Chapter 8
Taking the Next Step

8.1 Introduction

Each chapter of this book provides you with all of the elements you need to start productive conversations with your patients—conversations that will lead them to better health. This chapter summarizes what you've learned by reviewing the highlights of each chapter, which refreshes your knowledge and solidifies your ability to put your knowledge into practice. This chapter also provides you with an overview of what comes after you have successfully engaged your patients in taking the step into treatment. You will receive information that will guide you in educating patients about the disease of obesity and the need for long-term follow-up. You will learn more about the settings in which obesity is treated and how to refer to obesity specialists and bariatric surgery centers. For those who are interested in furthering their knowledge, additional educational resources will be provided.

8.2 What You've Learned

In Chap. 1 you learned that obesity is a chronic, progressive, relapsing disease that needs to be approached as any other chronic condition. Your deepened knowledge about the pathophysiology provides you with an enhanced understanding—one that is lacking in many clinicians—as to the numerous complexities, contributing factors, and the significant health risks of obesity. You are now aware that the goals of treatment are to improve health, reduce body weight, improve body composition, and improve quality of life. You know that when obesity is treated first, other conditions improve or resolve, and further complications may be prevented. You are keenly aware that the earlier the intervention, the better the outcome. All of this knowledge will prevent you from falling into treatment inertia and will mobilize you to address it with your patients.

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In Chap. 2 we dove into the prevalence and seriousness of weight bias and how it plays out in every aspect of your patients' lives. You know that weight bias and stigma are at the root of why obesity is not recognized and treated as a disease. You learned how common it is in healthcare settings and how it negatively impacts your patients' physical and psychological health. Your knowledge about all the ways in which patients are stigmatized in healthcare settings expands your awareness about the need to identify and reduce weight bias in your practice setting and the importance of approaching your patients in an unbiased manner.

Chapter 3 provided you with strategies for reducing weight bias in healthcare, including tools that you can use to identify, explore, and manage your own weight bias. You received resources that will expand your understanding of obesity etiology and treatment. And you have a better understanding as to how this knowledge reduces weight bias. You also received additional educational resources on weight bias. You learned about the ways in which you can educate other members of the healthcare team and why it's important for you to be an agent for change. If you are an educator, you were given resources that can be used to incorporate obesity education into the curriculum and how doing so is vital to reducing weight bias in healthcare providers. Lastly you learned how to recognize and reduce internalized bias in your patients with the goal of improving their health.

Chapter 4 explored the numerous barriers that block you and your patients from having effective discussions about weight. We imagined that each barrier is a brick, and that one by one they build a wall which prevents clinicians and patients from engaging in productive conversations. You learned that many of the bricks are formed by a lack of clinical education about obesity and a lack of knowledge about strategies for discussing it with knowledge and sensitivity. But it isn't just a lack of education that adds bricks; time limitations, poor reimbursement, weight bias, and clinicians' fear of making patients uncomfortable are also barriers. Patient barriers were also explored, many of which are rooted in internalized weight bias. You were shown how to identify your patients' internalized bias and recognize its role in preventing productive discussion. After an exploration of each barrier, you learned how to dismantle the wall, brick by brick, and pave a new path. This process requires you to seek education about the complexity of obesity and then share your knowledge with your patients and colleagues. Lastly, you received tips on how to initiate time-efficient conversations.

In Chap. 5 you learned how to create an environment in which effective conversations can take place. You learned the importance of ensuring that the physical environment is safe, accessible, accommodating, comfortable, welcoming, and nonshaming. When this is not the case, it is another manifestation of weight bias, and contributes to patients delaying or avoiding healthcare. The need to create a positive emotional environment was stressed, as the language and practices of the office and clinical staff have a big impact on whether or not patients have a respectful, nonshaming experience. You learned that People First Language for obesity is the standard of care and that failure to use it demonstrates weight bias.

Chapter 6 provided you with a framework from which to initiate effective conversations. The value of building a respectful, collaborative partnership with your patients was emphasized, as was the need to keep the conversation focused on

health. Motivational Interviewing (MI) provided you with guidance on how to elicit your patients' motivation, keep the conversation focused on your patients' goals, and honor your patients' autonomy. The 5As of obesity management provided you with a structure that will guide you through the process of initiating a discussion to arranging treatment in a manner that is patient-centered and keeps the therapeutic partnership intact. Guidance on how to select patients who will be most receptive to your message was provided.

In Chap. 7, clinical scenarios and conversations demonstrated how to start conversations in different practice settings with a variety of patients. Each scenario was followed by an explanation as to which strategies and principles were employed to build the clinician-patient relationship and move patients into treatment. These scenarios, and the explanations demonstrated how you can bring all of your knowledge into practice.

8.3 The Next Step

Now that you know how to initiate effective conversations with your patients, the next step is to educate them about obesity and guide them into treatment. If you will be providing your patients' obesity treatment, the next step is to schedule an obesity-specific history and physical appointment during which you will complete your comprehensive assessment and formulate a treatment plan. You may provide some or all components of treatment or refer to other clinicians, professionals, and community resources as needed. If you will not be providing treatment, appropriate referrals should be made.

8.4 Patient Education

When patients are considering treatment or are embarking on it, they need information about obesity and how it is managed. Whether or not you will be treating patients or referring them to other clinicians and resources, it is important to provide patients with an overview of their condition and how it is treated. If time permits, this can be discussed with the patient. If not, it is advisable to provide patient education materials that cover the elements discussed below. When discussion has taken place, patient education materials are still advisable as they reinforce what has been discussed with the clinician and provide patients with something to reference after the conversation. Education can be provided in the form of printed handouts, brochures, or be available on clinic websites.

Education should start with an introduction to the concept that obesity is a chronic health condition that requires a long-term treatment approach. Clinicians should explain the associated health risks and the benefits of a modest weight reduction of 5–10%, with attention to the specific health risks for the patient. Patients

should be told that effective treatment is available and that they don't have to figure it out on their own. They should be informed that a thorough assessment will be performed, and a personalized plan will be given. Clinicians should frame the clinician-patient relationship as a partnership, reassure patients that all decisions will be made collaboratively, and that each element of the treatment plan will be implemented in a stepwise manner. The five comprehensive treatment modalities—nutrition, physical activity, behavioral counseling, pharmacotherapy, and bariatric surgery and procedures—should be introduced so that patients have an overview of the components of treatment. If bariatric surgery is being considered, patients should be informed that surgery is one aspect of treatment but that it doesn't replace the four pillars of nutrition, physical activity, behavioral counseling, and pharmacotherapy. They should be informed that appointments will be more frequent in the beginning in order to establish an effective treatment plan and to provide the support they need to implement and follow the plan, and that frequency will decrease when the condition stabilizes. It is important to reassure them that if challenges develop or relapses occur, appointment frequency will increase until stability is reestablished.

8.5 Obesity Treatment Options

As more clinicians recognize that obesity is a serious chronic condition, they are becoming educated on how to provide treatment in their current practice settings. Whether they are in primary or specialty care, they are finding ways to offer treatment that range from multi-disciplinary comprehensive models, to single clinicians providing all aspects of treatment, to coordinating treatment with other providers and resources. Although time, resources, and reimbursement for obesity treatment are limited in many practice settings, clinicians are finding creative ways to address obesity. While the situation in many practice settings is less than ideal, things are slowly improving. This section will provide you with information about the most common ways that treatment is provided.

Regardless of who is providing treatment, regular, obesity-specific appointments optimize outcomes. Although it is optimal to have a minimum of 16 appointments in the first year (1), this may not be possible for all patients. Appointment frequency may be limited by time, cost, clinician availability, treatment resources, transportation, and many other factors. When barriers preclude more frequent appointments, it is best to focus on regular follow-up, even if appointments can only occur once every 2–3 months.

8.5.1 Primary Care Settings

What can be accomplished in a primary care setting is dependent on time, resources, and other factors. Primary care providers who have completed additional obesity education integrate comprehensive obesity treatment into their primary care

practices. They initiate conversations with appropriate patients during annual wellness visits, follow-up care, or when providing treatment for other conditions. When patients agree to treatment, these clinicians assist their patients in arranging it. Some have their patients return to see them for obesity-specific appointments that are integrated into their daily schedules. Others see their patients in comprehensive obesity treatment clinics that they operate one or more days per week within their practice setting. Some of these clinics are multi-disciplinary whereas others are staffed by a single clinician.

Some primary care clinicians manage obesity but refer patients to other healthcare professionals and community resources for some components of treatment. An example of this scenario is when a primary care clinician conducts a comprehensive obesity assessment, formulates a personalized treatment plan, and follows up regularly to manage the patient's response to treatment, prescribe and monitor anti-obesity medications, make any needed modifications to the treatment plan, and refers the patient for nutritional counseling, physical activity instruction, health coaching, or mental health counseling. Regardless of the practice model, if primary care clinicians are not getting an adequate response to treatment, they should refer their patients to an obesity specialist or bariatric surgery center.

Some primary care providers do not treat obesity but refer their patients to in-house clinicians and professionals who do. Those who do not have in-house resources refer their patients to outside clinicians and resources. See Table 8.1 for a list of potential referral sources. When referring patients to outside treatment, it is advisable to schedule follow-up in 2–6 months to ensure that the patient has accessed the treatment and is attending appointments regularly. This follow-up may be in the form of an appointment, phone call, or electronic communication. Any issues with access, follow-through, or other barriers can be addressed so that treatment can begin or resume.

8.5.2 Specialty Care Settings

Specialty care clinicians are increasingly incorporating obesity treatment into their practices. When treating the complications of obesity, they recognize that when obesity is treated first, the complications improve or resolve. For this reason, some offer comprehensive obesity treatment in their specialty care settings following

Table 8.1 Referral sources

Nutrition	Physical activity	Behavioral	Specialists
Dieticians	Physical therapists	Health coaches	Obesity specialists
Commercial weight loss programs	Exercise physiologists	Psychotherapists	Bariatric surgery centers
Cooking classes	Exercise trainers	Eating disorder specialists	
Community resources	Community programs & classes	Support groups	

similar models to those that take place in primary care. Examples of specialties that do so are endocrinology, obstetrics and gynecology, gastroenterology, orthopedics, cardiology, nephrology, sleep medicine, and rheumatology. If in-house obesity treatment is not available, they refer to obesity specialists and bariatric surgery centers.

8.5.3 Obesity Specialists

Obesity specialists may practice in primary and specialty care clinics or in separate obesity treatment clinics. These clinics may be independent or affiliated with a healthcare organization or hospital-based system. Some are multi-disciplinary and have obesity specialists, dieticians, health coaches, mental health professionals, and other types of providers on staff. In others, the clinicians deliver all components of comprehensive treatment. Some comprehensive obesity treatment centers have both non-surgical and surgical providers. Patients are evaluated and managed by obesity specialists and are referred to in-house surgical clinicians and surgeons for bariatric surgery but continue to be managed by the non-surgical specialists.

8.5.4 Bariatric Surgery Centers

Bariatric surgery centers offer multi-disciplinary surgical treatment. They are typically staffed with surgeons, nurse practitioners, physician assistants, registered nurses, dieticians, and mental health professionals, as well as clinical and office support staff. Some surgery centers have non-surgical obesity specialists who manage obesity prior to and after surgery and provide long-term obesity management.

Table 8.2 provides resources for locating clinicians who specialize in surgical and non-surgical obesity treatment.

Table 8.2 Resources for locating obesity specialists and bariatric surgery centers

Organization	Website link
American Society for Metabolic and Bariatric Surgery	https://asmbs.org/patients/find-a-provider
Obesity Action Coalition	https://obesitycareproviders.com/
Obesity Canada	https://locator.obesitycanada.ca/?_ga=2.24132794.1288463157.1609626881-1241536302.1608340333#!/
Obesity Medicine Association	https://obesitymedicine.org/find-obesity-treatment/

8.6 Summary

This book has prepared you to initiate productive conversations about obesity with your patients. Your knowledge of the seriousness of obesity and role of treatment in improving health, quality of life, and preventing complications will guide and inspire you to open the conversation. When you take the first step, it will lead you to the next and the next and the next. As your skills and confidence grow, you will find yourself opening the conversation earlier and more frequently. And as you do, you will watch your patients' health improve with each conversation.

Reference

1. Apovian CM, Aronne LJ, Bessesen DH, McDonnell ME, Murad MH, Pagotto U, et al. Pharmacological management of obesity: an endocrine society clinical practice guideline. J Clin Endocrinol Metab. 2015;100(2):342–62.