SAMUEL GBADEBO
Samuel's BMI is 40

Rethink Obesity® Education

Best practices for motivating your patients to lose weight and make healthy lifestyle changes

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Welcome and Introduction

Obesity is a complex chronic disease,[1] influenced by genetic, physiological, environmental, psychological, socio-economic, and political factors,[2] which should be treated by health care professionals.[1] As a health care professional, you are uniquely qualified to initiate and guide your patients through the process of weight loss, weight maintenance, and better health.

- Health care professional (HCP)-initiated discussions and advice regarding weight loss encourage patients to change their behaviour[3]
- Counselling and advice from health care professionals can have a positive effect on patient action regarding weight management[3]
- Achieving and maintaining weight loss requires long-term intervention[1]

By simply recognizing the complexities of excess weight and the implications of addressing the condition, you are ready to help your patients improve their weight, and as a result, their health.

STEVE LANTZ
STEVE'S BMI* is 39

Content Overview

To facilitate a good discussion with your patients, it may be helpful to use techniques, such as motivational interviewing and behavioural therapy. The aim of this education booklet is to present a foundation for these techniques that will hopefully enable you to have an effective consultation around weight loss with your patients.

Furthermore, the education booklet is a background resource for the discussion guide *Rethink Your Obesity Discussions*, which provides specific talking points and questions that can be used directly during a consultation with patients.

In addition, the current guidelines of obesity management set out by the American Association of Clinical Endocrinologists (AACE) published in 2016 are provided for reference. There are several guidelines for obesity management, so you may find another that better suits your practice. We have included web addresses to other resources and guidelines.

The following sections address these topics:

- Motivational Interviewing
- Keys to Successful Conversations
- Behavioural Therapy
- Treatment Overview

Additional resources and information are provided throughout this booklet.

Goals and Objectives of Rethink Obesity® Education

The aim of this resource is to enable you to:

- Utilize strategies and principles of **motivational interviewing**
- Have **successful conversations** with your patients
- Implement **behavioural therapy** in the time frame of existing appointments
- Gain a better **understanding of treatment** guidelines

*BMI=body mass index.

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The 5As of Obesity Management

The 5As model was originally designed as a behavioural intervention strategy for smoking cessation in patient consultations.[4] The model was modified for obesity management for health care professionals to use as a framework to guide a conversation. The 5As model has been associated with increased patient motivation and behavioural change when used by HCPs in weight-management consultations with patients.[5]

The 5As of Obesity Management are as follows[6]:

1. ASK	• Ask for permission to discuss weight • Explore readiness for change
2. ASSESS	• Assess obesity class and stage • Assess for drivers, complications, and barriers
3. ADVISE	• Advise on obesity risks • Explain benefits of modest weight loss • Explain the need for long-term strategy • Discuss treatment options
4. AGREE	• Agree on realistic weight-loss expectations • Focus on behavioural goals (SMART*) and health outcomes • Agree on treatment plan
5. ASSIST	• Address drivers and barriers • Provide education and resources • Refer to appropriate provider • Arrange follow-up

For more information on the 5As of Obesity Management, please visit www.obesitynetwork.ca/5As. Additional links to guidelines can be found on page 31 of this booklet.

*SMART: Specific, Measurable, Attainable, Relevant, and Time based.

Motivational Interviewing

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Motivational Interviewing

Summary

Motivational interviewing is an engagement strategy that aims to enhance a patient's motivations and commitment to change. As a method of communication, motivational interviewing is inherently collaborative—seeking to guide rather than direct patients through change.

Through the strategies of motivational interviewing, health care professionals can collaboratively explore patients' motivations for change and formulate a plan of action. The strategies of motivational interviewing include[7]:

- **O**pen-ended questions
- **A**ffirmative statements
- **R**eflections
- **S**ummary statements

It can be helpful to use the acronym **OARS** to remember these strategies. The talking points and questions provided throughout the *Rethink Your Obesity Discussions* guide model the motivational interviewing approach to help guide health care professionals and their patients.

Defining Motivational Interviewing[7]

According to motivational interviewing developers, Steven Rollnick and William Miller, motivational interviewing is "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Principles of Motivational Interviewing[7]

There are 4 key principles that guide the practice of motivational interviewing in weight management with patients.

Expressing Empathy	Supporting Self-efficacy
This reassures your patients that you are listening to them and seeing their point of view regarding the problem. Expressing empathy can show a deeper interest in the patient's perspective.	Motivational interviewing is based on patients' existing capacity for change. By focusing on previous successes, they will feel capable of achieving and maintaining their desired change.

Evoking Motivations for Change	Developing Discrepancies
Evoking means having the patient lay out their reasons for change rather than being told. Therefore, patients talk themselves into change by exploring their own ideas and feelings.	Throughout discussions of weight management, you and your patients will begin to see the differences between where they are (current habits) and where they want to be (goals). Help patients realize these discrepancies while emphasizing their autonomy throughout the process.

The OARS Motivational Interviewing Strategy[7]

The practice of motivational interviewing involves some specific skills and strategies to help patients reduce ambivalence and advance their readiness to make changes. One model for motivational interviewing is the **OARS strategy**, which is a simple way to generate the intended benefits of motivational interviewing.

O **Open-ended questions**	Ask open-ended questions that encourage thoughtful responses and allow for a broad scope of answers. These questions give patients a choice in how they respond.	*How do you feel about your health right now?*
A **Affirmative statements**	Recognize and support your patient's personal strengths, successes, and positive behaviours. This will help promote a collaborative relationship.	*Your dedication to improving your health and losing weight is really noticeable. You've made a lot of improvements.*
R **Reflections**	Use reflective listening and respond thoughtfully by paraphrasing the patient's point of view to encourage further discussion and exploration.	*I get the feeling that there is a lot of pressure on you to lose weight, but you are not sure you can do it because of the difficulties you have had losing weight in the past.*
S **Summary statements**	Summaries are similar to reflections in that they help to recount and clarify the patient's point of view. Unlike reflections, summaries also help to pull together several points of your discussion.	*So what I'm hearing is that you have struggled with weight for most of your adult life and are now starting to recognize how it is affecting your health and quality of life. Let's discuss some strategies to develop a plan to help you address your concerns.*

Questions for Consideration

Ask yourself a few questions before getting started:

- On a scale of 1 to 5, my current motivational interviewing skill level is _____ (1 meaning very low skill level in motivational interviewing to 5 meaning very proficient in motivational interviewing)
- How often do I currently use motivational interviewing with my patients?
- How can I use motivational interviewing more frequently with my patients when discussing weight?
- Does my staff know what motivational interviewing is and how to use it in patient interactions?

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For more information, resources, and tools, please visit **RethinkObesity.com**.

Keys to Successful Conversations

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Keys to Successful Conversations

Summary

Collaboration, counselling, and medical support from health care professionals may help patients achieve clinically significant and maintained weight loss.[3] Studies have shown that successful conversations between health care professionals and patients help patients be more successful with their weight loss goals.[3]

The weight discussion can be an uncomfortable one, which makes word choices especially important.[8] Other communication strategies like active listening, empathy, and encouragement can produce positive health outcomes for patients.[9]

Introduction

Studies link communication behaviours, such as empathy, encouragement, and psychosocial talk with improved patient satisfaction and adherence.[9,10]

Studies have shown that when HCPs advise patients with obesity or who are overweight to lose weight, change their eating habits, or become more active, they were more likely to do so. While frequent discussions with patients about weight management are helpful, it is the quality of the discussions that actually lead to behavioural changes.[10]

There are a few keys to incorporate in your communications with your patients about their weight.

Positive Communication Behaviours[9]

Studies have linked certain verbal behaviours with patient satisfaction, compliance, understanding, and a positive view of their relationship with their health care professional. According to a 2002 study by Beck et al[9] published in the *Journal of the American Board of Family Practice*, positive verbal behaviours include:

- Empathy
- Courtesy
- Friendliness
- Reassurance
- Support
- Encouragement
- Respect for patients' questions
- Giving explanations
- Positive reinforcement

Terms to Avoid[8]

Research has shown that word choice plays an important role when discussing weight management. In a 2003 study by Wadden et al,[8] patients with obesity ranked the following list of terms as undesirable or very undesirable:

- Unhealthy body weight
- Fatness
- Excess fat
- Unhealthy BMI
- Heaviness
- Large size
- Weight problem
- Obesity

Addressing Weight Bias

Research indicates that patients with excess weight feel stigmatized in many areas of their life including health care settings.[11] The language you use and your environment are 2 key components to successful weight management. To promote successful interactions with your patients, it is important to consider the following checklist[13]:

Equipment for waiting area

- ☐ Open-arm chairs that can support more than 300 pounds
- ☐ Firm sofas that can support more than 300 pounds
- ☐ Weight-sensitive reading materials

Equipment for exam room

- ☐ Body weight scales with a capacity of more than 300 pounds
- ☐ Height meter
- ☐ Large gowns
- ☐ Step stools with handle bars
- ☐ Large adult and thigh blood pressure cuffs
- ☐ Tape measure
- ☐ Wide examination tables, preferably bolted to the floor
- ☐ Consider a hydraulic tilt, if possible

Tools

- ☐ BMI chart
- ☐ Self-administered medical questionnaire
- ☐ Eating pattern questionnaire
- ☐ Physical activity pattern questionnaire
- ☐ Graphing your weight gain chart
- ☐ Food and activity diaries
- ☐ Pedometers

Procedures

- ☐ Treatment protocols
- ☐ Medication use
- ☐ Referrals to other health care professionals

It is also recommended that scales be placed in a private area and that practice staff only discuss a patient's weight within a private exam room.[12]

Questions for Consideration

Ask yourself a few questions to assess your attitude toward patients with excess weight:

- How do I feel when I work with patients of different body sizes and excess weight?
- Do I make judgements about a person's character, intelligence, or abilities based solely on their weight or appearances?
- Consider your body language when discussing weight with your patients. Are your arms crossed over your chest? Do you make any empathetic gestures such as a tap on their shoulder or knee? Are you standing or sitting?
- When discussing weight with a patient, am I using person-centered language and avoiding labelling and judgemental terms?

Behavioural Therapy

For more information, resources, and tools, please visit **RethinkObesity.com**.

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Behavioural Therapy

Summary

Behavioural therapy is a treatment component in weight management that provides patients with a set of principles and skills that help them modify their current lifestyle habits, specifically as they relate to eating and physical activity.[14]

The primary goal of behavioural therapy is to change behaviours and to maintain those changes over time. In order to maintain change, behavioural therapy techniques seek to maximize a patient's ability to effect change and engage in self-care.[14]

There are several skills and strategies commonly associated with behavioural therapy for weight management, including[13]:

- Self monitoring
- Stimulus control
- Behavioural substitution
- Problem solving
- Cognitive reframing
- Goal setting

Introduction

Obesity is a chronic disease[1] influenced by genetic, physiological, environmental, psychological, socio-economic, and political factors[2], often requiring long-term management.[1] Weight loss is challenging for many patients and behavioural therapy is an important component of the treatment of obesity.

Typically, health care professionals cite time constraints and lack of training as barriers to initiating behavioural therapy. However, the aim of behavioural therapy is to maximize the patient's ability to effect change by enhancing and promoting self-care.[14] The strategies and skills for behavioural therapy provided throughout this resource are also embedded into many of the talking points and questions provided in the *Rethink Your Obesity Discussions* guide.

Characteristics of Behavioural Therapy for Weight Management[15]

While there are several skills and strategies associated with behavioural therapy, it is defined by the following characteristics:

- It specifies goals that can be measured over time
- The treatment focuses on the process of behavioural change
- It encourages small, manageable changes rather than drastic ones

Defining Behavioural Therapy for Clinical Weight Management

According to Wadden et al, "As applied to weight control, behaviour therapy refers to a set of principles and techniques for helping obese individuals modify eating, activity, and thinking habits that contribute to their excess weight."[16]

Strategies and Skills of Behavioural Therapy

To reach the potential benefits of behavioural therapy, it is important to pass along and build upon a skill set to your patients.

Self-monitoring[13]	Example
The simple practice of recording the patient's eating and physical activity habits, as well as thoughts or feelings connected to those habits, enables patients to track progress toward goals and gain perspective over behaviour patterns.	*Daily food and activity tracking.*

Stimulus control[13]	Example
After patients learn to identify the stimuli in their common environments that prompt incidental behaviours, they can modify the environment to limit their exposure to those stimuli.	*Listing common food cues and modifying the environment to reduce those cues such as removing high-calorie foods from accessible areas.*

Behavioural substitution[13]	Example
Identifying cues to eat that are not related to hunger and substitute alternative behaviours	*Listing common food cues and substitute responses like cleaning or other low-intensity activities.*

Problem solving[13]	Example
These are skills that help patients identify current problems or anticipate potential problems, devise and implement solutions, and assess the effectiveness of the solution.	*Most of the examples listed are examples of problem solving.*

Cognitive reframing[13]	Example
The ways that patients view themselves and their behaviours can influence their ability to initiate and sustain behavioural changes. Reframing a negative attitude into a positive one encourages patients to focus on progress as a habit rather than on a setback.	*Helping patients overcome negative thoughts after regaining a small amount of weight by focusing on health and quality of life improvements.*

Goal setting[13]	Example
Setting goals for behavioural weight management should focus on progress and achievement over time. More discussion goals can be found in the section titled Setting Individual Goals of the *Rethink Your Obesity Discussions* guide.	*Setting a goal to cook most meals at home for 2 weeks with an incentive of dining out at the end of that time period.*

Benefits of Behavioural Therapy

Successful behavioural therapy sessions between health care professionals and patients can generate beneficial results, such as:

- **Gradual and sustainable changes:** Behavioural change can be an overwhelming and often time-consuming process. Behavioural therapy promotes a gradual process to build sustainable change[15]
- **Increased capacity for self-control:** Behavioural therapy allows patients to come to their own realisations about the stimulus-response relationships in their lives that are enabling certain behaviours[14]
- **Results:** Research has shown that comprehensive lifestyle modification, which includes diet, physical activity, and behavioural therapy, induces weight loss of approximately 10% of the patient's starting weight in 16 to 26 weeks of treatment[17]

Treatment Overview

For more information, resources, and tools, please visit **RethinkObesity.com**.

Treatment Overview

Summary

The 2016 AACE guidelines have been developed by obesity specialists to provide guidance and support to HCPs diagnosing and managing patients with obesity or who are overweight. They use BMI and obesity-related complications to stage and treat the disease. The AACE guidelines stress that obesity is a chronic disease and requires complication-specific staging and treatment.[1]

Regardless of your patient's obesity disease stage, healthy eating and physical activity should be included in any treatment plan.[1] Health care professionals play a significant role in guiding patients to incorporate healthy eating and physical activity habits into a lasting routine. Patients may run into some challenges as they begin and maintain their healthy eating and physical activity plans. Be sure to begin by discussing those challenges and managing their expectations for weight loss.

As you begin, encourage patients to start with realistic, measurable first steps and set reasonable expectations for safe and sustainable weight loss. Included in this guide are some best support practices for supporting healthy eating and physical activity.

AACE Obesity Treatment Framework[1]

AACE has established an advanced framework for the diagnosis, treatment, and management of obesity. While anthropometric measures like BMI are used in the AACE framework, the complete diagnosis considers the impact of weight on the patient's overall health by accounting for the presence and severity of specific obesity-related complications. The staging of complications can be used to guide the selection of treatment modality and the intensity of weight-loss therapy. Visit **www.aace.com/files/final-appendix.pdf** for the full version of the advanced framework.

While the AACE treatment overview is a great place to start, each weight-management plan should be customized to individual patients according to the presence and severity of their obesity-related complications as well as their individual goals and level of motivation.

AACE Guidelines for the Management and Treatment of Obesity[1]

Diagnosis and Medical Management of Obesity

DIAGNOSIS		COMPLICATION-SPECIFIC STAGING AND TREATMENT		
Anthropometric Component (BMI kg/m²)	**Clinical Component**	**Disease Stage**	**Chronic Disease Phase of Prevention**	**Suggested Therapy (based on clinical judgment)**
<25 <23 in certain ethnicities waist circumference below regional/ethnic cutoffs		Normal weight (no obesity)	Primary	• **Healthy lifestyle:** healthy meal plan/ physical activity
25-29.9 23-24.9 in certain ethnicities	Evaluate for presence or absence of adiposity-related complications and severity of complications • Metabolic syndrome • Prediabetes • Type 2 diabetes • Dyslipidemia • Hypertension • Cardiovascular disease • Nonalcoholic fatty liver disease • Polycystic ovary syndrome • Female infertility • Male hypogonadism • Obstructive sleep apnea • Asthma/reactive airway disease • Osteoarthritis • Urinary stress incontinence • Gastroesophageal reflux disease • Depression	Overweight stage 0 (no complications)	Secondary	• **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions
≥30 ≥25 in certain ethnicities		Obesity stage 0 (no complications)	Secondary	• **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions • **Weight-loss medications:** Consider after lifestyle therapy fails to prevent progressive weight gain. (BMI ≥27)
≥25 ≥23 in certain ethnicities		Obesity stage 1 (mild-moderate complications)	Tertiary	• **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions • **Weight-loss medications:** Consider after lifestyle therapy fail to achieve therapeutic target or initiate concurrent with lifestyle therapy. (BMI ≥27)
≥25 ≥23 in certain ethnicities		Obesity stage 2 (at least 1 severe complication)	Tertiary	• **Lifestyle therapy:** Reduced-calorie healthy meal plan/physical activity/ behavioral interventions • **Add weight-loss medications:** Initiate concurrent with lifestyle therapy. (BMI ≥27) • **Consider bariatric surgery:** (BMI ≥35)

a. All patients with BMI ≥25 have either overweight stage 0, obesity stage 0, obesity stage 1, or obesity stage 2, depending on the initial clinical evaluation for presence and severity of complications. These patients should be followed over time and evaluated for changes in both anthropometric and clinical diagnostic components. The diagnoses of overweight/obesity stage 0, obesity stage 1, and obesity stage 2 are not static, and disease progression may warrant more aggressive weight-loss therapy in the future. BMI values ≥25 have been clinically confirmed to represent excess adiposity after evaluation for muscularity, edema, sarcopenia, etc.

b. Stages are determined using criteria specific to each obesity-related complication; stage 0=no complication; stage 1=mild-to-moderate; stage 2=severe.

c. Treatment plans should be individualized; suggested interventions are appropriate for obtaining the sufficient degree of weight loss generally required to treat the obesity-related complication(s) at the specified stage of severity.

d. BMI ≥27 is consistent with the prescribing information mandated by the US Food and Drug Administration for weight-loss medications.

Reprinted with permission from American Association of Clinical Endocrinologists and American College of Endocrinology.[1]

BMI=body mass index.

Obesity-related Complications That Can be Improved by Weight Loss[1]

The AACE guidelines recommend treating obesity based on the presence and severity of obesity-related complications. Each stage of the disease corresponds to the severity level of 1 or higher of these complications. Several of the complications below have a corresponding clinical marker that can be used in assessing the presence and severity of the complication. By using these clinical markers as well as information gathered from physical examinations and discussions with your patients, you can stage the disease.

- Metabolic syndrome
- Prediabetes
- Type 2 diabetes
- Dyslipidemia
- Hypertension
- Cardiovascular disease
- Nonalcoholic fatty liver disease (NAFLD)
- Polycystic ovary syndrome (PCOS)
- Female infertility
- Male hypogonadism
- Obstructive sleep apnoea
- Asthma/reactive airway disease
- Osteoarthritis
- Urinary stress incontinence
- Gastroesophageal reflux disease (GERD)
- Depression

A full list of complications-specific criteria can be found at **www.aace.com/files/final-appendix.pdf.**

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Healthy Eating and Physical Activity Planning

Initiating healthier eating and physical activity habits is a fundamental step in weight management. Regardless of your patient's disease stage, healthy eating and physical activity plans are recommended by the AACE. Even if more aggressive treatment options like surgery are decided upon, a healthy eating and physical activity plan needs to be initiated.[1]

Common Patient Challenges to Healthy Eating and Physical Activity

As you create a plan for healthy eating and physical activity with your patient, it may be helpful to discuss common challenges patients often face.[18-20]

- Comorbid health conditions
- Time
- Long work commutes
- Motivation
- Diet and fitness myths
- Cost
- Personal preferences
- Access
- Unrealistic expectations
- Safety
- Self-consciousness
- Confusion
- Self-doubt

Strategies for Improved Healthy Eating Habits

According to A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society (AHA/ACC/TOS), evidence suggests that no single dietary modification plan or strategy is more effective than another, provided the goal is to achieve a 500 to 750 daily calorie deficit.[21]

If you feel that patients need more guidance, consider referring them to dietitians or nutritional counsellors.

Best Practices for Supporting Healthy Eating and Physical Activity

The following are some strategies to support your patients' efforts with healthy eating and physical activity:

Healthy Eating[22]

- Help your patients see that healthy eating doesn't have to be about restriction. Encourage them to eat more healthy foods rather than recommending that they eat less
- Remind patients of the importance of establishing regular meal times. Emphasize that skipping meals can lead to overeating later
- Advise patients to slowly introduce dietary substitutions rather than changing their entire diet
- Discuss portion control with patients and remind them that they can still enjoy their favourite foods in moderation
- Help patients be more conscious of their eating triggers. As patients become more aware of these triggers, they can make changes to avoid them or substitute other healthier behaviours

Physical Activity[20,21,23]

- Match your recommendations for physical activity to the patients' abilities
- At least 150 minutes of moderate intensity physical activity per week to prevent significant weight gain and reduce associated chronic disease risk factors
- Help patients develop and achieve realistic goals for physical activity
- Remind patients that physical activity can be divided into smaller segments throughout the day
- Connect patients' interests to opportunities for increased physical activity and remind them that physical activity does not have to be a structured exercise routine
- Discuss your patient's barriers to physical activity and problem-solve together
- Take patients' health status and any comorbid conditions into account when making recommendations for increased physical activity
- Discuss your patients' support network and encourage them to enlist support of friends and family or participate in group activities
- If patients struggle with increasing physical activity, recommend that they start by decreasing the amount of sedentary time
- Help patients develop strategies for incorporating physical activity into their routine

Examples of Other Guidelines for Treatment and Management can be Found at the Following Websites:

The ACC and AHA have collaborated with the National Heart, Lung, and Blood Institute (NHLBI) and stakeholder and professional organizations to develop clinical practice guidelines for assessment of cardiovascular risk, lifestyle modifications to reduce CV risk, management of blood cholesterol, and overweight and obesity in adults. The guidelines were approved for publication by the ACC, AHA, and TOS.

2013 TOS/AHA/ACC Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society
circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation

National Institute of Health Clinical Guideline of the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults
www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf

Edmonton Obesity Staging System (EOSS)
www.drsharma.ca/edmonton-obesity-staging-system.html

American Society for Bariatric Professionals (ASBP)
www.asbp.org/obesityalgorithm.html

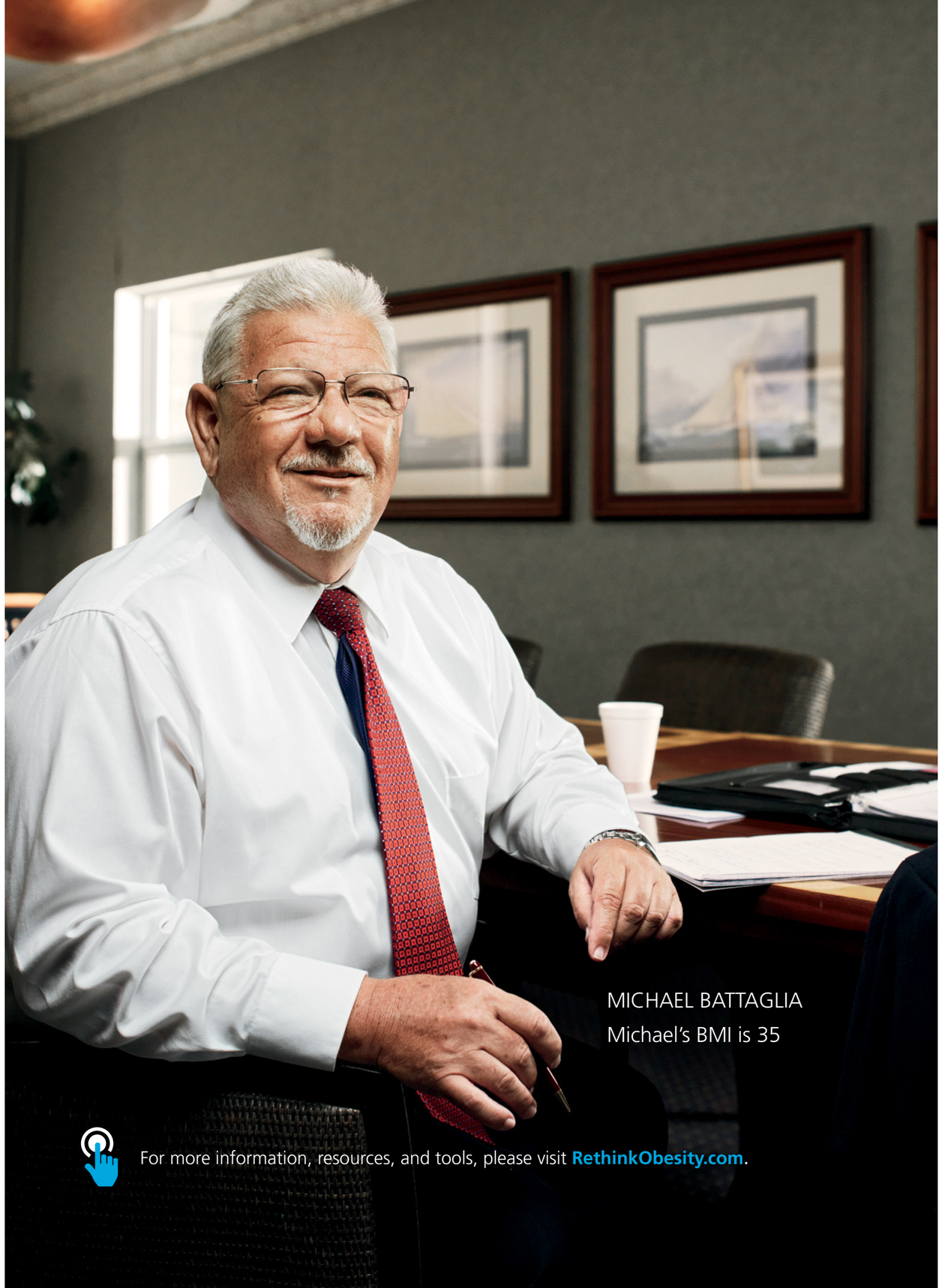
U.S. Preventative Services Task Force
Final Recommendation Statement Obesity in Adults: Screening and Management
www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management

NICE guideline
Maintaining a healthy weight and preventing excess weight gain among adults and children (2015) www.nice.org.uk/guidance/ng7

EASO guideline
www.gucdv1wwi8pslzdfpv7t0dk6.wpengine.netdna-cdn.com/wp-content/uploads/2015/12/2015-OMTF-European-Guidelines-for-Obesity-Management.pdf

Canadian Task Force
www.canadiantaskforce.ca/guidelines/published-guidelines/obesity-in-adults

For more information, resources, and tools, please visit **RethinkObesity.com**.



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Notes:

Notes:

Visit **RethinkObesity.com** to learn more and to explore resources and tools.

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