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Application of Motivational Interviewing and Shared Decision-making Techniques in Obesity Management

Announcer Open:
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Dr. Zalinov:
Hi everybody, my name is Daniel Zalinov. Welcome to a presentation on the Application of Motivational Interviewing and Shared Decision-making Techniques in Obesity Management brough to you by Clinical Education Alliance.

Today, for our presentation, we have a great panel. We have Megan Adelman, PharmD, Family Medicine Pharmacy Specialist at Center for Family Medicine at the Cleveland Clinic Akron General in Akron, Ohio. And then we have Dr. Donna Ryan, Professor Emerita at Pennington Biomedical Research Center in New Orleans, Louisiana. And as I mentioned earlier, I am Daniel Zalinov, I'm a PA Internal Medicine at Atrium Health in Charlotte, North Carolina.

And we will then move into the answer which is, D: I plan to lose 20 pounds in 6 months by using an app to log my daily calories and adhering to the 1,500-calorie diet.

So, now we're going to hand it over to the faculty about the importance of motivation interviewing and shared decision-making.

Dr. Ryan:
Yeah. Thank you so much, Daniel. I think what we want to do is kick this off with a study. So, this is a telephone survey of over 3,000 American adults aged 40 and up, and they were called and asked about 9 commonly encountered medical decisions. So, the medical decision was defined as having a medical action, such as getting screened for cancer, starting a medication, or having surgery within the prior 2 years, or having a discussion about taking such an action with a healthcare professional in the past 2 years. So, Megan, tell us about the results of the Decision study.

Dr. Adelman:
Yeah. Donna, thanks for that introduction. Now, you may be wondering, I'm in a weight loss continuing education, why are we starting with this? It's so important as we lead into this discussion as we set the foundation for, why are we doing motivational interviewing. This study focused on some of our most common bread-and-butter of primary care. Some of which where I'm really focusing on is the medication aspect. So, high blood pressure, high cholesterol, depression, common, common disease states, similar to obesity. Unfortunately, we saw a relatively low prevalence where some sort of shared medical decision was made place both for in the 20s down to 12% with depression.

On a positive note, we do see that this did raise when we had patients evaluate. were they offered an opinion from provider or were they asked any questions in terms of these. And we see the varying rates. Again, why we point this out is because, unfortunately, these are our bread-and-butter where we probably feel very comfortable as providers to have these discussions with patients where there's not, maybe, as many stigmas as we compare later on to our weight management.

I do want to highlight probably one of my favorite things from this study, which is what patients really valued in terms of their healthcare. You know, a lot of the times in my practice, I hear a lot of; Well, I got on Google to start looking at things; or I really favored the internet – maybe family and friends. Certainly, there's this whole picture, or scope, of how patients make decisions. And really, the overwhelming majority took very high value in terms of what their healthcare provider said, which further pushes more towards having the provider at the center of some of those decision, but certainly engaging in that discussion with patient care as well.

Dr. Ryan:
Excellent. You know, I think where the rubber hits the road, Megan, is not just having the discussion, not just making a recommendation about what to do, but it's actually following up. And this is so true in weight management. You know, this is a chronic disease, and we need a long-term approach to managing weight if we're going to use weight as a pathway to better health for our patients.

So, although we've got 42% of the US population with a BMI of 30 or higher, we're not doing a very good job of managing weight in those patients. So, in the ACTION study, we know that obesity was actually diagnosed in about 55% of patients who met that BMI of 30 or higher criteria. But even if a conversation was had with the patient, only about 24% of patients were scheduled for a follow-up visit. So, I think what we all need to learn to do, if we're going to address weight management as a treatment, we've got to a better job of talking to patients, getting patients to change their behaviors around diet, physical activity, sleep, taking medications, whatever. But we've got to do a better job and that's the whole purpose of this conversation.

Dr. Adelman:
Donna, you bring up some great points. And I think that this is really important as, you know, we talk about some of the faculty wholistically as a panel that are talking about obesity. A lot of the times when I'm talking with my family medicine residents, we almost have to flip the dialogue that we talk about so many different healthcare related issues and then obesity kind of falls in the last two minutes and it really becomes a side-swipe of, well, we really need to maybe work out and eat cleaner. What does that mean though?

So, really, I think when we have the diagnosis of obesity where we see individuals may be interested in the discussion, allowing people to have that avenue that they know they can go to the providers. Because a lot of times this is shocking to patients that they can talk to their healthcare provider about this. They think it's much more correlated to going to the gym, or maybe a nutritionist. I mean, we've seen that in terms of the literature saying that patients are much more successful when they involve the healthcare team.

We'll talk a lot about motivational interviewing because this can be such a stigmatized topic to discuss, and a lot of the time patients are coming in very discouraged and not feeling like they have many options.

I can't stress enough that when you're dealing with obesity, I think, a lot of the times we have to go back to our motivational interviewing where we really put the patient centric in terms of making them feel like they're in the driver's seat for this. This is frequently something that does not happen overnight, so patients have been dealing with this for years. So, seeing really where they are and helping to build that collaboration and partnership is going to be critical. Finding out their motivations, what they're willing to do, and really where the state of change is, is really going to help you in the long run to determine how successful a patient will be and where you can fit into the piece of that spoke with a wheel to help with obesity management.

Dr. Ryan:
You know, this motivational interviewing came out of treatment of alcoholism, but we use it for so many things. We use it for smoking cessation, we use it for weight management. It's a really good technique. An old dog like me, I was not taught this. I was taught, well, we'll make the diagnosis, we'll make a recommendation, and the patient was expected to do it. But you know, the only person who can change behaviors is the patient, it's not me. So, the me, the very essence of this motivational interviewing is this green box – it's listening with empathy. You actually must put yourself in the patient's shoes to understand where they're coming from if you want to expect them to make some changes. And then, the orange box – understanding and explore the patient's own motivation. The patient has to change, not me.

And then, the blue box – resisting the writing reflex. This is the one I had the hardest problem. I just want to cut to the chase and tell people what's the right thing to do, but no, I've got to use these motivational interviewing techniques to have patients explore for themselves why they are off-center with their goals and what they're actually trying to do. And then finally, the yellow box, it's what it's all about, it's empowering the patient.

So, I think these communication skills are the things that really elicit behavioral change. So, we don't argue, we roll with resistance, and we help build that discrepancy, that inconsistency between the patient's goal – what they want to do, and their behavior – what they're actually doing. I think to be a successful motivational interviewer, you have to support the patient where they're coming from, their self-efficacy, their own ability to change, and provide them with hope and self-confidence that they can actually change.

So, what about these two techniques? I think, Megan, you use these all the time. On the scale of 1 to 10, you ask the patient. Tell us

how you do that.

Dr. Adelman:
Yeah. Donna, and I know you do, too. So, it's a nice technique. I like doing this, especially within practice when starting the conversation to see where people are. Some patients, you know, we assume the goal is to lose weight. Maybe that's not where they are. I feel like weight management really is right time, right place, right people that are involved in terms of the healthcare team. So, I think this is a great opening line, and we'll talk about, really, some good wording to help with it. But this is a great starting point in terms of, on a scale of 1 to 10, why is weight loss in your factor. If they answer in the lower range, you know, why was it a 2 and not a 3, or why was it a 2 and not a 1? Really illicit some of the initial conversation.

The same part being confidence. Where are we in terms of confidence? Sometimes the discourse between these two really helps illicit some of the further discussion to have for patient care.

Dr. Ryan:
You know, Megan, I love these questions because what it does is it makes the patient aware of their lack of confidence, or their confidence, and makes them aware of what their thoughts are on importance. So, it's a wonderful technique.

Dr. Adelman:
I agree. And I think sometimes we have some discourse between what's important to us as healthcare providers, and what's important to the patient. So, I think it has some great dialogue with that. On the flip side, and I know, Donna, you do this in your practice a lot, is asking about what barriers are, or what's some of the resistance. Because a lot of the times if we don't discuss this up front, on the backend this can be really difficult. So, what barriers are you identifying that may be triggers for our success in losing weight.

We've highlighted here some that are frequent discussion points, because I think that this is part of the pairing that we can do to help individuals overcome these barriers initially, or help develop strategies for that.

Daniel, we'd like to hand it over to you for our first patient case to discuss.

Dr. Zalinov:
Absolutely. So, we'll head into a patient case. Our patient is Ms. King. She's seeing you for her yearly annual physical exam. She is 42-years-old, is a web designer working from home, single. Previous medical history: you know, fairly nondescript, just a history of hypertension. You can see her vital signs there: BP of 130/80, pulse 75 beats per minute, weight is 202 pounds which puts her in a BMI of 33.6. When you do the physical exam, some notable findings of acanthosis nigricans on the neck and under her arms, as well as some truncal obesity.

As far as medication review, that she's on combination of valsartan/hydrochlorothiazide medication, which she is takin regularly on a daily basis for her hypertension. Labs that you get drawn today: we see an A1C here of 6.0%, which puts her in that prediabetic range. You know, up slightly from a year ago, but not significantly so. And then we see that lipid profile there with the HDL LDL and the triglycerides.

So, when you're talking with her about the labs, you know, it's mentioned there's some prediabetes, metabolic syndrome, and you just ask, you know, how've you been doing. She says that it's been busy, which is apparently good for her, and says that blood pressure, she's been checking it at home, which we always of course like to do with our patients. And generally, she's feeling fine, no acute complaints or issues.

And now for our faculty, Donna and Megan, how would you go about, you know, talking about the patient's health and weight with them on that individual one-on-one basis?

Dr. Ryan:
You know, this is a patient that is so common. I mean, this patient thinks she is healthy. She's checking her blood pressure at home and she feels fine. She's busy at work. She's at home, sedentary – has a sedentary job. She's got obesity but she's not talking about that to us. But when I look at her exam, I'm concerned. You know, yeah, she's got hypertension, but it's controlled on medications. This woman has metabolic syndrome. You know, that's that truncal obesity. We haven't measured her waist circumference, but we know it's elevated. She's got high triglycerides over 150, she's got low HDL – for a woman, that's low – and she's got evidence of dysglycemia and insulin resistance. That's what that acanthosis nigricans indicates, it indicates insulin resistance. And she's got prediabetes. Her A1C is marching upward, and she is marching towards not only type 2 diabetes, but also cardiovascular disease. And that's the problem with metabolic syndrome.

So, this patient isn't concerned, I'm concerned. So, you know – and I know that the best way to improve all of these things, to improve blood pressure, to improve lipids, to improve glycemia. The best way to improve all of those things is weight loss. But I don't want to

lead with weight loss. I'm – if I do, the patient will think I'm talking about how she looks. I don't want that patient – I love this patient, I love how she looks. I want this patient to be concerned about her health. So, I would lead with the bottom choice, and that was, I'm concerned about your health. Let's talk about some of your blood test findings. And then I would find them.

You know, I think that prediabetes is such a misleading term. It's not pre anything. There's increased risk for cardiovascular disease and both macrovascular, and microvascular complications. So, we need to be not complacent about dysglycemia.

Megan, what do you think?

Dr. Adelman:
You know, I think you summarized it so incredibly well. I think the other thing that wasn't completely captured in this, is that I'm excited that she's showing up and doing a lot of the preventative care that's worthwhile. So, we're catching all of this in terms of health, relatively early. And I frequently discuss a lot of this is preventable, and we are in such an action phase that we can make some differences. But, Donna, I think you highlighted many of my thoughts really well.

Dr. Ryan:
Yeah. You know, it's such a sensitive topic. Let's move on and talk about the language to use and how to actually talk to patients who have this, where we need to raise weight management as the pathway to better health.

Dr. Zalinov:
So, faculty, pose that question back to you. How would you go about posing that question to that patient that you have there in your clinic?

Dr. Ryan:
Well, Daniel, you gave us four good options. I like them all, actually. I think this is where the art of medicine comes in. I just want to point out that nowhere in these choices is there, you have obesity, you need to lose weight. That is not part of the conversation. These are much softer ways of raising the issue with the patient. The last thing you want to do with your patient is offend them. And when you lead with weight, and when you start talking about obesity, you will – you're turning your patients off and you risk losing them. And what you really want to do is keep those patients coming back because this is a disease that takes a lot of care over time. So, I'm okay with all of these.

What about you Megan?

Dr. Adelman:
I agree. I think all of them – a discussion surely has to be had about weight, so I don't go away from the term weight, but I agree with you. What really sticks out to me is I love that I don't see obesity, extreme of weight. I don't see BMI. All negative stigmas associated with it that I think you'll lose an individual to follow-up. So, I'm completely fine with all of these. This does open the discussion of having that conversation and asking permission. Because, Donna, I know that, you know, you really value, in terms of the initial conversation, having that. Can you speak a little bit more to your practice and how you bring that up?

Dr. Ryan:
Yeah. I think asking permission is important. So, you know, even when – and, you know, I'm a weight loss doctor, they know why they're coming to see me. But I still, I'm careful about this. I'm careful about the words I use. And it's always, Is it okay if we talk about this? And then I'm very careful to always make this about health.

So, look at the script that's being shown now. It's really all about how your health is being impacted by your weight. It's not really, you need to lose weight because you're too big, or you have excess abnormal body fat. No. What it's about is health. And so, I'm always talking about health. The tests show there's some health issues, some changes that might affect your weight. It could really improve this. Are you concerned about the effect of your weight on your health? You have a number of symptoms and signs that could be related to excess weight. Can we talk about how this weight is affecting your health? It's all about health.

So, I think we're used to asking permission about weight. We don't ask permission to talk about blood pressure. But it's so sensitive. You know, patients feel judged when you start talking about their weight because they think you're judging their body size. So, I think just asking that permission and always framing it within the concept of health is a good idea. But, let me tell you, you will have a patient who says, no, I don't want to go there right now. Let's not talk about my weight. So, what do you do? Well, I think it's a good opportunity to jump in and say, that's fine, I understand. The single best thing you could do to improve your health would be to make some changes that might produce some weight loss. Let's agree to talk about this at our next visit. You say that with a smile, and that patient's going to come back.

Dr. Adelman:

And, Donna, I just want to – I think you highlighted so many great points. I want to just add a few more that I usually think about. I think we have to flip the stigma of obesity. So many individuals that are obese, or are considered overweight based upon BMI, really know that coming in. And there's so may different things that they have to deal with that really I think – I'm always amazed when people share different stories with me and healthcare is just one stigma attached to it.

But I think we really have to do our homework. If somebody's coming in to talk about weight management, just like we would do a thorough chart review for somebody that's coming in for hypertension management, for diabetes management, making sure, you know, the backstory. So, what's maybe worked in the past hopefully that's well-documented. I always say, have you used medicines. We can see that very clearly in our health medical record, and we have to start flipping the stigma. Obesity we have to think of as a medical diagnosis. That it's not somebody whose choosing to be obese, that there's some laziness factor to it. We know there's a lot of genetic components to it that are outside of the patient's control. So, we really want to make sure that we are staying empathetic through that whole journey and making sure that we know their history. Now certainly, part of that may be questions. Tell me more about – I didn't see any medicines that you've used in the past for weight loss, is that something you want to discuss? But that really continues to focus on that shared medical decision to make sure that we know the patient and that builds that trust.

Dr. Zalinov:
So, coming back to Ms. King. You have this discussion with her obesity, about the diagnoses associated with it, and the value that you would gain from them by choosing some weight loss there. And, you know, as you're having this discussion, Ms. King says that, you know, she knew this was coming. She just hasn't had the opportunity to take as good care of herself as she should. The pandemic had been really stressful for her. You know, that's a very common refrain that we've been hearing from a lot of our patients over the past three years now. She doesn't know how much she can do. In the past, she's just never been very successful with weight loss. And of course, as with a lot of our patients, financial stressors and burdens can cause a lot of issues as far as how to proceed with health lifestyle habits and that weight loss journey that we want to make sure we're having that discussion about.

So, Donna and Megan, if this patient was in your clinic, if you were having that one-on-one conversation, how would you approach and broach the subject with them?

Dr. Ryan:
Megan, why don't you go first this time.

Dr. Adelman:
Sure. I'm happy to. So, I find all of these very appropriate. What I like about all of them, actually, is that this takes the ownership off of me and me saying, this is what I want you to do, to talk to me about what you view our situation as, or where do we go from here. So, it opens up a further dialogue for active listening on my part to see, where do we need to go from here.

Donna, additional thoughts from you?

Dr. Ryan:
Yeah, you know one thing – I agree with you, I think all of these are perfectly appropriate. I like the "I hear" in the first one at A. One of the techniques in motivational interview is to mirror the patient, to let the patients know that you hear them. So, repeating what they say. And another thing I use sometimes, not just, I hear, I know you said. So, I think patients are validated in their beliefs and it becomes much easier to go to where they are in order to be able to start on that journey of developing a treatment plan. These are all four good options.

So, I think readiness, you know that readiness to change, is really important. And where is this patient? I think our patient is in contemplation. So, here are some suggested ways that we can, sort of, query how ready this patient is to really embark on developing that weight loss plan. And we are giving you this because we don't want you to waste your time in launching into some explanation of some diet or physical activity plan. You need to go to where the patient is. Another good tip is on this slide, and that is to consider screening with the University of Rhode Island Change Assessment Scale. But this patient is in contemplation, and we want to move her to preparation and then to action.

So, Megan, your turn.

Dr. Adelman:
Yeah. And I want to stress, in my clinic we actually use the URICA as a prescreening. We found a lot of success with that, where we actually mail that out prior to appointments and then we assess that going in, because I think it's so important. If you assess somebody and assume that they're in the action phase when really, they're in the pre-contemplative, you've already lost some of the active dialogue that you could be having, as well as probably some of the trust that's already breaking down because I'm at step 7 and patient is at step 1. So, it just is so important to really assess state of change. We see so much with the state of change with, you know,

tobacco cessation, with other ones, but I really love getting into the nitty gritty of this because I feel like it's really helped build some of that trust.

So, we have our five different stages. The pre-contemplative where the patient's really not there yet. They might not even know what they don't know, and this is really where healthcare providers can step to the plate to hopefully get them into more of the contemplative and preparation. For contemplative, we may be thinking more about it, but not really in the change state of mind yet, ready take some action for that. The preparation, ideally if someone is coming in, we're hopefully at that point, and I argue that most individuals if they're seeing somebody for weight loss are probably in that stage, but not really sure where to begin. And even better is if somebody comes in in action phase, they might have already started doing some of the changes.

How I usually see this in patients, I'm able to demonstrate. I saw somebody the other day that, even before coming to the appointment, we frequently talk about, okay, why don't we start tracking our food intake. She already came in with a food journal, so that demonstrated to me, okay we're ready to kind of step forward with this. And then maintenance is certainly more along the lines of our follow-up, more for the monitoring once we've successfully lost the weight. So, based off of this patient assessment, I would argue that she is in the contemplative phase.

I think this is so important because this really, more so than anything else, fosters some of our dialogue in terms of where we can move forward in setting smart goals, which I know we'll talk about before. On this slide we really have some great prompts as examples to utilize, and that I really like to discuss within my practice, again, trying to foster more of the understanding of where a patient is.

Donna, do you have anything to add in terms of that?

Dr. Ryan:
You know, the language you use is so important. We always use people first language when we talk about obesity. So, it's people with obesity. They're not defined by their disease, they're people first. So, it's not an obese person, it's a person with a disease, a person with obesity. We weight and unhealthy weight, it's much more motivating than fat, obese, extreme obese, and I think we really need to scrub out language of that pejorative term, morbid obesity. Yeah, I know it's in the ICD-10 codes, but we still should not use that word. It's very pejorative.

I think we really want to talk about, you know, what we hope to achieve by changing behaviors, and diet and physical activity, and producing changes in health. So, one thing that I do is ask patients, what is your single most important outcome of our effort that we're undergoing to lose some weight? Is it health indicator, like is it the A1C? Is it lipid control? Is it mobility and other patient-reported factors that are related to quality of life? And look, there's nothing wrong with a better self-image and more confidence that occurs with a smaller body size.

Dr. Adelman:
Donna, you bring up something so great. I wanted to add one more thing, because I know you do this within your practice, too. In terms of wording is just at the heart of the matter. We've also within our clinic started switching some of the dialogue in terms of – instead of saying diet, talking about food choices, because diet has such a negative connotation. We've even moved away from exercise just because so many people find that overwhelming to what kind of activity. And really getting back to the food, we talk a lot about there's no good and bad food, it's this is nutrient dense food, or this is something that's going to be a little more filling just so that, again, we never restrict because that should never be an option. We talk about portions so that nothing feels off limits. We always talk that this is more about health rather than just weight.

Dr. Zalinov:
So, you're with Ms. King still at her physical exam. She is filling out a weight history form and she's drawing her weight trajectory for you. So, she was 140 pounds in college, gained weight while on Depo progesterone contraception, about 25 pounds there. Gained some more weight, about 20 pounds, when her relationship ended about three years ago. She was previously successful with commercial diets and a phentermine clinic, but she always gained that weight back afterwards. When you ask her about her 24-hour dietary recall, she mentions about 3 sodas per day, she likes to end her night with some ice cream as a dessert. And then, with her activity log, no real regular physical activity. And as you recall, she does work from home as a web-based designer, so her job is largely sedentary. She is interested in some devices that track steps, has thought a little bit about those. And then, you know, after some discussion with you, she does agree to do some more research on the internet and return for a follow-up visit for goal-setting discussion.

So, how would we help our patient explore and compare some of the myriad of treatment options that we have available to us?

Dr. Adleman:
You know, thanks for that lead-in. So, I think one of them, again, is just making sure that individuals, coming back to the shared medical decision, know all of the options that are on the board. Frequently with weight management, it's not a clear-cut everybody is going to get

this food prescription or activity prescription. So, I think walking through, really, the different options and weighing what the patient thinks about each of them. There's clearly differences, you know, if we really want to dig into the food first, or activity. Similarly, you know, as a pharmacist I'm always thinking about, are you interested in medicine. Some people say no, and that's okay, too. But there's multiple foundations when we talk about weight management. Certainly, when something starts to intrigue somebody, and then we're walking down the side of, okay, what benefits do you see from that, but then also what barriers do you see. You know, if somebody says, oh, great, I'm really interested in maybe increasing my activity level, my follow-up question is, what do you expect may be a barrier for not doing that already. You know, is that a work schedule? So that we can come up with different strategies to work around that.

And certainly, at the end, this is so overwhelming, so I think having some key takeaways or teach-back to make sure that they understand the full implications of it. Sometimes I find, wow, that is not what I took out of that discussion. That's okay, but let's make sure we have 3 or 4 key takeaways of what we're doing and then move forward.

Donna, talk to me a little bit more. How do you feel like you promote active listening within your practice, then?

Dr. Ryan:
Well, you know, for this patient there are multiple options that could be available to her. Medications, certainly. She's got some comorbid conditions that we would really like to achieve 10% or more weight loss in this patient. And we're most likely to do that if we combine a lifestyle intervention with a medication. But she may just want medication, but she may just want lifestyle intervention alone. So, there are multiple options. So, I think, what you said is very important, and that is you're going to lay out the options to the patient. What I like about this patient is that we're giving her some homework. She's going to go away and is going to explore what might work for her in her situation and come back to us. So, it's not really me prescribing a ketogenic diet, or me prescribing, oh, you got to join a health club. No, no, no, it's about, let's work together to create a plan that will best work for you. It's really, you need her input in this.

Dr. Zalinov:
So, you have Ms. King follow-up with you in the clinic, you know, however months or weeks later. You just kind of sit down, talk about what she has done with her homework that you've given her. She says that she's looked up some medications on a list and really thinks the metformin may be the best option for her from a pharmacologic perspective. She also wants to sign up for a diet plan again. There are some really good online options that she found. Right now, you know, as far as a physical activity perspective, she just doesn't feel like going to the gym or signing up for a membership is best for her for the time being.

So, Donna and Megan, out of some of those options, or even supplemental to that, what are some things that you would talk to Ms. King about? What would you say to her in regard to her thoughts and plans?

Dr. Ryan:
Well, A is definitely off of my list. You know, first of all, the patient has made a decision, and supposedly a shared decision. Metformin was one of the options, and why would you want to change that? And why would you want to change it with a medication that you've been using off-label. Tirzepatide is not approved for weight management yet, although it's under review by the FDA. And then, there again, you're being too prescriptive with number B. Get a standing desk – this has to be – the patient must take a part in developing the plan. So, I like C the best. I do think one thing that hasn't been discussed with her is, what is this weight management effort going to look like? Is it going to be just trying to improve some aspects of diet and physical activity and lifestyle and sleep and so forth? Or are we really going to have a more intensive weight management effort. We haven't really done that. So, it's not really appropriate to say, how much weight do you want to lose unless we have that conversation.

Megan?

Dr. Adelman:
I would agree with you. C would be my favorite here. Again, it's focusing on taking away from the weight only and really focusing on health. I agree with you, A and B would be completely off my list because that is 100% authoritative and the patient's probably already going to shut down because you're not taking intent on anything else.

Dr. Ryan:
It is true, now, that she won't lose much weight with metformin. It's very good for insulin resistance, but it doesn't produce much weight loss – maybe 2, 3, 4% depending on how high a dose you can get to with the metformin.

Dr. Adelman:
I would agree. And I think this brings us to a great discussion in terms of the SURE Method. And we've alluded to some of those already, but this I think is a good structure if you're starting some of your initial conversation about weight loss, some of the key things to think about. We've talked extensively about making sure that we seek our individual's participation. So, having that dialogue. Helping them to explore treatment options, and that may even be a contrast. We use the example of tirzepatide, that that was more prescriptive

in nature, but we can certainly talk about the different medication options and compare and contrast what they'd be willing to do. We've talked, as well, about making sure that we seek their values and preferences. Really what may be barriers, but what they also like. And then, finally, really the last couple of steps is making sure that we have a clear cut decision moving forward because that really helps with follow-up to help with accountability, as well as making sure that individuals don't have any questions following up. And we're going to get into the Smart Polls, because I think so many times individuals feel very frustrated with their weight loss efforts with healthcare system, because it is so incredibly generic. You know, saying I'm going to lose weight by eating healthier and working out more is just not acceptable when we're talking about obesity management.

And then finally, evaluating the patient's decision. So, on the next slide, we actually have some dialogue that uses an example. So, the first one; I notice that you're frustrated. That's kind of the mirroring that Donna talked about a little bit earlier. Let's talk more about that. Let's go over the different options. Which of the options fits best well with what we've discussed? So again, focusing and coming back to what the patient preference is. And then, finally, making sure that we have a follow-up.

Dr. Zalinov:
So, as part of that discussion during the follow-up visit with Ms. King, especially that discussion about increasing activity, she does state that part of her plan is to adopt a dog, both for companionship and to increase activity. So, then the next step is, okay, let's talk about a goal and a timeline so that we can follow some steps and achieve those goals.

What of those do you feel would be appropriate for Ms. King to go over with?

Dr. Adelman:
So, Donna, I would argue that I think answer D would probably be the most appropriate one in terms of, again, trying to facilitate some of that discussion. And I hope if nothing else is a takeaway from this seminar, that you as an audience member are feeling a little bit more confidence with what are some of the verbiage to use, what are some of the questions. I have to say, thought, and Donna, I'd love your input, I like parts of C, though. I like D the best, but I think C is interesting because I think it lends itself to that support that you are not going to be doing this alone. My patients laugh because I always say, listen, you're the quarterback so you're making the decision, but I'm the coach on the sidelines that is supporting you through that. So, I never want you to feel like you're throwing your arm out without any support.

Tell me more about your thoughts, though.

Dr. Ryan:
Yeah. I like D first, and then I would follow quickly on with C. You know, I think that if we ask question A, that this patient wants to weigh what she weighed when she finished college. We all do, you know, but that is not a goal that we want to set because it's not an achievable goal. And it's not a goal that's really linked to health improvement. You know, so I think for individuals who have metabolic syndrome, who have free diabetes, like Ms. King, we want to start a weight loss goal of at least 10%. We want to be able to achieve that by 6 months I would think. But I don't talk about 10% to the patient. No, the patient doesn't understand that percentage. We think in percentage because we link that percentage to a health benefit for patients with established type 2 diabetes, that we're going to do a more intensive weight loss effort, I want to aim for 15% or more. I always convert that to pounds. So, in this patient, 10% is 20 pounds. So, I think – you know, and I do not want an unrealistic goal. And I want that goal linked to a health thing. So, what I'm hoping to achieve with this patient is to somehow negotiate the concept that, you know, if we could make some changes and we could achieve 20% weight loss over 6 months, we could probably go back to normal glycemia, we would improve those triglycerides, we would get that HDL up and her blood pressure may be even better than it is now. So, that's what I want to do with this.

Dr. Adelman:
And, Donna, you hit such a clear point that I usually frequently talk about. So, ideally, within my practice at least, I try to have people leave with anywhere between 2 and 4 very concrete plans or processes. So, and I bring that up. I really like – I've actually prescribed patients or individuals to read "Atomic Habits" by James Clear because I think the discussion is so much more about the journey versus the final ending.

So, when we focus on weight – okay, you want to be down 20 pounds. Well, what does that mean? You know, that doesn't just happen overnight. So, what kind of processes and what kind of goal-setting processes are we doing for that? And I know we're going to talk, Donna, and I'd love for you to get into talking more about the smart goal. I know this is probably reminiscent of a lot of our medical training maybe early on, but I sometimes see where this is a huge gap in actual healthcare, especially obesity management.

Dr. Ryan:
Oh, absolutely. You know, and one additional thing on this patient, and that is, that six week appointment. You know, she started a new medication, she's embarking on this lifestyle change, we need to make sure she's going in the right direction. So, I like that 6 and 12-

week follow-up. Excellent.

You know, it's very important that we follow this on SMART recommendations for setting our goals. The goals should be specific, it should be measurable, it should be achievable, it should be relevant, and it should be time-sensitive. So, in this case, the specific is, we're going to try to achieve 10% weight loss – 20 pounds of weight loss – in 6 months. But to get there, we're going to make some changes in our physical activity, we're going to be walking the dog every day. We're going to be looking at a new type of eating plan that she has chosen herself. And we're going to be taking a new medication, metformin. So, the measures are, taking the medication, doing the physical activity, and following the diet plan. These are realistic goals, they're achievable. They're relevant because we know these goals will result in positive health outcomes. And we set a time limit on those goals. That's how to do it.

What do you think, Megan? Were my goals SMART?

Dr. Adelman:
Yeah. I love them. I think, from the practical standpoint, what I'd like to share with providers that are, again, dipping their toes into this and wanting to make this a practice, is that I continue to try to focus on really making it a specific portion – I feel is where we really fail patients. So, if somebody says, you know, okay, the activity portion is really exciting to me, I like walking outside. Great. How many times a week is that? Okay, three. Where are we going to? Is that in your neighborhood? Is that a park? You have to give me some specific, and then what does that time frame look like. If patients are willing, and this comes back to our state of change – I think there's some great literature, you know, "The Power of Habit" really comes into mind as a great book that discusses this – that people that are the most successful are also planning this and writing this down. So, if they have – if they use their phone as their calendar, I say, break that out – that's actually – I'm going to keep rolling with activity. But what days are we going to do that? Is that Monday, Wednesday, Friday, or do you expect a barrier to be your work schedule? Maybe we're doing Friday, Saturday, Sunday.

So, starting somewhere. My practice tends to be, the more specific that we can get into that, the more successful individuals are. And that also helps with my follow-up as the coaching role to say, okay, how was that? Did you enjoy the tracking? Were we able to keep on track with that, and do we see that as a barrier moving forward at all?

I actually also really like – we have obviously an electronic medical record that we do where, from the primary care side, I can have an after-visit summary print off and we go through for part of the weight management and have those very specific goals anywhere between 2 and 4 following the SMART method. And I will type those as we are developing them together and then I turn them around at the end of the visit and say, you know, this is what we came up with. Does this seem in line with what's appropriate? So, we have that shared medical decision as well.

Donna, do you have any other, like, practical tips that people can incorporate that into practice, because I think that this is really – if we have nothing else that we want somebody to take home, I think that this is critical for weight loss success, as well as health success.

Dr. Ryan:
Yeah. Absolutely. To me, the most important thing is to keep the patient coming back, and we're going to go there now.

Dr. Zalinov:
So, Ms. King does come back. At her – and this is our 12-week follow-up. In the interim though, at 6 weeks, she started developing some diarrhea side effect from the metformin, so she decided to stop the metformin from a pharmacologic perspective. She lost about 4 pounds on her commercial diet plan and she is the proud owner of a new labradoodle who she is very happy with and keeping her very active and busy, I'm sure. At her 12-week follow-up, though, her weight is only down by about 5 pounds, which 5 pounds is still very good, but still some room to go with that. She makes a comment that she is very hungry all the time. Could we consider some other medications and see if her insurance does cover some anti-obesity medications? And through some wizardry, you find out that she has a magical insurance that is going to cover all anti-obesity medications without question, and you tell her this.

So, which would you all have that discussion with? Which question? Which answer? What would be that next step in discussion with Ms. King?

Dr. Ryan:
I'm so glad to have a pharmacist with me to answer this question. And Megan, I'm going to give you the honors first.

Dr. Adelman:
Awesome. So, I am definitely trending more towards D. You know, the funny thing that I always – not so funny depending on how you look at it – the fun part about weight management, and we'll talk about this in the other portion of the seminar, is that there's not a lot of meds to learn. The downside is that there's not a lot of meds to choose. So, it tends to be a relatively quick discussion. So, I really like option D the best. I think that there's a couple of caveats that I want to allude to that, too, is that coming back to – and Donna, you

discussed this about one of our prior questions about the tirzepatide – is does this patient even want to be medicine? Certainly, we can achieve weight loss with just lifestyle interventions alone. That I would even take a step back and say, where do we want to go from here?

The other thing that I think is so important, too, to discuss is that – Daniel, highlighted this so well – I would be celebrating the fact that she's lost weight. I mean, any weight is weight loss. That I think it can be very discouraging, and I have people come in saying – and, Daniel, I love how you said this – the only portion. Like, they say, I'm only 5 pounds down. Well, that's 5 pounds that you weren't down before. So, I think that we do have to have a celebration about that to discuss that, I'm sorry that you didn't react to one medicine, but that is the flip side. You know, sometimes we don't react, and we can always try something else, but is that one of the decisions that you want to move forward with? You know, we didn't like one medicine, but does that mean you still want to move forward with medicines? If you do, great, let's have a discussion about that and go through the positives, as well as some of the limitations with some of those.

Donna, your thoughts on how you would continue to have this discussion.

Dr. Ryan:
Yeah. So, let me deal with the metformin first. You know, I think the diarrhea is a side effect. One thing we can do is give extended-release form of metformin. It can be more expensive. But that's one strategy to deal with diarrhea. You know, metformin has a very frequent side effect. So, that's one thing that we can do is try again on that. However, she's talking about appetite, she's talking about hungry. And, you know, so, I think we need to listen to our patient and explore the other medications that are available. You know, almost all of our medications have effects on hunger. The only one that doesn't is orlistat. Orlistat works by blocking the absorption of fat and has no effect on hunger. So, the ones I would put on the table for consideration are phentermine alone, phentermine topiramate, naltrexone bupropion, liraglutide and semaglutide. These are all approved for weight management. Phentermine alone is not approved for chronic weight management, so it would be my least – the one I would be least interested in for now. I think she has long-standing obesity, she has hypertension, and phentermine, which is sympathomimetic would not be my first choice. But I would want her to look at all of the medications.

And I'll frequently make a list, send patients home, and tell them to explore these on the internet. Look, they're going to go and look on the internet anyway, we might as well be giving them some homework to look at on the internet. But, I'm glad this patient is interested in medications. I think that the key point to get across here is to make sure that this patient has realistic expectations about what medications can and cannot deliver. They work through appetite, so you must use them to support your intention to have a healthier diet.

Dr. Adelman:
Donna, I know you talked about, too, I think that this is critical in terms of that I'm so glad. I think the other thing I always try to do is saying, our other big success is that you're showing up today. You know, this is something that's it's not – I love the behavioralist that I work with, she says that obesity is not an overnight – it doesn't become an overnight problem, so it's not going to be an overnight solution, either. So, the follow-up is so critical in making sure that individuals don't get discouraged at all. So, I think having a very clear setup.

This is unfortunate in terms of depending on your practice. And, Donna, I'd love to hear more about yours. We, unfortunately, can't do weekly visits. Our weight management clinic has become so incredibly popular that really, I'm looking, usually, more at anywhere between 3 and 6 weeks just from that standpoint. Now, certainly, we use other methods.

So, I did want to at least talk about practical tips from that standpoint. I love – we do have a certain electronic method that also incorporates messages that can be sent back and forth through MyChart, which I found to be very successful, especially when, as a pharmacist, if I'm initiating therapy and doing some follow-ups. This is also where, if I harken back to the use of the after-visit summary, I will utilize that, copy/paste the goals and then send a quick MyChart message at 2 weeks saying, where are we with this? What barriers? And that has been relatively well received. So, this does come back to – we've got our United States Preventive Task Force has some great guidance on that. Unfortunately, that's just not within my practice that unfortunately, we don't have that space.

Donna, do you have any thoughts, though?

Dr. Ryan:
Yes, I do. I have some strong feelings about this. You know, the USPSTF really browbeats us to give more counseling for weight management. But then, it's almost impossible to do within a routine clinical practice. Their evidence base for this are these big studies that I was a part of where we gave a lot of weekly visits. Weekly visits for the first month, biweekly for months 2 to 6, and then monthly visits for month 7 to 12. That is 16 or more visit a year. Now, you know, you're only going to be paid a small amount for that counseling service.

What you can do is, shared medical appointments can work, commercial programs can work. And some of those commercial programs, like WW, they can be affordable. So, it's very, very difficult to give the intensive counseling that really results in the weight loss of 5 to 10% that we're trying to achieve. So, I don't hesitate to refer out to commercial programs, provided those commercial programs have shown that they can deliver those sessions and produce effective weight loss.

Dr. Adelman:
Donna, I think that's so well said. The other thing that I do want to put a plug in, I really liked – I was moved by Jake Poore has a book out that's called "99 Lessons I Learned from Working at Disney," and it talks about setting expectations. So, you know, you think about, you go to Disney, and you see that plaque card that says this wait time is 45 minutes. It's probably 30 minutes because they don't want to underproduce, they want to overdeliver. So, I think that, frequently, during my first appointments as well with an individual, I'm really setting clear cut expectations. This is for us. We initially do – we want six appointments with you. Ideally, we're seeing you every, again, 3 to 6 weeks, so that everybody knows the accountability portion of that, and that they know that they're going to get support. I frequently also say, you may, at the end, you will be hearing from me in 2 weeks via MyChart as a follow-up. And meeting those expectations so that continues to help with the follow-up in my show rates as well as individuals feel that support coming back to their shared decision. So, I think having that very clear cut discussion, really, patients appreciate. It helps fill some of those gaps that we just talked about.

Dr. Ryan:
You know, Megan, this was a wonderful experience doing this with you. And, Daniel, thanks so much for narrating our questions and for participating in this. I think, you know, the takeaway messages from this are that it is so important that we all develop our communication skills with our patients, that we all ask permission to bring up weight in the context of health. That we know some motivational interviewing techniques, that our goals be SMART, and that we keep the patients coming back. That we have our patients back so that our patients know that they can expect to be seen in a nonjudgmental empathetic way in our clinics, and that they can get good weight management from us.

Megan, thank you so much for participating in this, and Daniel, you, too. I learned a lot from both of you.

Dr. Adelman:
Same back, Donna. It was a pleasure. And Daniel, thanks so much for leading us.

Dr. Zalinov:
Absolutely. Thank you all for leading and participating in the discussion.

So, with everything that we've learned over the past hour, and now we can reevaluate the correct answer, which is D. And the whole point of the SMART method of goal-setting is that it's specific, measurable, achievable, relevant, and time-sensitive. And out of all the four answers that we have there, D does fall under all of those parameters. The other three either don't have a time frame, or specific, they're time-sensitive but not specific. D really is the one that falls into that overarching SMART method of goal-setting.

So, on behalf of all of us, thank you for participating. Thank you for joining us for the last hour. I hope you all learned a lot. To earn the CME and CE credit for this activity, please click on the button below, and I hope you have a great rest of your day.

Take care.

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