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info@reachmd.com
(866) 423-7849

Building a Comprehensive Obesity Care Clinic

Announcer Open:
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Dr. Zalinov:
Hello everybody. Welcome to our presentation today: Building a Comprehensive Obesity Care Clinic, brought to you by Clinical Education Alliance provided by Clinical Care Options. Today – with our faculty today, we have to give our discussion Dr. Caroline Apovian, Professor of Medicine at Harvard Medical School. She is co-Director there at the Center for Weight Management and Wellness at Brigham and Women's Hospital. We also have Dr. Scott Butsch. He is the Director of Obesity Medicine with Bariatric and Metabolic Institute at the Cleveland Clinic in Cleveland, Ohio. And I'm going to be your moderator today, Daniel Zalinov. I'm a PA in Internal Medicine with Atrium Health.

The answer is actually, C; would be the most appropriate answer in this case. We will revisit this towards the end, but now on to the primary portion of our lecture and talk today. I'm going to turn it over to Dr. Butsch to go ahead and discuss barriers to obesity care.

Dr. Butsch, go ahead.

Dr. Butsch:
Yes. Thanks, Daniel. So, you know, it's really important to understand just from the beginning that there's going to be an element of bias around that interaction that you have with patients, as well as setting up your practice. Common misconceptions are that, you know, patients should just be able to treat themselves. If it's a behavioral problem, and obesity is not considered a disease, which of course, we disagree with, you know, the thought is that the patient should be doing the work by themselves, focusing on some kind of behavioral change model. And really, for the most part, there's been sort of this one-size-fits-all approach where it should be just the low carb diet, or just, you know, one element that is missing that everyone should try to find and seek, and that should be the benefit for them to lose weight. But, if you think about obesity as a disease, which it is, we should really treat it the same as other diseases. So, consistent follow, a chronic care model of, you know, us following up with patients. We should think about the use of medications as adjunct to lifestyle interventions.

And then really, what we try to do with every patient, is really individualize that care, not have that one-size-fits-all approach.

In 2013, Dr. Apovian and others had created treatment guidelines for obesity. And really, what we have seen now 10 years later is that we still don't have a standard-of-care model. We have a lot of guidelines out there, but there is this gap. And, you know, thinking about primary health providers using BMI and waist circumference to try to assess somebody's disease risk, what we see in clinical practice is really there's a failure to diagnose. We don't see obesity actually on diagnosis labels when people are billing for their patients. And traditionally, the guidelines have said to lose about 3 to 5%, and that is very helpful for decreasing disease risk. As well as understanding that we should get out of the practice of thinking this is all about mathematics, and we should reduce caloric restriction by 500 calories a day and that should be a pound a week and everybody, if they do that one thing, should be able to resolve their obesity.

We have learned too much to understand that that's really not the right approach, and that there's really no ideal diet. And I think one of the biggest issues, and Dr. Apovian, chime in when you want to, is that what happens is, is that the set up is: well, if the low carb diet isn't working, well maybe that patient's doing something wrong, and the patient actually believes that. And so, there's this sort of failure to escalate the treatment options. And that's what the guidelines we were practicing, sort of, told us to do. Right?

Dr. Apovian:
Right. So, here's the thing, Scott. You can be a primary care provider, you can see a patient in 10 to 20 minutes with a BMI of 45, hypertension, elevated blood sugar and lipids, and you usually will take care of the blood pressure if it's high, you'll deal with the blood sugar if it's high, and the lipids. But you can let that patient walk out of your office without once talking about their BMI. And that's the fact. You are still considered a great doctor. And this is what the problem is.

Dr. Butsch:
Yeah. It's right there in front of your eyes and you don't even address it. And actually, if you look at the rates of actually treating appropriately a BMI of 40, which you would imagine per guidelines, which the suggestion would be to think about bariatric and metabolic surgery. Less than 1% of people who actually meet that criteria have severe obesity don't even get referred to, and don't get bariatric surgery. So, again, a huge gap here that we see from the guidelines and from what we see in just regular practice.

Going along with that, this is more of the same, but thinking about medications. So, anti-obesity medications which are effective. We've seen even recently, and you've learned in the modules, that, you know, over the last 2 years we've seen highly effective medications reaching 15, 20% weight loss after a year.

But, again, that general concept in actual practice is that these medications are dangerous, that they should be used for the short-term, that, you know, you should really maximize the lifestyle and this person should have, you know, nothing wrong with them in terms of their lifestyle before you think about medications. And, you know, again, many, many people would qualify with a BMI over 30, or a BMI over 27 with comorbidities to be considered where anti-obesity medication could be used, and what we see is probably about 2% of the population that meet that criteria actually receive pharmacotherapy. Again, you know, this gap lies straight in front of our eyes.

The underlying tone for all of this is really the failure to really recognized obesity as a disease. And that we see in many different situations, whether it's the provider, the institution, public, etcetera. And that misbelief about management of obesity, again, bleeds into this clinical practice. If you look at polls of the ACTION study, which is a study done several years ago which polled over 600 providers, many of them believed, actually, obesity is a disease, yet may still did not bring up the conversation about obesity, or about somebody's weight, or their patients' weight, because they listed lack of time or, you know, that there were important things. Actually, Dr. Apovian, you just mentioned earlier, more important – the blood pressure is more important than the obesity. And therefore, you know, there's this shoving aside the elephant that's in the room, which is the person's obesity. So, a lack of formal diagnosis, a lot of people are concerned they won't get reimbursed so why even bother. And then, again, the thought is that if it's not a disease, then to push back on the patient. And actually, in that study a quarter of the providers – again over 600 providers polled – thought that the patient was not interested, or the patient was not ready, or the patient still had to work on their behavioral modification. And this is exactly what, Dr. Apovian, you were just saying. This sort of shift that we should consider, yet we still haven't gotten in front of our own feet where we continue to sort of feel comfortable with treating the complications of obesity, like high blood pressure, high cholesterol, diabetes, etcetera, and not even treating the obesity. And again, I think that's where, sort of, providers, perhaps uneducated in obesity, perhaps biased, etcetera, are very comfortable with doing what they've done the whole time of treating the comorbidities and not treating the obesity. But the shift, Dr. Apovian, you would think, you know, how do we help people shift?

Dr. Apovian:
Well, yeah. So, this is a great schematic because what it's asking us to do is to change the way we practice medicine in the United States, and world-wide, but in the United States. So, if every single primary care provider would use this paradigm to treat the obesity first, then what we're going to do eventually is prevent hypertension, diabetes, lipids, heart disease. Okay? We will prevent it because we'll treat the obesity first which causes everything. But that's going to take a few years and certainly, it's going to cost more up front because we're going to be treating it with medications, not just diet and exercise, but medications and surgery.

Eventually 10, 20 years down the line, we are going to reduce the healthcare burden in the United States.

Dr. Butsch:
We already see these, you know, the clinical endocrinology society already adapting, sort of, this treat-the-obesity-first model and, you know, we commend them for doing that. So, we're seeing the shift begin, but important to understand. And all in all, again, I think hovering back to these ongoing bias – systemic bias that exists, is that if you're a patient seeking treatment, and you go, and your doctor or provider tells you just to eat less and move more and, you know, moves onto the next topic, you're not too excited to go back to that provider. So, certainly we see low rates of patients seeking treatment. They, again, in that ACTION study, they actually believe that, you

know, it's their responsibility. The majority of people, over 3,000 people polled in that study, still believe that their weight is their responsibility. But we have to educate primary care and healthcare providers about the benefits of therapies, of combination therapies with medications. There is a certification, the American Board of Obesity Medicine provides a certification of knowledge. And then, you know, the unfortunate side effect of having the medications that are new and effective, is the fact that insurance companies themselves, perhaps several amounts of bias that exists, don't think obesity is a disease so why bother covering these medications. So, a lot of barriers to practicing good care with our patients with obesity.

Again, you see on the right reasons for not prescribing medications. Providers are uncomfortable with that, they don't have familiarity, they fear about that these medications are very dangerous. And again, these all have been refuted and education is key at the point as well.

Again, here we see that if you think about patients, 48% of patients with obesity believe that they could lose the weight themselves. And again, that is the bias that the patient brings to the table when we see them. And a lot of patients want the autonomy and say, okay, well I guess I've lost 100 pounds before; I know I can do it again. And want to have that autonomy to choose, but this is where the lack of understanding, the lack of knowledge about the science of obesity and metabolic adaptation, which you've learned in these models, comes back to really help the provider drive that as well.

Yeah, and I can't say too much about this unfortunate problem, which is just the lack of reimbursement. And insurance companies are clearly bias in this. Many insurance companies out there just refuse altogether to cover these medications. And again, if you think about the education factor, if you don't believe that obesity is a disease and don't understand the pathophysiology, why would you want to cover these medications. But a huge injustice.

I love this quote from Petty Niece. People talk about these drugs as game changers, and I'm sure all of you have seen this in the headlines over the last couple years, how this can really help patients lose weight. But it's never going to be a game changer if they can't afford it, or they can't get access to it. So, really solid on that, and I think that really explains most of what I want to say here.

Again, think about Medicare, again, covering a majority of our patients. The Treatment to Reduce Obesity Act has been something that I've been personally involved in over the last 10 years, and still, it is a struggle trying to get people on board. We're doing better and better every year, but it continues to not receive a vote or get attached to another bill.

America's health insurance plans decline to whether they would support. We do see the federal government employees getting covered these days. This happened about last year. But again, health insurance companies continue to review the evidence, they understand the evidence, but they continue not to cover these medications.

Moving on to multidisciplinary approach to obesity treatment. This is very important. So, again, what does it take to treat obesity? If we think about who's involved. Certainly, a team of providers. We understand the complexity of this disease, therefore it needs a treatment to match that complexity. Insurance, again, is a problem, but there are treatments that work. Now, obviously, clinics will be different from one another, but clearly the players involved are an obesity medicine specialist, which can be a physician, an APP, advanced practice provider. But again, that level of expertise is really lacking. There's only probably about 100 people in the United States who've completed fellowships in this obesity medicine. Dieticians and psychologists are clearly involved, but that depends on the practice, but are clearly needed. Bariatric surgeons who perform surgery, gastroenterologists who do endoscopic devices and procedures, all can be interventions that we can use. And obviously, understanding obesity is a complex heterogeneous disease, that there's going to be people who need some of those or all of those providers because it's not one-size-fits-all. And so having all those options available is obviously the ideal scenario. But what we run into again, is we can have all the options, but if we don't have access or we can't afford it, we're still behind the times.

The guidelines that Dr. Apovian worked on show that, and we all know, is that probably about a 5 to 10% weight reduction can clinically be beneficial for many complications of obesity. These effective approaches, though, were really found within this multidisciplinary team. And again, a team that can provide all of the options is going to be the team that you're going to want to be able to take care of yourself. But again, this should be at the core of all obesity care practices out there, but it's not unfortunately. And again, the fundamental principle of chronic disease management needs to complement that committed patient, and also with informed providers, to effectively match the chronicity and the complexity of that disease.

So, in lies the point again of having multidisciplinary care, which includes many players as I had mentioned just before. I would just add right here that having an insurance coordinator – I don't know, Dr. Apovian, if you have one – but, there are so many prior authorizations now that we actually need one person to do all these prior authorizations, and so – because of these complication and these barriers.

What are you seeing in your practice?

Dr. Apovian:
Yeah. We have a pharm tech doing our prior auths, we need two. We have, you know, five doctors, three nurse practitioners. We saw 10,000 patients last year, and so one is not enough because the prior auths can take days. But, having said that, if every single primary care provider sent in prescriptions for the patients with obesity, which should be happening, somebody has to do something, right? There's going to be a barrage of prescriptions out there for obesity treatment that no one is covering, and yes, we understand that the companies would go bankrupt. Medicare and Medicaid will go bankrupt if they start covering obesity. But guess what, somebody has to subsidize this so that 20 years from now we protect the health of the country. That's what has to happen.

Dr. Butsch:
We need more advocates like you and myself out there. Yeah, and again, I think, you know, this is a patient-centered treatment. We're all in the conversations that we have with patients, our shared decision-making process of informing the patient of what the options are that are available. Maybe – I'm sure you do – Dr. Apovian and I, we do a lot of education up front to really make sure that that patient's at the level of understanding to be informed to make a good decision with us as a provider. Again, the physician, the APP, are really at the center of this and there's a lot of trust in physicians and I think that's been a big problem among treating obesity is the lack of trust of patients for their providers who clearly are biased or don't understand obesity. So, we are considered the best source of health information, but again, that has to change with education because clearly, we're not meeting that mark.

Again, talking about medications. Again, this is a chronic disease, so even though patients might undergo metabolic and bariatric surgery, we know that, you know, there are going to be people who don't respond at all. Some people respond very well but they still have obesity. So, this study looked at, you know, when to address weight regain, or weight gain, after surgery. Again, those definitions of what is weight gain are still out, and we haven't really come to a consensus. But this was a very good study looking at the rate of weight gain and looking at the severity of the amount of weight that is gained. And really using that multidisciplinary team to best address that person's weight gain. And certainly, investigation of what the causes may be. But again, delivering effective therapies, and sometimes that involves an anti-obesity medication after bariatric surgery.

We think about a cancer model and somebody getting surgery for cancer, then getting chemotherapy or radiation. The same way, we should think about obesity. Again, treating obesity as a disease using multi-disciplinary care. But this was an excellent study.

Dr. Apovian:
And just like, you know, when we have cancer therapy that, you know, and you get recurrence of the cancer, we don't say, well, you know, it didn't work. The cancer is aggressive and recurred. So, this is the same paradigm that we should be using for bariatric surgery. It worked, but most people regain some amount of weight because of the aggressive nature of obesity in this environment and the treatment for weight regain requires intensive monitoring and most likely an anti-obesity medication before you consider surgical revision.

Dr. Butsch:
Yeah. I mean, obesity is a progressive relapsing disease, and I think that is just critical to understand and really believe as we care for our patients after big interventions like a surgery, that they still need to be treated. And again, there's going to be multiple healthcare professionals in there, whether the obesity medicine specialist will take a good weight history - it's very important to take a weight history. I know you've learned that in these modules. Looking at medical complications of obesity, risks and benefits of medications, dieticians are also part of that. But again, the dietician's job isn't necessarily to help that patient lose weight, they should really just optimize the nutrition and the health of the diet of that individual. So, the burden of having to lose weight and cause weight loss really is relieved from the dietician. Exercise specialists clearly should help someone integrate health activities and get the health of the muscle back. Therapists are sometimes optimized, not only mental health of the individual, but also to reduce those psychosocial barriers to engaging in a lifestyle modification. And then clearly, our surgeons and endoscopists are available for those procedural interventions that are sometimes needed as well.

Again, creating an office environment not only from the environment of the office, the physical space, but also the space within the providers is very important. So, imaging and having chairs that can fit patients that don't have arm rests on them. Physicians themselves should be engaged in health activities. Vending machines – again, I want you to think about, not only that physical space of a clinic, but the institutional space and be advocates for patients with obesity in getting some of that imaging or of those food options. There's been numerous studies by several physicians looking at how things are displayed in hospital cafeteria and that can really have an impact, not only on your patients, but also on their families. I think walkable programs over lunch is a great way to have an office meeting, or just doing that individually. Or even walking with your patient during a clinical encounter.

Clearly the role of the physician and the healthcare provider is very important of how they address the disease of obesity and how they're acting themselves. And this is just an interesting study in looking at the activity of a physician or healthcare provider is more

likely to provide better counseling to their patients. So, again, engaging in health lifestyle yourself can really help your patients. And this is more of the same, being a good role model. This is a larger study looking at the physical activity levels of physicians and their attitudes and practices towards counseling. Again, if you're engaging health practices, your ability to counsel is going to be more significant.

And this is, again, a multi-centered study, and it looks like a systemic analysis of multiple studies. Again, showing a positive association between the healthcare provider's lifestyle and their ability to counsel.

On the other side, overweight physicians, physicians who are struggling with the disease themselves, may not be sending strong messages. You may see that in other disease states where you have cardiologists who are smoking, telling their patients to quit smoking. Again, think about your own lifestyle when you are being a role model and your ability to deliver counseling.

We understand that this is a progressive relapsing disease, therefore long-term therapies are needed. And so, that commitment to your patient and the frequency of communication is critical to managing our patients. That multidisciplinary team is going to, again, help all patients. You know, there's different subtypes of obesity, and therefore patients may need certain therapies, whereas others different therapies. That multidisciplinary effort is going to be really helpful.

The skills of the healthcare provider, dietician, and other team members is essential, but I would say their attitudes is even more important. The attitudes around obesity as a disease and the chronicity of that disease. And speaking of chronicity, again, that long-term commitment and frequent communication is key to keeping patients engaged and keeping them pointed in the right direction towards their goals.

Dr. Zalinov:
Thank you for that, Dr. Butsch. So, of course, you know, with us as, you know, a lot of us are practicing in primary care, a lot of times that's the first entry and first discussion where people have that, you know, at least thinking about losing weight, obesity management, you know, even well before they even consider weight management evaluation or referral. So, between the both of you, what are your thoughts and recommendations about how primary care providers, whether it's internal medicine, family medicine, can incorporate some of those obesity management services into their own day to day practice?

Dr. Apovian:
That's a very good question, and something that you can do fairly easily. If you try to do it by yourself without APPs, you're going to see that very quickly you're going to have quite a long waiting list to get in because, you know, 42% of Americans need these services, 42% of Americans have obesity. Even more are at risk. So, I would recommend that if you want to do that that you enlist the support and help from your dieticians. You should have at least one, or two, or more, in your practice so that you have support for dietary therapy. It's very difficult to get exercise physiology help because usually it's hard to get reimbursement for these services, so make sure that either you or someone in your practice, maybe a PA or an NP, have specialty care – have some kind of training in exercise recommendations, exercise physiology, or is a personal trainer and got some kind of credential and that can be very helpful as well. And then, to consider employing PAs to help you see these patients. So, right now that's what we're doing. Every single provider in my practice right now has a 12-month waiting list and we are attempting to see our patients. We're trying to see them every few months because that's what you need for intensive counseling, and it requires either APPs in your practice so that you can reduce your waiting list, or some kind of an internet-based program where you can send patients. And we're going to be talking about that in the next few minutes.

Dr. Butsch:
Yeah. I'll just quickly add. You know, starting with the end in mind, obviously if you're beginning to think about incorporating, you know, obesity management services in your own practice, you're caring for your patients who have obesity, as Dr. Apovian was just saying, you know, over 40% of American adults have obesity. So, thinking about even setting up a very good supportive clinical environment as I spoke about with the right chairs and furniture. Having the scale in the practice not in the middle of where everybody can see it, so having privately, a scale that can measure up to weights of maybe 500 pounds just for example. Having right messaging in the literature and information you have in offering in the waiting rooms. And really educating your own providers and staff members in your practice about obesity, that it's a disease, and treating people who have obesity with respect. Just those little things is one of the best ways to get things started. And obviously, incorporating other providers into your practice can be one options, as Dr. Apovian was just saying, but another option is just finding these providers who make up a team that you can refer to. Making sure they have the same attitudes and beliefs that you do, but really don't feel like you have to hire a whole service, where the referral process certainly can happen as well.

Dr. Zalinov:
Thank you for that. And to proceed, I'm going to hand it over to Dr. Apovian to discuss telemedicine and obesity management. Go ahead, take it away.

Dr. Apovian:

Alright. So, this can be very helpful to support your patients. And the benefits of these programs can be seen in practices that are already adopting them. Really, you will spend the time in your office to encourage diet, exercise, along with medications, and even assisting patients considering bariatric surgery. But for any treatment plan, diet and exercise alone, medications, or bariatric surgery, long-term weight loss requires behavioral management, and this can be assisted with eHealth. So, now, it's true that if you look at an eHealth element alone, you're not going to see as much as – it's not as efficacious, let's put it this way, as in-person support. However, if you compare it to control, which is, you know, pamphlets and things like that, it certainly comes close to in-person support. So, the weight loss is nearly the same. And we typically say, if you look at the literature on eHealth versus in person, hybrid programs where you get in person and eHealth come very close to in-person alone, and you get about three quarters of the weight loss and maintenance of that weight loss as you do with in-person completely. It really comes close, so I recommend this because you're going to be able to see more patients, more new patients. As you see the new patients, your eHealth will take care of even assisting with the weight loss and, most importantly, the weight management.

Okay. And also, eHealth is convenient. It obviously minimizes travel time in and out of the office. You know, we used to have support group meetings that were weekly. We still have those, and people who can come into your hospital or clinic every week for a support group meeting, we have that here, it's called our Incentive Lifestyle Therapy Program. Yeah, they do great. But very few people can do this. So, if you can combine an in-person support group with the ability to do this virtually, you will capture more patients and get almost the same outcome.

Alright? So, what programs are there out there? You can use MyFitnessPal, you can use telephone-delivered cognitive behavioral therapy, video conference-delivered group interventions, and this is what we do with our program. Okay, so, what does it take to incorporate eHealth into your practice? Well, certainly, you know, your patient has to have access to the technology. Now, most people now have a smart phone, so this is not an issue even in settings where you have safety net programs. Standardization, you've got to have a standardized program so that your outcome doesn't depend on who's giving the program. You know, your attitudes have to be positive towards this, so you need to adopt, you know, attitudes that are positive, that yes, these programs can help. You need some kind of aptitude and training to use this technology, and of course, advocacy is always important.

Now, as of June 2015 we see that not many primary care providers recommend weight loss programs, and so we need more advocacy and more positivity towards weight loss programs. And communications for tech-enabled programs are increasing, but slowly. And there are many reasons for this. Most of the time, the primary care doctor is so busy that this kind of tech is not even being considered.

So, how do you choose mobile health. Again, it's 84% of the United States now own a smartphone, and I can say, it's probably our burdening geriatric population that may not be as tech savvy, so they need more support revolving this. But, still, 84% do. And the benefits are myriad, availability, flexibility, low-cost – that's very important, and it can allow for the virtual check-in so that there's less travel time and less time away from work. Alright? So, you can track the weight loss, physical activity, and monitor progress with these programs. And the market is increasing. The top-rated apps, MyFitnessPal, MyNetDiary. But, you know, it's important to pick what is going to work for you and your practice.

Okay. So, it's important to start slow in your practice. What is the biggest mistake that a physician can make that using, you know, these data dumps that don't affect your clinical outcome. You know, you don't need all of the data. You're not going to look at it, so don't collect the data if you don't have the means to sort and use it. This is true, you know, for these apps that will track every single calorie you put in your mouth. If you don't know what to do with that, then don't use it. Alright? And it's important to get an idea of what your patients would like to do, because if they don't want to do it, then it doesn't matter. If they can't implement it, then of course it's not going to matter.

So, let's have a discussion about what we've implemented. I can tell you that right now at Brigham, we have a PCORI funded program called PROPS 2. We are utilizing a program called RestoreHealth and we are enrolling 8,000 patients from all of our PCP sites, who are interested in losing weight and the primary care physician just has to approve it and the patient is enrolled into this program where we can track. They are given a personal coach online, we send them a scale, we track their exercise, their workouts, their weights, and provide dietary health habits. And it's going very well, and we are really able to, from our weight management waiting list, we're able to get these patients at least into RestoreHealth while they're waiting to see the obesity medicine provider.

Scott, what kinds of things are you doing?

Dr. Butsch:
Yeah. If we think about just at the core of what the benefit of providing some kind of eHealth or mHealth to the patient, from the patient's perspective – and as you were saying earlier, you can keep up that frequency, those touchpoints with the patient. So, we engage – and we have sort of a hybrid of using virtual. And Cleveland Clinic prior to the pandemic was doing a lot of virtual visits and we do those still. But you can incorporate the sort of, a hybrid. Increase that frequency where you might not be able to provide that anyway. But from a

patient's perspective that self-monitoring is very helpful.

And again, as long as they're engaged, I think it's helpful to, depending on the level of knowledge and what providers are comfortable with, you can go beyond looking at just a diet or calories, you can look at timing. You know, the more we know about circadian rhythms, then the timing of eating can be a very invaluable asset to observe and try to work with a patient on.

On the provider side I think it gives that element whereas a provider with perhaps a higher-level degree, you can have a lower-degree provider – you can have a nurse, you can have a dietician, a nurse practitioner do a great work in providing the same amount of care through eHealth, or interacting, you know, whether it's through EMR, whether it's on the telephone. So, the ability to touch people with a degree of frequency, and the amount of people. We do a lot of shared medical appointments in the Cleveland Clinic in our practice where we see multiple patients virtually in one setting, and that really is helpful for that group mentality and support as well as providing excellent obesity care.

Dr. Apovian:
Yeah. The patients will love it that you can get more of your patients treated, that the doctor whose doing obesity medicine treatment can see more patients and then get them into an eHealth program.

Alright, so let's talk about web-based interventions if you compare in-person and completely in internet delivered programs. As I said before, in-person gives you the best weight loss, best weight maintenance, however, if you do a hybrid program like we're talking about where, you know, you can see the person maybe initially and then every 6 months, if they're into this internet-based program where you have a provider talking to them over the internet, you can still get good weight loss. Now, this doesn't show the three quarters. The best hybrid programs will give you three quarters of the weight loss and weight maintenance as in-person.

What resources are available to you as a primary care provider? We talked about internet and commercial programs, communities, self-help books. You do have the obesity specialist. So, if you're a primary care provider, find out where your nearest obesity specialists are. You know, we're still training people for this, and we need more in this country. Find out who your bariatric surgeon is and your dietician. The YMCAs are fabulous for this, but so are parks, running clubs, walking groups, hiking, after-school sports, and this is specifically for exercise.

Remember that, you know, it's calorie reduction that's a major predictor of weight loss. The problem is, how to do it and, you know, the diet doesn't matter. Pick the diet that's going to be most amenable to your patient and the calories will be reduced. And if they're not, because you know, the way to reduce calories with a diet is to make sure you have nutrient dense volume of the food with high fiber. And if that doesn't work, then you really need to consider one of our medications. Dietary recommendations: you know, you need fat, you need protein.

You need higher protein if your patient is losing weight in order to support less loss of muscle mass. So, that's very important. We usually promote high protein diets. You still need carbohydrates, but make sure they're high fiber carbohydrates. Less added sugar, and your beverages should be low calorie.

There are many structured weight loss programs that are available. You can use meal replacements. We don't have too much time to talk about this, but still a great way to go.

Dr. Zalinov:
Thank you for that, Dr. Apovian.

We have a 36-year-old woman. She has a past medical history of, you know, type 2 diabetes, class 1 obesity. And she's just following up with you as her PCP for just a routine follow-up. She reports to you that she has been on dulaglutide, she lost about 15 pounds since starting it, but she is trying to lose additional weight by making lifestyle modifications, which we love to hear as PCPs. You know, she wants to incorporate a healthier diet and improve her physical activity. But she mentions that she is struggling to make some healthy food choices and has been thinking about and looking into some commercial diet programs just to help keep her stay on track.

We see her vitals there. Of note, A1C 7%, BMI 32.9. Her medications: She's on max dose metformin 1000 mg twice a day, empagliflozin daily, and then dulaglutide daily. And I'm going to turn it over to the faculty just to get their input on what they think would be a great approach ritual and appropriate next step for this patient.

Dr. Apovian:
Well, the important thing here is that, you know, nothing's really wrong. They're all great options. But there is probably one thing you can do that would be the best option. To me, it would be changing dulaglutide to tirzepatide. Same kind of an injectable, but tirzepatide being a GLP-1 GIP moiety, would increase dramatically the potential weight loss that that patient would get, while still treating the hemoglobin A1C of 7. And since it's still 7 on dulaglutide, you do want to do something about the diabetes. Now, you can also add an anti-obesity

medication, but you would be adding another medication to the dulaglutide, so I would think that provided insurance coverage is going to, you know, work here, tirzepatide is very expensive. And the insurance company may say, well, no patient is on dulaglutide so you're going to have to advocate, so is the patient, for switching to tirzepatide. But that's what I would do. Certainly, reviewing options for commercial diet plans and recommend the patient join the gym, those are not bad options, but for the biggest bang for your buck would be doing that. Would you agree with me, Dr. Butsch?

Dr. Butsch:
Yeah. No, I think it's on target. You have somebody who's maxed out on the other diabetes medications. You know, to your point earlier, treating the obesity first, you know, with that switch to tirzepatide you're not only having a more effective medication that's helping diabetes, you're having a more effective medication in terms of weight loss. Where you have, you know, clearly significantly better outcomes with tirzepatide. And I think, unfortunately, the key line that you just said is, provided insurance coverage, which is really what we have to talk about these days, which is the most boring topic but the one that has to be part of the conversation. I mean, obviously, you know, this kind of patient that may come to you, what, for me, it conjures up – and if you take a sort of a weight history – what this person might be really frustrated with the fact that they've lost some weight and they've begun to plateau and I think, again, getting back to sort of the bias around how we think about obesity, and understanding, you know, obesity as a disease. Plateaus are often seen and perceived as negative, as if something's not working or I'm doing something wrong. And so, I think it's important to realize that patients like we have in this case are coming to the encounter with that in mind, and it's really important to sort of get them off the edge and educate them saying, you know, looks like you've responded pretty well to the dulaglutide, but obviously your body has responded, and you've begun to plateau. And that's okay, but that means we have to add something else. Adding another medication to treat the obesity, obviously which would help the diabetes. All along, doing that behavioral modification, whether it involves a commercial program or going to an exercise trainer. I mean, we all have to do that regardless of our weight. So, I think that would be my, sort of, thought. And then I would be remiss not to mention bariatric surgery, you know, if all options are not working. We just know that surgery provides a weight independent effect on diabetes. So, regardless of weight loss, you have an effect on diabetes. So, it really comes down to that patient's quality of life and how badly that diabetes is for them, and the chronicity of that diabetes.

Dr. Apovian:
Exactly correct. That's great. So, and going back to that, I just want to reiterate that, you know, we do have new guidelines from the surgical programs where this patient may actually be a candidate for surgery now, because, you know, the BMI is basically 33 with diabetes. And has done lifestyle, also on medication, and has exercised. So, this patient may actually be a candidate at this point for a surgical option. That's very important to understand. It used to be greater than 40 BMI, or greater than 35 with diabetes, sleep apnea, or another serious condition, but now we certainly have guidelines for metabolic. We're calling this now metabolic surgery, not just bariatric surgery. Because as Dr. Butsch said, we are also treating not just the obesity, but the metabolic complications of obesity, sleep apnea, diabetes, heart disease, and lipids. It truly is metabolic surgery.

So, I just want to summarize. We talked about multidisciplinary programs being effective. So, what do we mean by a multidisciplinary program? Physicians, PAs, NPs, behaviorists, exercise physiologists, and one of the most important factors, are dieticians that can help promote dietary change. We didn't really talk too much about psychologists, but that's also a very important part of obesity treatment. HCPs, or healthcare providers, are still considered the best source of health information. Behaviors and attitude are important for the PCP to impart to the patient. If the primary care provider does not address the obesity, then the patient is not going to get the right idea that treating the obesity is going to reduce the complications later on.

Long-term commitment: frequent communication is key and that's why it's not just about the PCP, you've got to have support teams that can effectively communicate. And if you don't, then you should adopt an internet-based program to help you support the patient. EHealth can be almost as effective as in-person visits. We know in-person is the best, we just can't manage that for the 42% of Americans who have obesity. Community resources and commercial plans can be effective tools to assist you as the HCP, and we have many community resources out there, Weight Watchers, the YMCAs, and other commercial plans.

And Dr. Butsch, any last-minute summarizing?

Dr. Butsch:
No, I think you summarized it very well. Again, the hope is after this module and the other modules, you've begun to understand the importance of treating obesity as a disease, and that it's not just sort of a quick, short-term therapy. This is something that you'll need to work on with patients for a long period of time. And that commitment and that attitude that you have is very important to have.

Dr. Zalinov:
So, again, this kind of synthesizes our discussion today and you can see here, that C would be the most appropriate option.

So, again, that's our presentation for today. On behalf of Dr. Apovian and Dr. Butsch, we want to thank you for joining us today. Hope

you all learned a lot. And just as a reminder, to earn the CME and CE credit for this activity, click on the button below. And I hope you have a great rest of your day.

Dr. Butsch:
Thank you.

Dr. Apovian:
Thank you.

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