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ACTION

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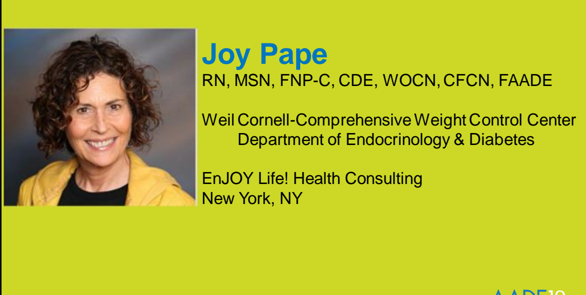

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Treat the Causes of the Complications Comprehensively!

Objectives
- Explain Weight Bias and Stigma
- State 3 Ways to Have a Weight Friendly Environment
- Create a Weight Based Medical Plan For a Patient Who Has Diabesity

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Treat the Causes of the Complications Comprehensively!

Real Help for Your Patients With Overweight and Obesity

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Treat the Causes of the Complications Comprehensively!

Definition(s) of Diabetes
- AADE_A complex disease that requires daily self-management - making healthy food choices, staying physically active, monitoring your blood sugar and taking medications as prescribed. www.diabeteseducator.org/living-with-diabetes
- ADA_A complex, chronic illness requiring continuous medical care with multifactorial risk-reduction strategies beyond glycemic control.
  Diabetes Care 2018 Jan;41(Supplement 1): S1-S2.

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Definitions

The World Health Organization–Overweight and Obesity

- Abnormal or excessive accumulation of fat that may impair health
- BMI is a rough guide
- Take population into consideration

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Treat the Causes of the Complications Comprehensively!

1. Is Obesity the Cause of Diabetes?
2. Is Diabetes the Cause of Obesity?
3. Is Diabetes a Complication of Obesity?

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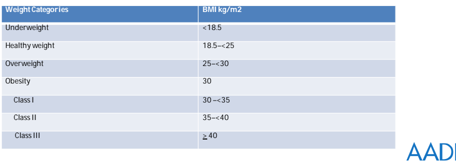
Definitions

The World Health Organization–Overweight and Obesity



Weight Categories	BMI kg/m2
Underweight	<18.5
Healthy weight	18.5–<25
Overweight	25–<30
Obesity	30
Class I	30 –<35
Class II	35–<40
Class III	≥ 40

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Treat the Causes of the Complications Comprehensively!

Is Obesity a Disease?

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Treat the Causes of the Complications Comprehensively!

Definition of Diabesity

Diabetes + Obesity

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What Is A Disease?

According to the definition of *disease* by the AMA

- An impairment of the normal functioning of some aspect of the body (abnormal physiologic and biologic regulation of body weight)
- Has characteristic signs or symptoms (lipotoxic effects of abnormal fat tissue drives dysmetabolic effects; physical burden plays role)
- Produces harm or morbidity (comorbidities associated with obesity)

American Medical Association. http://www.npr.org/documents/2013/jun/ama-resolution-obesity.pdf.

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Risk Factors (Non-exhaustive)
Individual
-Energy Intake >needs -Calorie Dense-Nutrient Poor
-Low Physical Activity -Sedentariness
-Sleep-little or too much -Genetics
-Pre and perinatal -Certain diseases
-Psychological -Drugs
-Socioeconomic
-Low education -Poverty -Rich
Environment
-↓ access-environment -Food Deserts
-Viruses -Microbiota
-Obesogens -Obese social ties

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Weight Stigma and Bias
- Negative attitudes toward individuals with obesity
- Perceptions of the cause. Controllable vs Uncontrollable
- Socially acceptable form of discrimination
- Stereotypes leading to:
  - Stigma
  - Rejection
  - Prejudice
  - Discrimination
- Verbal, physical, relational, cyber
- Subtle and overt

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Complications (Co-Morbidities?)
Common-Non-exhaustive
-Type 2 diabetes -Hypertension
-Dyslipidemia -Heart Disease
-Osteoarthritis -Infertility
-Certain Cancers -Respiratory conditions (Sleep apnea, asthma)
-Liver diseases -Gallbladder disease
-Trauma treatment -Trauma survival
-Infection -Psychological/psychiatric conditions
-Early mortality -Physical disability
-Absenteeism/↓ productivity
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4859313/table/T2/

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Weight Stigma and Bias
- It keeps patients affected by obesity from seeking help and professionals from offering it.
- Bias hampers our nation's efforts to effectively combat the obesity epidemic.
- Bias is a primary driver around the current limitations of access to treatment.
- Recognizing and combatting bias, both your own and in the community, is an important step in addressing obesity.

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Treat the Causes of the Complications Comprehensively!

What do You Think?
Are You Ready?
Do You Have Weight Bias?

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Treat the Causes of the Complications Comprehensively!

Evidence of Bias in:
- Media
- Employment
- Education
- Healthcare
- Interpersonal Relationships
- Youth

Puhl & Brownell (2001); Puhl & Heuer (2009)

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People First Language

"Avoid labeling (and thus equating) people with their disabilities or diseases (e.g., the blind, schizophrenics, epileptics). Instead put the person first. Avoid describing person as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from, stricken with, maimed). Avoid euphemistic descriptions such as physically challenged or special."

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Treat the Causes of the Complications Comprehensively!

Nurses view patients with obesity as:

- Lazy
- Lacking in self-control
- Non-compliant

In one study…

- 31% "would prefer not to care for patients with obesity"
- 24% agreed that patients with obesity "repulsed them"
- 12% "would prefer not to touch patients with obesity"

OAC

Poon & Tarrant, 2009; Brown, 2006; Bagley, 1989; Hoppe & Ogden, 1997; Maroney & Golub, 1992

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Weight Bias and Stigma in Healthcare

- Physicians
- Nurses
- Medical Students
- Psychologists
- Dietitians
- Fitness Professionals

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Treat the Causes of the Complications Comprehensively!

Physicians view patients with obesity as:

- Less self-disciplined
- Less compliant
- More annoying

As patient BMI increases, physicians report:

- Having less patience
- Less desire to help the patient
- Seeing patients with obesity as a waste of their time
- Having less respect for patients

Hebl & Xu, 2001; Huizinga

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Weight Bias and Stigma in HealthCare:

- Non-compliant
- Lazy
- Lacking in self-control
- Awkward
- Weak-willed
- Sloppy
- Unsuccessful
- Unintelligent
- Dishonest

Ferrante et al., 2009; Campbell et al., 2000; Fogelman et al., 2002; Foster, 2003; Hebl & Xu, 2001; Price et al., 1987; Puhl & Heuer, 2009; Huizinga et al., 2010

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Reactions from patients:

- Feel berated & disrespected by providers
- Perceive that they will not be taken seriously
- Report that their weight is blamed for all problems
- Reluctant to address weight concerns
- Parents of children with obesity feel blamed/dismissed

Anderson & Wadden, 2004; Bertakis & Azari, 2005; Brown et al., 2006; Edmunds, 2005

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Weight Bias & Stigma

Provider interactions
- Less time spent in appointments
- Less discussion with patients
- More assignment of negative symptoms
- Reluctance to perform certain screenings
- Less intervention

Bacquier et al., 2005; Bertakis & Azari, 2005; Campbell et al., 2000; Galuska et al., 1999; Hebl & Xu, 2001; Kristeller & Hoerr, 1997

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Treat the Causes of the Complications Comprehensively!

Appointment starts at first contact
- Staff/office prepared?
- Seating
- Supplies-including scales
- Your attitude-knowledge-words
- Referrals-It takes a multidisciplinary team
- Follow Up

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Treat the Causes of the Complications Comprehensively!

Patients with obesity are less likely to obtain…
- Preventive health services & exams
- Cancer screens, pelvic exams, mammograms
- Having less patience

and are more likely to…
- Cancel appointments
- Delay appointments and preventive care services

Adams et al., 1993; Drury & Louis, 2002; Fontaine et al., 1998; Olson et al., 1994, Ostbye et al., 2005; Wee et al., 2000; Aldrich & Hackley, 2010

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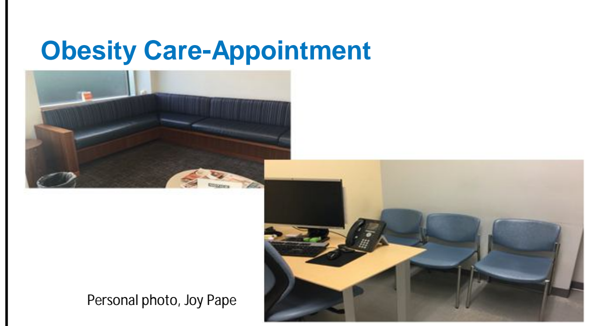
Obesity Care-Appointment



Personal photo, Joy Pape

Treat the Causes of the Complications Comprehensively!

Are You Ready?

The Appointment

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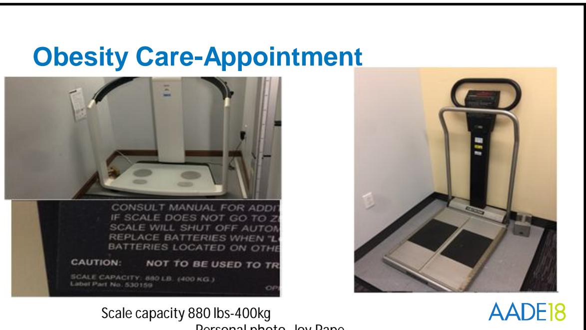
Obesity Care-Appointment



Scale capacity 880 lbs-400kg

Personal photo, Joy Pape

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Obesity Care-Appointment

Personal photo, Joy Pape

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Primary Obesity Guidelines

TOS AHA ACC
Jensen MD, Ryan DH, Donato KA, et al. Guidelines (2013) for managing overweight and obesity in adults. Obesity 2014;22(S2):S1-S410

Endocrine
Apovian CM, Aronne LJ, Bessesen DH et al. Pharmacologic Management of Obesity: An Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 2015;100(2):342–362.

AACE
Garvey WT, Mechanick JI, Brett EM, et al. American Association of Clinical Endocrinologists and American College of Endocrinology comprehensive clinical practice guidelines for medical care of patients with obesity. Endocr Pract. 2016; 22 (Suppl 3): 1-203.

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Treat the Causes of the Complications Comprehensively!

Know the Obesity Guidelines

- -Diseases have guidelines
- -If obesity is a disease it needs/deserves guidelines
- -Diabesity-Type 2 diabetes in obese has a diagnosis code-E11.69

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Primary Obesity Guidelines

ADA
American Diabetes Association. Obesity management for the treatment of type 2 diabetes. Sec. 7. In Standards of Medical Care in Diabetes 2018. Diabetes Care 2018; 41(Suppl. 1):S65–S72

OMA
Bays HE, Seger JC, Primack C, McCarthy W, Long J, Schmidt SL, Daniel S, Wendt J, Horn DB, Westman EC: Obesity Algorithm, presented by the Obesity Medicine Association. www.obesityalgorithm.org. 2016-2017.

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The Primary Obesity Guidelines

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Treat the Causes of the Complications Comprehensively!

Discuss the 5 A's

1. Ask
2. Assess
3. Advise
4. Agree
5. Assist

http://www.obesitynetwork.ca/5As

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Treat the Causes of the Complications Comprehensively!

Multidisciplinary Team
- Nutrition
- Activity
- Medical & Surgical Management
- Behavior
- Others

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ADA Recommendations

- At each routine patient encounter, BMI should be calculated and documented
- Providers should advise overweight and obese patients that higher BMIs increase the risk of cardiovascular disease and all- cause mortality.
- Providers should assess each patient's readiness to achieve weight loss and jointly determine weight loss goals and intervention strategies.
- Strategies include diet, physical activity, behavioral therapy, pharmacological therapy, and metabolic surgery. The latter two strategies may be prescribed for carefully selected patients as adjuncts to diet, physical activity, and behavioral therapy.

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Treat the Causes of the Complications Comprehensively!

Nutrition

What Should I Eat?

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ADA-Diet, Physical Activity, and Behavioral Therapy

- BMI should be calculated and documented in the medical record each encounter
- Diet, physical activity, and behavioral therapy designed to achieve > 5% weight loss should be prescribed.
- Interventions should be high intensity (>16 sessions in 6 months) and focus on diet, physical activity, and behavioral strategies to achieve a 500–750 kcal/day energy deficit.
- Diets should be individualized, as those that provide the same caloric restriction but differ in protein, carbohydrate, and fat content are equally effective in achieving weight loss.

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ADA

The goal of this section is to provide evidence-based recommendations for dietary, pharmacological, and surgical interventions for obesity management as treatments for hyperglycemia in type 2 diabetes.

Obesity Management for the Treatment of Type 2 Diabetes (From page S 57)
Diabetes Care 2017;40(Suppl. 1):S57–S63 | DOI: 10.2337/dc17-S010

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ADA-Diet, Physical Activity, and Behavioral Therapy

- For those who achieve short-term weight loss goals, long-term (>-year) comprehensive weight maintenance programs should be prescribed. Such programs should provide at least monthly contact and encourage ongoing monitoring of body weight (weekly or more frequently), continued consumption of a reduced calorie diet, and participation in high levels of physical activity (200– 300 min/week).
- To achieve weight loss of >5%, short-term (3-month) interventions that use very low-calorie diets (<800 kcal/day) and total meal replacements may be prescribed for carefully selected patients by trained practitioners in medical care settings with close medical monitoring.
- To maintain weight loss, such programs must incorporate long-term comprehensive weight maintenance counseling.

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ADA Pharmacotherapy

- When choosing glucose lowering medications for overweight or obese patients with type 2 diabetes- consider their effect on weight
- Minimize medications for comorbid conditions associated with weight gain
- Weight loss medications may be effective as adjuncts to lifestyle
- If response to weight loss medications <5% after 3 months or safety/tolerability issues, the medications should be stopped and an alternative be considered.

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Obesity Care-5A's of Obesity Care

http://www.obesitynetwork.ca/5As

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ADA Metabolic Surgery

- Metabolic surgery (MS) should be recommended to treat type 2 diabetes in appropriate surgical candidates with BMI ≥40 kg/m2 (BMI ≥37.5 kg/m2 in Asian Americans), regardless of the level of glycemic control or complexity of glucose-lowering regimens, and in adults with BMI 35.0– 39.9 kg/m2 (32.5–37.4 kg/m2 in Asian Americans) when hyperglycemia is inadequately controlled despite lifestyle and optimal medical therapy.
- MS should be considered for adults with type 2 diabetes and BMI 30.0–34.9 kg/m2 (27.5–32.4 kg/m2 in Asian Americans) if hyperglycemia is inadequately controlled despite optimal medical control by either oral or injectable medications (including insulin).
- MS should be performed in high-volume centers with multidisciplinary teams that understand and are experienced in the management of diabetes and gastrointestinal surgery.

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Q&A

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ADA Metabolic Surgery

- Long-term lifestyle support and routine monitoring of micronutrient and nutritional status must be provided to patients after surgery, according to guidelines for postoperative management of MS by national and international professional societies.
- People presenting for metabolic surgery should receive a comprehensive mental health assessment. Surgery should be postponed in patients with histories of alcohol or substance abuse, significant depression, suicidal ideation, or other mental health conditions until these conditions have been fully addressed.
- People who undergo MS should be evaluated to assess the need for ongoing mental health services to help them adjust to medical and psychosocial changes after surgery.

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Treat the Causes of the Complications Comprehensively!

Thank You!

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