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Disclosures

- None

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Objectives

1) Understand the obesity stigma and weight unconscious bias among health care providers.
2) Review methods for discussing excess weight with patients, including nutrition and physical activity counseling.
3) Evaluate new weight loss medications and novel approaches for adults with obesity.
4.) Review MoHealth Net Biopsychosocial Treatment of Adult Obesity Benefit

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Increasing Adult Obesity Rates in US

- 71% of adults had either overweight or obesity in 2015-2016
- Rates of obesity are expected to increase during the COVID pandemic
- According to the NIH, obesity/overweight together are the 2nd leading cause of preventable death in the United States (close behind tobacco use)

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Implications for the practicing clinician

- 2018 USPSTF recommendations to screen all adults for obesity, those with BMI >30 should be offered intensive, multicomponent behavior interventions (Grade B)
  - Most interventions last 1-2 years with >12 sessions in first year
  - Focus on problem solving to identify barriers, self-monitoring, peer support, relapse prevention
- Frequency of office visit every 1-3 mo recommended

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MOHealth Net Biopsychosocial Treatment of Obesity for Adults Benefit

- Benefit goes into affect 3/30/21
- Similar to the Youth Benefit, the Adult Biopsychosocial Treatment includes:
  - Intensive Behavioral Therapy (IBT)- individual and group, and Medical Nutrition Therapy (MNT)
- Eligibility criteria for adults: age ≥ 21 Years, BMI ≥30
- Requires referral from physician or licensed practitioners and **Prior Authorization** from MO HealthNet
- Intervention period (0-6 mo): a maximum of 3 hours of individual IBT and 9 hours of group IBT and 1 hour and 45 minutes of MNT
- Continuation period (6-12 months): 1 additional hour of IBT and 2 hours of group IBT, an additional 30 minutes of MNT

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Tips for reduce obesity bias and stigmatization among health care providers

- Obesity bias results in inferior care: 23% of providers don't recommend treatment to obese patients, 47% report weight management counselling inconvenient
- Avoid use of terms: "fat, morbidly obese, chubby" or maybe even "obese". Instead consider using terms: "weight, excess weight, unhealthy weight, overweight"
- Take the Weight Implicit Association Test to evaluate your weight unconscious bias:
- https://implicit.harvard.edu/implicit/takeatest.html

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Other tips for discussing weight

- Ask permission to address "Is it ok if we talk about your weight today?"
- Express for concern for health impact/wellbeing "What health concerns do you have you about your excess weight?"
- Emphasize positive motivation- significant encouragement, point out wt loss even if it's only a few lbs or even maintenance of weight with no wt loss
- Don't attribute complaints to obesity alone, look for other causes
- Provide specific wt loss goals (**5-10% of baseline weight**)
- Avoid scare tactics, usually not effective. Be honest but don't bully patients into changes they aren't ready for
- **Respect the patient's autonomy-** gauge the patient's interest in talking about weight loss and if not there, revisit at a future time, plant the seeds for a future discussion

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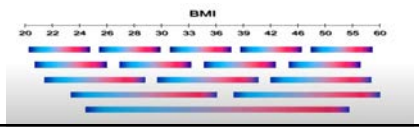
Obesity set-point theory

- Obesity is a consequence of the complex interplay between **genetics and environment**
- body weight is maintained at a stable range, known as the "set-point," despite the variability in energy intake and expenditure
  - Energy expenditures decrease after periods of weight loss and increase during weight gain



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Nutrition and Physical Activity counseling

- Offer dietician referral (or Biopsychosocial Treatment)
- Reduction of 500-1,000 kcal per day should result in weight loss of 1-2 lbs per week
  - Weight loss plateau: obese patients who lost 10% of their baseline weight experience at 15% reduction in energy expenditure
- Adding physical activity to calorie restriction may results in modest improvements, but physical activity alone does not produce significant weight loss
  - Try to add small acts of PA into your/your patient's daily routine
  - **Go for a walk everyday after you are done with your work**

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Weight Loss Medications

- *Obesity is a chronic disease, not a personality trait or weakness*
- Consider medications for patients with Obesity (BMI >30), or Overweight (BMI>25-27) with obesity-related condition
- Not for every patient, wt loss medications generally have to be continued to maintain wt reduction
- Treating co-morbidities:
  - Some diabetes medications can help reduce weight- metformin, empagliflozin (Jardiance), liraglutide (Victoza)
  - Depression- bupropion (Wellbutrin)

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Liraglutide (Victoza, Saxenda)

- MOA: GLP-1 agonist, regulates appetite and caloric intake
- Initially a DM medication (Victoza), but being used for wt loss without DM now too (Saxenda)
- **Significant cardiovascular benefits**
- **Subcutaneous injection daily**, increase weekly, re-evaluate after 16 weeks
- SE: **nausea, vomiting**, hypoglycemia in T2DM; not recommended with severe renal or hepatic impairment; rarely pancreatitis and gallbladder disease
- **Very expensive** $1,330 for 5x 3mL pens

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Phentermine-Topiramate ER (Qsymia)

- MOA: Phentermine- stimulant appetite suppressant, topiramate- anticonvulsant, appetite suppressant
- **Scheduled IV-due to phentermine**
- **Most effective medication for wt loss**; 70% of patients taking recommended dose lost at least 5% of their body weight
- SE: tachycardia, paresthesia, dizziness, dysgeusia, insomnia, constipation, dry mouth, teratogenic, depression/anxiety, impaired attention
- **Contraindication: pregnancy (topiramate),** HTN, CHD
- **Cost for Qsymia $180/month**, may be cheaper if rxed as phentermine and topiramate separately

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Orlistat (Xenical) (OTC Alli)

- MOA: inactivates gastric and pancreatic lipases, reducing GI absorption of fat by GI tract by 30%
- Results in 6.6 lbs of wt loss more than placebo and behavior inteventions; also improve glycemia, lipids, and BP
- **Effectiveness limited by SE's**: diarrhea, abdominal cramping, oily stools
  - **resolve if diet fat decreased <30% total diet**
- **Out of pock cost: about $150/month**

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Bupropion-naltrexone SR (Contrave)

- MOA: Bupropion- antidepressant, naltrexone- opioid-receptor antagonist used in opioid and alcohol treatment
- **Recommended second-line, less effective than other options**
- Reduces wt by 4-5%
- SE: nausea, constipation, HA, vomiting, dizziness, insomnia, dry mouth,

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Sympathomimetics Medications approved for short-term use

- MOA: noradrenergic sympathomimetics
- Phentermine, diethylpropion (schedule IV)
- Benzphetamine, phendimetrazine (schedule III)
- **Offer modest weight-loss short-term, but evidence lacking for long-term risk and benefits**
- **Recommendation is to limit to <12 weeks**
- SE: tachycardia, HTN, insomnia, dry mouth, constipation, nervousness
- Contra-indications: CHD, moderate to severe HTN, hyperthyroid, h/o drug abuse, glaucoma, pulmonary HTN

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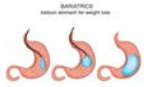
Newish FDA approved weight-management devices

- Plenity- cellulose capsules swell with water in stomach causing earlier satiety and less consumption; indicated for overweight and obese adults
  - Limited release in US currently
  - FDA approved in 2019

- Liquid-filled intragastric balloon systems (Obera, ReShape)
  - FDA approved in 2015
  - Risk of hyperinflation and acute pancreatitis



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In Conclusion

- The extreme increase in obesity requires that PCP's get comfortable managing it
- There are new options for **Biopsychosocial Treatment including nutrition and behavior counseling for MO HealthNet patients**
- We need to identify and address our own obesity biases
- Start with lifestyle modifications, but if that's not effective refer or treat

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