelchair-accessible bathrooms
Equipment	• Large-sized or thigh-sized blood pressure cuffs • High-capacity weighing scales (ideally >500 lbs [to convert to kg, multiply by 0.45]) • Extra-large gowns
Staff	• Educated about obesity and weight bias

Modified from the Strategies to Overcome and Prevent (STOP) Obesity Alliance website.[41]

offer a dedicated nutrition course—a decline since the status of nutrition education in US medical schools was first assessed in 1985—and few medical schools achieve the 25 hours of nutrition education recommended by the National Academy of Sciences.[49] A review of obesity-related content on the US Medical Licensing Examinations found that obesity-specific content was rarely included in examinations and most relevant topics were entirely absent.[50] Additional barriers often cited by HCPs as a reason for not following counseling guideline recommendations include insufficient training and counseling skills,[51-53] limited time,[53-56] lack of confidence that obesity counseling is worthwhile,[52] shortage of appropriate clinical space and resources,[52,56-59] and the challenges of reimbursement.[54,58] These barriers likely result in missed opportunities to engage patients in discussions about weight, to screen for obesity, and to engage in weight loss counseling.

From a patient perspective, barriers to effective screening and diagnosis may occur even before they have visited their HCP. Many people with overweight or obesity feel stigmatized and unwelcome in the clinic (eg, waiting room furniture, weighing scales, or examination tables are of insufficient capacity for heavier patients), have had prior negative health care experiences (such as being shamed by physicians to lose weight), or believe that seeking help signifies moral failure.[51,57] The stigma of having a formal diagnosis of obesity may also prevent individuals from consulting a physician, and evidence suggests that patients with higher BMIs experience less respect from physicians.[60,61] Additionally, patients often expect HCPs to proactively broach the topic of excess weight; if weight is not discussed by HCPs, patients may assume it is not a concern.[62] Even when obesity is discussed, in many cases no follow-up appointment for ongoing care is scheduled.[55] These barriers may result in patients delaying preventive screening, which results in increased health risks associated with obesity because diagnosis is delayed.[57]

PRACTICAL GUIDANCE FOR CLINICAL PRACTICE

Several relatively small considerations can improve HCP–patient interaction regarding obesity and improve obesity-related care and outcomes.

Using People-First Language and Motivating Terminology

The words used to describe excess weight can be polarizing and may be demotivating. For example, the term *obese* is consistently rated as least desirable and off-putting by patients.[63,64] In contrast, neutral terms, such as *unhealthy weight*, are generally preferred and may be perceived as motivating, thereby helping patients feel supported and empowered in their weight management efforts.[63,64] As with other medical conditions, the use of people-first language ("patient with obesity" or "having obesity"), as opposed to condition-first language ("obese patient"), is recommended terminology for both academic and clinical settings.[65,66]

Ensuring an Appropriate Clinic Environment

Paying attention to the physical requirements of the clinic space and procedures can greatly improve the health care experience for patients (Table) and is more likely to encourage them to seek help and to be receptive to counseling. Even simple steps can be beneficial, such as ensuring that scales are in private areas and offering medical equipment that is suitable for larger individuals.[67]

Integrating Digital Technology

Technological aids—such as electronic reminders to prompt BMI measurement, which are often standard in electronic health record (EHR) programs—can considerably improve obesity diagnosis and documentation. In a recent

study in which physicians were randomized to receive a BMI reminder prompt as part of patients' EHR, they were 3 times more likely to document a diagnosis of overweight during a patient consultation than physicians who did not receive the reminder (22% vs 7%; *P*=.02).[68] Notably, 91% of physicians who recorded BMI using the EHR admitted the tool alerted them to patients they did not realize were overweight.

Use a Structured Framework for Counseling

Numerous frameworks are available to help HCPs structure obesity counseling. A useful framework for counseling is the "5As" (Ask, Assess, Advise, Agree, and Assist) intervention strategy (Figure), which was initially developed to support smoking cessation and has been adapted for obesity management.[70]

A 2014 study found that implementing the 5As framework in primary care clinics doubled the initiation of obesity management compared with clinics that did not use the intervention, was easy to implement, and resulted in positive health-related behavioral changes by patients.[71] A 2013 study that randomized internal medicine residents to receive structured training in the 5As via an obesity counseling curriculum vs receiving standard residency training reported that patients attending appointments with the 5As-trained residents lost significantly more weight over the course of 12 months compared with patients of the residents in the control group, who gained weight.[72] A study conducted in 2010 found that patients who received counseling using parts of the 5As framework had more than 30% greater odds of being motivated to lose weight.[73]

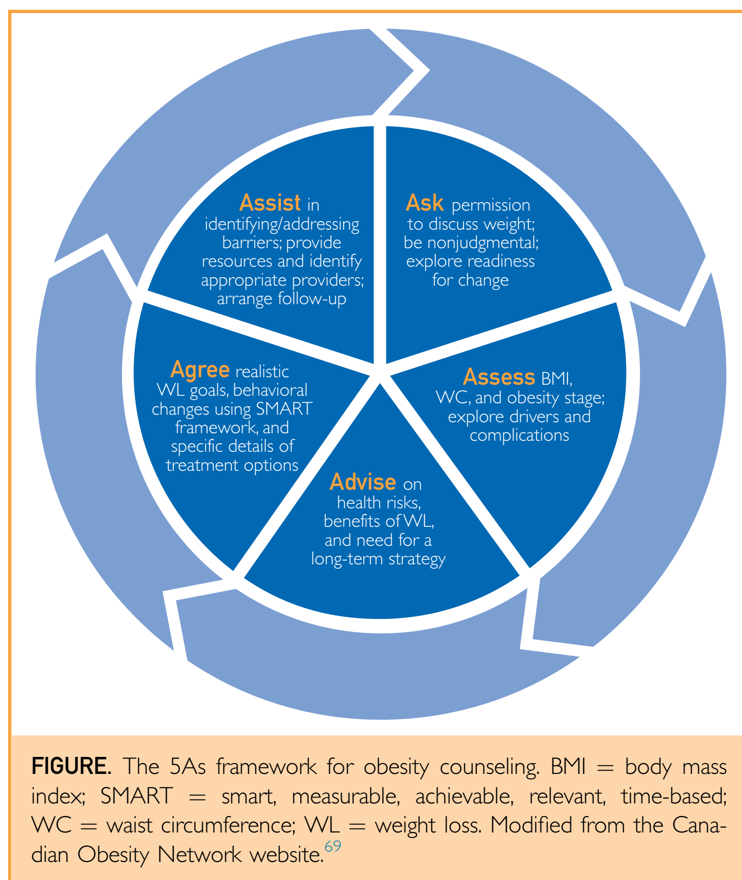

FIGURE. The 5As framework for obesity counseling. BMI = body mass index; SMART = smart, measurable, achievable, relevant, time-based; WC = waist circumference; WL = weight loss. Modified from the Canadian Obesity Network website.[69]

Begin With Small Steps

Analogous to the advice that patients receive regarding the value of small steps for behavioral change, HCPs should follow the same advice. Simply starting a dialogue about obesity by asking the patient's permission to discuss weight, as described in the 5As, may help to broach an often sensitive topic and is less likely to be interpreted as judgmental.[70,71] Asking permission conveys empathy and respect for the patient, which has been shown to increase motivation for behavioral changes in nutrition and physical activity, whereas perceived judgement about weight negatively influences weight loss.[74]

A recent randomized controlled trial in which physicians were trained to engage in a 30-second obesity intervention found that even exceedingly small steps can lead to positive outcomes.[75] Physicians were randomized to an intervention group in which they initiated a discussion regarding weight, offered patients referral to a weight management program, and offered a follow-up appointment compared with a control group that only advised patients that weight loss would improve their health. Both physicians and patients found the intervention acceptable and helpful. Patients counseled by physicians in the intervention group lost more than twice as much weight over 1 year and had more than twice the odds of losing at least 5% and at least 10% of their starting body weight.

Use Available Educational Resources

For practicing HCPs who do not have the benefit of ongoing improvements in obesity

training in medical schools, it is now becoming easier for them to improve their knowledge about obesity via self-study or in-person or online continuing medical education. Many professional societies also offer tools, guidance, and continuing education on obesity in order to improve HCP knowledge of and confidence in screening for and diagnosing obesity.[58,76,77] In 2012, the American Board of Obesity Medicine began certifying physicians who specialize in obesity to become "diplomates."[78] Because of the lack of obesity medicine fellowship options, American Board of Obesity Medicine certification requires extensive continuing medical education credits, which has led to growing options for this type of HCP education.[78] A recent systematic review found that training physicians to improve communication and counseling regarding obesity leads to improved patient outcomes, including lowered BMI.[79]

Do Not Go It Alone

Training in counseling techniques, such as motivational interviewing, is challenging for many HCPs.[62] However, a multidisciplinary team approach can minimize the burden of obesity management by sharing the patient's care across HCPs, both within and outside the clinic.[58] Multidisciplinary team counseling approaches also help people maintain long-term weight loss. Employment of physician extenders, such as a dietitian, health coach, behavioral counselor, or other HCP who is trained in obesity management, should be considered.[80,81] In one study that evaluated the effectiveness of on-site dietitians to provide obesity and lipid counseling at an outpatient physician office, 80 patients seen by a dietitian at 2 visits achieved an average maximum weight loss of 5.6% at a mean follow-up of 1.75 years. It was anticipated that earlier and more frequent follow-up could result in greater and quicker weight loss.[82] Further, integrating community resources for obesity management with clinical care can significantly extend the reach and impact of HCPs with respect to obesity counseling.[83]

Use Available Reimbursement Options

Although insufficient reimbursement is cited frequently as a key barrier to effective obesity counseling, access and coverage of counseling is steadily improving. For example, in 2011, Medicare began reimbursing for intensive obesity counseling in primary care.[84] However, existing reimbursement options are rarely used by HCPs. A recent study evaluating the use of the Medicare reimbursement for obesity counseling reported that fewer than 1% of eligible patients received this counseling.[85] Both Medicaid and private health insurers are increasing their coverage for obesity counseling and related services, and this trend is likely to continue in the future. Health care professionals should attempt to maximize their use of reimbursed services.

Long-term Support Is Required

Many patients do not adhere to sufficient long-term weight management support from HCPs.[80,86] Extended-duration weight loss counseling significantly improves long-term weight loss and maintenance of weight loss.[87] More intensive counseling over the long term (up to 5 face-to-face counseling sessions with a physical activity specialist and a registered dietitian over a 6-month period) has been reported to result in greater patient motivation and a greater reduction in weight, blood pressure, and cholesterol level compared with patients who only received standard information.[88] Because most of the general patient population see their physician on average 3.9 times a year, this creates multiple opportunities for ongoing interaction and weight management.[89] Moreover, Medicare, and increasingly private health insurers, cover long-term HCP counseling for obesity as long as patients lose at least 3 kg during the initial 6 months of counseling.[68]

CONCLUSION

The complex, multifaceted nature of obesity presents a myriad of challenges to the treating physician. Evidence suggests that, in many cases, people with obesity are not engaged by their physician and the recommended clinical pathway is not being followed. The reasons for lack of engagement are numerous, not least the feeling that obesity treatment is futile. However, where effective strategies are implemented, the health benefits are clearly evident, even with relatively small weight loss. Using simple tools and strategies, and in some cases a multidisciplinary approach,

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patients can be engaged and ongoing support and motivation may be provided, thereby improving patient care.

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Abbreviations and Acronyms: **5As** = Ask, Assess, Advise, Agree, and Assist; **BMI** = body mass index; **EHR** = electronic health record; **HCP** = health care professional; **NAMCS** = National Ambulatory Medical Care Survey; **NHANES** = National Health and Nutrition Examination Survey; **NHLBI** = National Heart, Lung, and Blood Institute; **PCP** = primary care physician; **USPSTF** = US Preventive Services Task Force

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Correspondence: Address to Scott I. Kahan, MD, MPH, 1020 19th St NW, Ste 450, Washington, DC 20036 (kahan@jhu.edu).

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