Episode 5 - Obesity Medicine (Evaluation and Counseling)

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Episode Summary:
In this episode of Everyday Medicine, Chris Chiu discusses obesity medicine with Dr. Allison Rhodes and Dr. Sara Li, focusing on evaluation and counseling approaches. The experts share insights on how to effectively discuss weight management with patients, set realistic goals, and implement comprehensive lifestyle interventions. They emphasize the importance of using non-stigmatizing language and individualizing treatment approaches while addressing various barriers to weight management.

[00:00:00] - Introduction and episode overview
[00:00:43] - Introduction of guests Dr. Allison Rhodes and Dr. Sara Li
[00:02:04] - Discussion on importance of treating obesity and using non-stigmatizing language
[00:04:20] - Approaches to discussing weight in primary care settings
[00:06:41] - Time management for obesity-related appointments
[00:09:09] - Motivational interviewing techniques
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[00:26:59] - Components of a weight loss program
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[00:34:18] - Physical activity goals and recommendations
[00:41:38] - Setting realistic weight loss goals
[00:44:02] - Final thoughts on stress management, sleep, and nutrition

Key Takeaways:

1. Patient-Centered Approach:
    - Ask permission before discussing weight
    - Use non-stigmatizing language
    - Meet patients where they are in their journey
    - Customize plans to individual circumstances
2. Comprehensive Assessment:
    - Review medical history for weight-related conditions
    - Evaluate medications that may affect weight
    - Assess sleep, stress, and lifestyle factors
    - Consider social determinants of health
3. Goal Setting:
    - Focus on 1-2 realistic goals at a time
    - Consider 0.5-1 pound weekly weight loss as successful
    - Emphasize sustainable lifestyle changes
    - Address barriers to success

4. Four Pillars of Health:
    - Appropriate nutrition
    - Physical activity/movement
    - Restful sleep
    - Stress management
5. Practical Recommendations:
    - Emphasize resistance training for metabolic benefits
    - Encourage post-meal movement (10-15 minutes)
    - Focus on hydration ("water first, veggies most")
    - Consider one-hour electronic-free wind-down before bed
6. Available Resources:
    - Exercise is Medicine program
    - Mid-Ohio Food Collective's Farmacy Program
    - Physical therapy and aquatic therapy
    - Dietitian referrals
    - Mental health support
7. Professional Development:
    - Obesity Medicine Association membership for resources
    - Continuing education opportunities
    - Collaboration with dietitians and other specialists

Transcript:

Transcript has been edited for clarity

[00:00:00] **Christopher:** Welcome to Everyday Medicine, a podcast from the Division of General Internal Medicine at The Ohio State University. This podcast is focused on primary care and aims to provide current information to medical professionals from experts in Ohio. We're also graciously sponsored by collaboration with The Ohio Chapter of The American College of Physicians.

[00:00:18] This discussion is in two parts. This first part is about evaluation and counseling of patients with obesity, while the next episode will focus on medication management.

[00:00:28] We're back to another episode of our Everyday Medicine podcast. I have two wonderful guests here. I have recently listened to both of them do separate discussions and presentations on obesity medicine.

[00:00:43] And so I thought it was great. It would be great to bring them both on for people to hear about some great pearls about how to manage patients with obesity and talk about lots of new things out there and people are talking about this and social media and pop culture. And so I think being able to give providers tools to be able to manage these patients and their questions would be great. So I have Dr. Allison Rhodes and I have Dr. Sara Li. Do guys want to say hi?

[00:01:08] **Allison:** Hi Chris this is Allison and I just want to say thank you so much for inviting us to speak today. I know anecdotally all of us practicing clinical medicine recognize that over the years it feels like more and more of our patients are struggling with their health as it relates to having excess adiposity. So I'm glad Sara and I can join you today.

[00:01:25] **Christopher:** Sara? Would you like to introduce yourself?

[00:01:28] **Sara:** My name's Sara, and I work here as a primary care doctor at the Ohio State University in the General Internal Medicine Clinic, and I'm a junior faculty. I'm about five to six years into my primary care practice.

[00:01:40] I became interested in obesity medicine last year. So I've been doing a lot of studying on my own, mainly out of frustrations of difficulty in treating these patients. And I'm currently studying towards my obesity medicine board for next year.

[00:01:53] **Christopher:** Oh, fantastic. Both of you have a good background in primary care, so I'm really excited to talk to you today to hopefully help me as the primary care physician and help my colleagues to figure this out.

[00:02:04] My first question and I'm going to start with Allison given your specialized training in obesity medicine. Can you talk about why obesity is important to treat and, why maybe we might want to go about this without stigmatizing language with the patient?

[00:02:17] **Allison:** Sure, Chris. Prior to getting ready for this podcast, I wanted to make sure I reviewed the latest data. And based on the latest NHANES data, which is from 2018, and you can imagine it's probably very different now in 2023, nearly 30 percent of adults in the U. S. are overweight and 42 percent of adults are obese.

[00:02:35] And I just want to let that number sink in, because I don't know if there's another condition that so many of our patients are struggling with. So just from the sheer number of patients that are being affected by excess adiposity, I think it's really important that providers feel comfortable addressing this with their patients, and feel like they have the tools in their toolkit that they need, not only in terms of non stigmatizing language, but also just medical tools for helping their patients achieve their most optimal health in this regard.

[00:03:05] **Christopher:** And so when we talk about obesity, is it obesity specifically that we're trying to manage and treat? Or is it just the downstream effects, the comorbidities, the things that we think that obesity actually affects?

[00:03:16] **Allison:** That's a great question. And when I think of my path in terms of helping patients that are struggling with obesity, it's really trying to figure out how exactly is this impacting their daily functions, how is this impacting their health trajectory, and so it really is multidimensional and multifactorial, so making sure to address not only the mental health components, but the physical components as well as any of the other chronic medical conditions that are impacted by obesity is all really important.

[00:03:45] **Christopher:** Now, Sara, I'm going to ask you a question from your perspective as a general internal medicine physician in primary care. I feel there are two ways in which talking about obesity in an appointment happens. One is when you're doing your physical or doing something else. You're looking at your vitals and you're seeing an elevated BMI. And then you're also assessing whether a patient has hypertension or they have diabetes mellitus or prediabetes and that's the discussion that you sort of want to approach and the other time it comes up is.... They schedule an appointment and they say I have a couple different problems and one of them is "I want to lose weight."

[00:04:20] Can you sort of address that and talk about a little bit and how you approach each of those situations differently?

[00:04:25] **Sara:** Yeah. I think both of them are very challenging, especially in primary care. Things to talk about, limited appointment time. So for the second case where the patient's specifically interested in talking about weight, in every single one of my primary care visits, I start by kind of agenda setting first. So I do want to make sure in that visit how many things that patient wants to talk about.

[00:04:45] If there are multiple issues, not just the weight, I will usually schedule a dedicated weight management intake visit just because I don't think I can do it justice with an obesity treatment intake visit if I'm also addressing back pain and knee pain and everything else.

[00:05:02] So that's kind of the one thing I usually try to separate those visits out. The first scenario that happens a lot is in your annual visit, you notice that BMI is high, or the patient has obesity related comorbidities. Those patients, I tend to try to assess where they are in the stages of change.

[00:05:19] So I'll ask permission to talk about their weight and depending on the patient and if they're ready to talk or not ready to talk, I will still go through the next stage of assessment, based on your BMI and your history of prediabetes, these may be related to your weight.

[00:05:37] And if the patient is ready to talk about it, we can discuss the treatment or recommendations. If the patient is not ready to talk about it, then I will defer and maybe revisit next year to see if the patient is ready.

[00:05:48] **Christopher:** I think it's super important to ask permission. It's an important thing and especially nowadays where there's a lot of glorification of people with lower BMIs and the stigmatization against those who have obesity... Asking permission from them to talk about it can be really important.

[00:06:04] We have our patients who may have had a lot of trauma, whether in school being bullied throughout their entire lives with this and a safe place should be with their doctor to be able to talk about this. So that's great.

[00:06:14] **Sara:** And I have actually had several patients that will tell me, Doc, I'm not ready to talk about it. And then, the next year when I revisit things might have changed.

[00:06:21] **Christopher:** So what... What about the second scenario?

[00:06:23] **Sara:** The scenario when the patient is ready to talk about it, then I will schedule a separate visit only to talk about weight management.

[00:06:30] **Christopher:** In your personal practice, how long is an intake apartment? Is it a 20 minute visit? Is it an hour long? Like how much time should someone expect to be able to give it a practical sense? I know we all have trouble getting patients into us.

[00:06:41] **Sara:** The ideal world, I would like an hour appointment, and I believe in the obesity specific clinic, they get one hour for the new patient appointment.

[00:06:50] In my own primary care appointment, I used to only get 20 minutes, and I have found that to be nearly impossible. So I have recently changed my template to reflect 30 minutes for all patients. So now I have 30 minutes, which is still challenging.

[00:07:05] **Christopher:** Actually, coming over to Allison. How much time do you have when a patient's referred to your clinic? How much time do you expect for an intake and for follow-ups?

[00:07:14] **Allison:** The way my clinic is structured is all of my new patients get an hour long visit with me and, prior to rooming they complete a two page intake form which goes into their weight loss and weight gain history, goes into a 24 hour diet recall history about what their current physical activity and or limitations what goes into their background in terms of history with weight related medications or prior weight loss medications and really gives me an overview of all the high points. And what I typically do is have the patient finish completing that while I'm getting logged into the computer. And starting to chat a little bit with them to warm up this space because I think, as Dr. Li rightfully said, patients are sometimes really anxious to talk about their weight. And even when they're coming to see me in a dedicated obesity medicine clinic, they know they're going to talk about their weight. There's definitely still a good bit of apprehension. They don't know how I'm going to approach them. They don't know if they're going to be approached with judgment.

[00:08:10] So I think, creating that atmosphere for a safe space and then what I like to do is then spend probably the rest, like the next 50 minutes, just talking to the patient and getting to know them and doing a wide overview of kind of all the medical etiologies through which their weight could be, related to either prior weight loss or weight gain, going over their intake form with them and starting to create a customized plan to meet them where they are in their journey.

[00:08:34] **Christopher:** Gotcha. Sara, do you use any type of intake form to help pregame?

[00:08:37] **Sara:** I do not, but I am considering using it. It's just difficult sometimes to predict what comes in through primary care. So having the structure sometimes it's difficult.

[00:08:47] **Christopher:** Well, I want to move on next about talking to the patient. One of the things we do often in primary care is motivational interviewing. And obviously, talking about obesity and management is more than just medications, despite what you may be seeing on Instagram or TikTok or whatnot. Sara, so do you want to start off talking about, what your experiences with motivational interviewing techniques and how you approach it as a general internist?

[00:09:09] **Sara:** Yeah. So I generally try to use motivational interviewing techniques for really all primary care. The short version that I use mostly in my clinic is the ask, tell, ask, and I combined that with another motivational interviewing technique and the acronym is OARS, so O-A-R-S, so that stands for open ended question, affirmation, reflection, and summaries.

[00:09:34] So in terms of ask, tell, ask, I would usually by asking for permission or asking patients what they want to know. For example, I might ask, Is it okay if I talk about your nutrition habits today? And then if the patient gives me permission, I might say or I might sometimes even ask, do you want to hear how some of my other patients have done in terms of nutritional changes?

[00:09:58] And I will tell you different things. Say, some of my patients have tried to count calories. Some of my patients have tried to cut down on carbohydrates. Some may have tried intermittent fasting. And then the last ask would be, based on what I have said, what do you think is possible in your life?

[00:10:16] I think this Ask, Tell, Ask is a very simple strategy that I use for everything, for nutrition, for exercise,for hypertension, , everything. Yeah.

[00:10:27] **Christopher:** Alison, any thoughts, anything different that you do in your personal practice?

[00:10:30] **Allison:** No, I think I generally follow Dr. Li's approach as well. I think one of the really unique things about motivational interviewing is that it lets you get to know your patient and, again, that sounds corny, but, and their motivations and what is motivating to them specifically by asking them more questions than giving them information or specific guidance.

[00:10:49] And one of the things that I try to frame for my patients, especially in follow up visits, because to get back to your earlier question, my follow up visits are 20 minutes long each. And so motivational interviewing there has to be pretty quick. And so I think, helping them to understand what their roadblocks are in terms of the road that they've already outlined that they want to travel and using motivational interviewing to really get through those tends to be very helpful.

[00:11:13] **Christopher:** So Sara as a primary care physician, you have a patient who comes in for their annual physical. You ask them if it's okay to talk about their weight, and now it's time for you to do some counseling. Do you have a script that you talk to them about? This is obesity, this is why it's important, and this is why we care.

[00:11:28] **Sara:** So let's hypothesize that the patient also has prediabetes. And then I might say, "You know I've noticed that your weight has been increasing over the last couple years. Your BMI will be in a category of obesity. And your A1c is in the prediabetes range. And the research shows that 5 to 10 percent body weight loss can help tremendously with this. Then "what do you think about it?"- will be my question back to the patient.

[00:11:55] **Christopher:** Are there any other things that you may bring up during this portion of your counseling, or is this pretty much how you mostly do that jumpstart?

[00:12:02] **Sara:** I think that's how I mostly jumpstart and sometimes, just by asking back, what the patients think, they will bring back their own concerns. And then I can jump from there. Oftentimes they'll ask you about, what can I do to help with this?

[00:12:17] And then, I could say, there are some nutritional things that could help with this. Would you like to hear about it? Or I might ask what is the biggest barrier that you see in your life that hinders in terms of nutrition and improving prediabetes?

[00:12:31] **Christopher:** Allison, what are other things that you do when you first initiate the counseling with the patient?

[00:12:36] **Allison:** So I like to think that my counseling actually begins the night before my new patient visits. So I spend about a half hour per patient going through their medical record and really trying to identify any medical conditions that might have contributed to weight gain. I go through their past medications as far back as I can see in the last, five to ten years and see are there any medications that they've been taking that could have caused iatrogenic weight gain?

[00:12:59] I go through their imaging studies and I look and I see, are there any manifestations of conditions that would have maybe limited their movement? Do they have severe osteoarthritis? Have they had spinal surgery? Am I seeing a history of multiple orthopedic injuries that again would have made them more immobile?

[00:13:14] I go through and I look for hepatic steatosis and I check all their labs again from the last five years, just like Dr. Li, I'm looking for those trends that are going to lead me down a path for understanding

medically all the different factors that could have contributed to their weight. I'm also looking for, have they had a sleep study? Do they have undiagnosed sleep apnea?

[00:13:33] Have they been seeing a psychologist or psychiatrist in our system regularly and trying to really get a sense of all the different factors that are going to be involved in this patient's treatment plan. So when I meet the patient, one of the first things I actually do is I tell them, I'm so glad that you're here today and I'm really excited to work with you. And, how is it that you feel like I can help you the best to feel your healthiest?

[00:13:55] And really taking cues from them about the things that they're concerned about. Some patients, it's great. They're going to say, my family member died from liver disease, and my primary just told me my LFTs are elevated, and I'm really worried about my liver. And thanks to my prep work, I've already got my spiel kind of prepared about, yep, your liver enzymes are elevated. You have had hepatic steatosis going five years back on imaging. Why don't we take some time to really unpack how all that's related? And that's where I'll bring in their A1C value. And I really try, and with most of my patients get into the pathophysiology of insulin resistance and explaining to them how their body system works and how their body system works when it's working to their best advantage and you know how things get dysregulated in our modern world where we just don't move enough and have ultra processed foods.

[00:14:43] So, I find that this tends to take the bulk of my initial visit, but it's so empowering to the patients because once they realize exactly how their system works, they realize how they can customize changes in their life. to really reverse these medical conditions, which oftentimes are their biggest concerns. And even if it's not, at least having them understand again their system, how it functions allows them to achieve the goals that they've set out.

[00:15:08] One of the things that I think is particularly important about being an obesity medicine specialist is being trained to recognize the under-recognized conditions that can contribute to excess weight. One thing I am particularly passionate about is diagnosing and recognizing lipedema. This is a condition that occurs predominantly in women and leads to excess adiposity in the lymphatic system and a lot of times these women, because of the particularly resistant nature of this excess adiposity in terms of fat breaking down and allowing for more rapid weight loss.

[00:15:41] These women will come to me and they've said, I've tried everything. I've done every diet. I've done every exercise program. They will have tried medications for weight loss before and maybe have not seen results and I think one of the biggest things that I can do is really explain to them about this condition, explain the very unique recommendations and help guide them on a path forward and if there was one wish I could make going into 2024 would be that more primary care doctors were aware of lipedema, aware of how to diagnose it because it is a clinical diagnosis.

[00:16:10] There's no imaging, there's no blood test and you learn some of the specifics for treating it. Because I think that helping this unique population, particularly with the mental health aspects in, just as you said, Chris, like how our society has been so stigmatizing of excess weight, that would be a really incredible thing to change in the future and health care.

[00:16:28] **Christopher:** Sara, you said something about barriers as you were doing the counseling. Can you describe some of the challenges that you face when you're talking about obesity and management in your clinic, in primary care?

[00:16:37] **Sara:** Yeah, I think in terms of just the clinic structure and everything the barriers for me are one, there's a lack of time and I just unfortunately don't have as long of an appointment time. I'd really love to delve in more details, but it's difficult in primary care. And once we start to get into the treatment

options, and, even if you're not starting medication for obesity... These patients do benefit from frequent follow up. In the ideal world, I would love to see all of my patients that I'm seeing for obesity every month. And I don't think I have the luxury of appointment availability right now. And then additionally, there's barriers of medication cost... difficulty with the prior authorization.

[00:17:17] It's really difficult to remember what each insurance will pay, and what their requirements are. What's preferred in their formulary? And even if not to talk about medications, eating healthy is expensive. Exercising is expensive for a lot of patients. These all come together to make it very difficult for our patients. And the providers.

[00:17:38] **Christopher:** So talking a little bit about exercise and diet and things, a lot of these effects are affected by social determinants of health.

[00:17:44] And, there are definitely a lot of differences that are out there. Especially in my patient population here on the near East side in Columbus. Can you speak a little bit to some of that? And any specific things that you have noticed that people may not be thinking about as a barrier?

[00:17:59] **Sara:** Yeah, and since Dr. Rhodes mentioned what she does in her clinic, I might also start by saying what I do in my primary care if I'm seeing for weight management.

[00:18:08] I also break down my clinic into like patient's weight history, nutrition. Exercise or physical activity. And then the last portion is the medical comorbidity, weight positive medications, maybe screening for comorbid conditions like the sleep apnea and things. So generally, like my first question is, tell me the trends of your life and what your weight's been.

[00:18:29] So I want to know when did they gain weight? What kind of things that they've struggled with and what kind of things they've tried in the past. What worked, what didn't work. And in that kind of a section, I also like to get patients' goals. I really want to know what is the patient's goal.

[00:18:44] Some patients might have a number. Some patients might say they want to feel healthy. Some might say they want to be able to walk more. Just want to know generally what motivates them. And in the nutrition section, I will usually start with doing a 24 hour diet recall. So I don't have an intake form, but I will ask patients, Can you just walk me through in the last 24 hours what you ate from the moment you wake up to the moment you go to sleep?

[00:19:07] And that really helps me get a sense of their trend. I might also additionally ask, What is the least healthy part of your diet in your opinion? And that also sometimes it may not capture in a 24 hour recall, but I get a sense of what's their indulgence. In an exercise, I will usually ask, and also walk me through a typical week or typical month, what is your exercise like?

[00:19:27] I want to know is, can they exercise, and what they see to be the barrier to their exercise. And I won't go into details about the medical kind of portion of that, but in terms of the nutrition, by doing a 24 hour recall and also asking what the least healthy part is, I really get a sense of what my patients understand to be healthy, what they consider to be healthy.

[00:19:49] And sometimes it really surprises me. But from that, I can say, some patients will say, I'm eating a bagel with cream cheese, but they consider that to be healthy. There might be some education involved there. Or some of my patients are truly saying that I'm eating 1,500 calories, I'm only eating salad, and I'm still not losing weight.

[00:20:09] That might take me down a different path, like looking for insulin resistance and things like that. So it helps me to understand what they consider to be unhealthy and what they understand.

[00:20:20] **Christopher:** I do have some patients who know what's healthy, but, when we talk about food insecurities, what food stamps can pay for. How people can stretch their dollars for a family of four or five. Everyone gets ramen every day for a week, and, unfortunately, sometimes healthier foods are more expensive. How do you approach that? What types of resources do we have here at OSU? And what type of resources do people maybe at other places, maybe have to look out for?

[00:20:46] **Sara:** Yeah, I think that's really challenging. Just because healthy food is expensive, even if it's frozen vegetables or even canned vegetables or canned beans, I try to discuss with my patient what's possible. And, I might refer my patients to a dietitian for further education. And then we're also lucky here in OSU that we also have a social work team too, so I might refer to them for additional assistance.

[00:21:10] **Christopher:** Allison, Do you have anything to add to that?

[00:21:11] **Allison:** Yeah, I was going to say that one of the resources that I've been introduced to here at OSU since joining the division in August is that we have a partnership with the Mid Ohio Food Collective. It's called the Farmacy Program, and this is really neat because, Yes, F. yes, exactly. It's like a farm, like, where we grow vegetables, and so this is a really great resource for our patients. And the referral will actually, Chris, you can tell me if I'm wrong, like, how the referral goes in, but I believe that the, our staff, our medical assistants, and our social worker are trained to help connect our patients with the Mid Ohio Food Collective food bank so they can access fresh produce.

[00:21:46] **Christopher:** That's exactly it and they have different ways in which the program is administered. But, I think if you're in Columbus and have access to this, I think it's an amazing resource that we have here. Anything else to talk about barriers, trying to overcome barriers, thoughts, resources?

[00:22:00] **Allison:** One of the things that I wanted to comment on what Dr Li said, and I love you know, what you were thinking about in terms of high yield from the 24 hour diet recall of asking what's the most unhealthy thing? When I'm thinking about a quick 20 minute follow up visit with a patient, I really tend to try and figure out what's the lowest hanging fruit in terms of food? What's the lowest hanging, intended, in terms of, their movement? Stress, sleep, all those things, and I may not have time to get to all of those and that quick follow up visit, but I think for me and my charting, like keeping a running tab of all right, last time we talked about food, maybe this time we're talking about movement, maybe next time we're going to talk about sleep, maybe the time after we'll talk about stress and just making sure we're hitting all of those four pillars of overall health.

[00:22:41] But one thing to jump back to about stigmatizing language for some patients I call it the dirty "E word" but the dirty "E word": exercise can be triggering, and they'll say I hate that, so I don't ever ask my patients about exercise. I ask them, how do you like to move your body? And I get some really great responses. Some people dance to commercials on TV and between their shows. Some people it's. Just take a walk around their block and they'll respond to that really positively. So, I am also thinking about the word choices that we use, not just, E for exercise, but asking them just about movement. and then instead of diet or nutrition or food sometimes I'll say, how do you like to nourish your body? And using again things that sound really positive, like movement, or maybe not even positive but at least neutral.

[00:23:25] **Christopher:** I'm reminded by a recent discussion I had with an expert and we were talking about pediatric hypertension and working on trying to get kids to be more active and to exercise. One example that he brought up was this young patient of his love to watch TikTok videos on dancing. There's a lot of discussions about social media use and healthy social media use in our children. But one of the

things that really got this patient to really get up and do things was they would do all these TikTok dances, which I don't know if you've ever seen them. They're pretty intense. That got her sweating and getting her heart rate and her cardiovascular health improved. And I thought that was something interesting.

[00:24:01] **Sara:** And actually the way you're saying about hypertension is something that I've always thought about, but for my initial intake visit for the exercise or the activity portion of it, I really just try to pick what patient can do, even if it's a tiny little step, but I have found that once I treat patients with medications and they lose weight, they feel better and they want to get more active.

[00:24:21] I've always thought that, when someone comes in with stage 2 hypertension, the guideline is don't ask patients to fail, low salt diet first. Why is it a requirement for patients with obesity to have to fail lifestyle intervention first? I feel like that's already stigmatizing.

[00:24:36] **Allison:** This podcast would end up being three hours long if you got me started on that. No, I totally agree, and one of the things that I think is organic that I've seen over time, practicing, this will be my fourth year practicing obesity medicine after completing my board certification. I do tend to start patients on medications that are going to help them with weight loss at the initial visit, even, again, if it's a quick primary care visit. And the reason why is because I do find that patients are more willing and open to talk about lifestyle factors if they've already started having some success. And totally agree with you. Exercise, the dirty "E word," doesn't have to be at that first visit, or even the third or fourth visit. It will come with time as the patient's successful.

[00:25:14] **Christopher:** Allison, in your previous statement you were saying something about some four pillars. I feel like you, I saw this on maybe one of your recent presentations. Do you have a second to talk about that?

[00:25:25] **Allison:** Sure. So when I'm thinking about lifestyle factors that are gonna really help my patients be successful. I keep mine to four, but I know the American College of Lifestyle Medicine has six, and I totally agree with those six, but I think I looped probably two of them into my four, but it would be appropriate nutrition, activity or movement, restful restorative sleep, and well managed stress. And, the American College of Lifestyle Medicine talks about avoiding toxic substances and so I kind of rope that in with stress and nutrition because alcohol and drugs tend to fall under both of those categories.

[00:25:59] So I, what I try to do is make sure in my intake form, I'm understanding all of those different pillars and how they are working. individually in my patient's life, and then making sure that I'm addressing all of those as we're going through our treatment plan at each of our visits. And so sometimes a visit with me might look like a therapy session. Sometimes my patients are just talking to me about how they lost a loved one recently and they've been devastated and they've been eating all the Twinkies in their house. And we're not going to talk about the Twinkies. We're going to talk about their grief. We're going to talk about how we can connect them with resources for their ongoing grieving. And, maybe it's a referral to a therapist. Maybe it's a referral to a support group. Maybe it's starting them on an SSRI, whatever that patient needs to deal with each of those pillars of health, I'll meet them where they are.

[00:26:45] **Christopher:** So both of you have talked a little bit about this already and I want to deep dive a little more into it if you guys have time. What does a weight loss program look like to you? Sara, What are your things that you specifically talk about in your practice?

[00:26:59] **Sara:** Yeah, and similar to what kind of Allison mentioned I've also thought about the pillars: nutrition, activity, behavioral and then I think it was medicine. I can't remember. But so generally I want to create a well rounded program that will work for that patient and that will get them to a healthier lifestyle and whatever that is. We're usually trying to set individual goals for each of these pillars that the patient

can adhere to, whether that's the change in their eating habits, activity and then stress and sleep as well as their medication list.

[00:27:31] **Christopher:** So let's talk about one of the hardest parts of this, for me and for many of my colleagues, many people say that in their general internal medicine residency, they weren't taught much about nutrition. Now, I'm Med-Peds trained. We did talk a lot about nutrition for my pediatric patients , but not as much for my adults. Do you feel comfortable talking a little bit about how to talk about nutrition with a patient or do you start the discussion and say let's get you to an expert like a nutritionist or a dietitian? How do you approach it in your primary care practice?

[00:28:00] **Sara:** I will usually start with a 24 hour food recall, asking patients what they consider to be the least healthy. And then from there, I might ask the patients, is it okay if I ask some suggestions based on your eating habits, the things that might improve your health, and then see if the patient's willing to. A lot of them, for me, are changing their current habits. So for my patients that are eating out too much, I will ask, how often do you think you can eat out less or cut out eating out? What's possible for you? For patients that are eating a lot of snacks at night, I might say, some of my patients have tried the method of brushing teeth right after dinner so that they don't eat anymore and what do you think about something like that? So I, it's more customized to them.

[00:28:44] If I have a patient with a specific comorbid condition, so for example, if someone has hyperlipidemia, and if their LDL is high, then I think based on some data that I have seen that, I might suggest a diet that's lower in saturated fat, more fruits and vegetables that are more fiber, food, so based on that condition, I might suggest this type of diet.

[00:29:10] I've also read some studies saying that if your HDL is low, a predominantly low carbohydrate diet is more helpful than a low fat diet. So I might make that suggestion because most of my patients would think that to raise HDL they need to eat less fat. But actually I think data is stronger to eat less carbohydrates. So if I know a specific area where certain data might be helpful, I will counsel towards that, but if that's not the case, then I will create a plan that works for the patient.

[00:29:39] **Christopher:** How many of these goals as a primary care provider do you try to hit? Do you have, do you like to write down a list like ten goals and say, all right, by next time I see you in three months we need to have accomplished all these? Or is it more we're gonna try one or two goals at a time and I'll see you back in a week or I'll have you follow up in two months. Like what does that look like in your own practice?

[00:29:59] **Sara:** More realistically, it's probably one or two, maybe at most three, like nutrition goals that, usually patient directed. And then I might even add one sort of activity goal for the patient. For some patients, my goal might be to eat out two days less in a week, and try to decrease their soda intake from, say, five cans per week to two cans per week.

[00:30:23] That will be the two nutrition goals. And the exercise, depending on where the patient is starting from, my only goal for the patient might be to try to get at 7, 000 steps a day. I think, at most, I try not to go more than a total two to three goals per clinic visit. And I find that any more than that is overwhelming.

[00:30:41] **Christopher:** Gotcha. Allison, I've seen a lot nodding. Yes. Like you, you totally agree. Any thoughts to add to that?

[00:30:47] **Allison:** Yeah, I totally agree. I try to keep my goals to one to two per visit. And the reason why is because I want my patients to take a deep dive into the barriers that are going to be there in terms of

preventing them from accomplishing these goals. A lot of my patients knew that these goals should have been their goals a while back, and they just haven't been able to figure out how this clicks for them in their lifestyle. They have the motivation. They just haven't figured out the barriers and how to find the pathways around them or over them. I really want my patients to be able to have the time and the space to be mindful and I find that if they have fewer things on their mind and they're really able to hone in it's better. In terms of, overall nutrition and the education we get as providers

[00:31:26] I think that was actually one of the biggest frustrations I had in my medical training. In my internal medicine residency at the University of Pennsylvania, we didn't really get a lot of education on nutrition. We did get some in the intensive care unit, but as a primary care doctor, we're not seeing patients in the intensive care unit, and there's not a lot of TPN formulation going on. I was able to get additional nutritional education through the Tulane Goldring Institute of Culinary Medicine and that really was what made me realize, oh, my gosh, the field of nutrition is vast, and there's a lot of information. There's also a lot of contradictory information out there. And there's a lot of, I think, questions that are not yet resolved by the latest data. So, it just made me realize that this was going to be a deeper dive in my career. And then, that is ultimately, I think, what led me to study for my obesity boards after finishing my residency. And so I do want to highlight that the Obesity Medicine association has fantastic continuing medical education for providers, and if you join the Obesity Medicine Association as a clinician member, then you actually get about two to three CME virtual sessions that you can watch not necessarily in real time, but you can watch them later, and a lot of those are focused on nutrition, and so it's a really great way to get high quality CME on a regular basis, and I try to always attend those when I can in person. I'm thinking about, all right, I'm busy in my practice, how do I start learning more about nutrition? That would be, I think, the place I would start. And then also, read the dietitian's notes when you get those, cc'd back to you on your patients. And, don't be afraid to talk to your dietitians. I think one of the things that was great for me when I first went in practice was the five or six dietitians that I worked closely with in my obesity medicine practice. I would always talk to them about why they were making certain recommendations to my patients, or I would ask them different questions. Utilize your human resources that you have around you as well.

[00:33:15] **Sara:** And I just want to say so I am also, I joined the Obesity Medicine Association to study for my board. But just by joining, you get access to their really comprehensive obesity medicine algorithm. It's a PDF, it has 400 pages, but it flips through very fast and it's free.

[00:33:31] **Allison:** If you are a clinician in training, the membership fee I believe is $25 a year and it gives you again, like, I think the best deal for 25 bucks. I forgot what the cost is for attending, but....

[00:33:43] **Sara:** It's more expensive than that. It's like 400.

[00:33:44] **Allison:** ...more than 25.

[00:33:46] **Christopher:** Oh gotcha, gotcha. If you guys have time, I want to talk a little bit more about each of these goals because I think it's really important because that's, this is like the nuts and bolts. Do you set activity goals with your patients? I think for me, I've traditionally been told the AAC/AHA says that you need to do at least, I don't know, like 150 minutes of cardiovascular exercise where your heart rates up and things like that, but as long as it's spread out throughout the week, as long as you hit that goal for the week, do you set these types of goals for them? I know we already discussed a little bit about sometimes it's just get up and do something, whatever they can do, but do you ever try to hit any of these types of activity goals?

[00:34:18] **Sara:** Yeah, so I know the official guideline, so the goal for physical activity is 150 minutes of moderate intensity in a week. So moderate intensity means that you're able to have a little bit of conversation while doing the activity along with at least twice a week of muscle strengthening exercise.

[00:34:36] That's the official recommendation, and that's my lofty goal, if the patient's willing to get there, and it just depends on where the patient's coming from. So if a patient doesn't exercise at all, then, my first goal is just get them active, whether that's walking during their work or parking further.

[00:34:56] I like to set the 7000 step as my initial goal just because some research shows that 7000

[00:35:03] step already offers some health benefits and I don't have to be hung up on the 10, 000 step goal. It's much easier for my patient to hit.

[00:35:10] Some of my patients, they're not able to do anything during the work. I will probably focus more on muscle strengthening exercises if they have no time.

[00:35:19] I find that any exercise that builds lean muscle is a little bit more bang for my buck in terms of weight loss. Even though I tell my patient, cardiovascular exercise is also great for your health in many different ways. But if you are, your goal is to lose weight and you have no time. I want them to focus starting on that muscle strengthening exercise twice a week.

[00:35:40] If I get my patients to 150 minutes plus twice a week, that's wonderful. But if not, then I want them to focus more on muscle strengthening and that could be so many different ways. It doesn't have to be going to the gym and doing circuits. It could be having a three, three pound dumbbell in your office.

[00:35:58] It could be just buying some resistant band. For some patients that have bad knees, bad back, I might suggest just buying some resistant band, and there's some exercise you could do. Some patients, I even suggest getting TRX straps to hang on your door, that you can do at your work. So there's so many different ways to get that incorporated.

[00:36:15] **Allison:** Dr. Li I'm now looking forward to coming to your office and hopefully seeing some TRX bands the next time I'm in New Albany.

[00:36:21] **Sara:** home, but

[00:36:21] **Allison:** Yeah laughed Chris, when you said, do you give your patients specific guidelines and the answers? I don't think in the last four years I've been in practice for obesity medicine, I've ever given my patient like a very clear goal of anything, except for what Dr. Li said, resistance training, I tend to be more focused on that because as you increase your lean muscle mass, you're going to increase your metabolic rate, and that will allow patients to have a greater caloric deficit eating the same amount of food, so they become more successful with weight loss. It also helps improve insulin sensitivity. So, what I try to do is, when I'm hearing the ways that they like to move their body, try to focus on how I can actually increase that resistance. The other thing is that, you know, me just, and I'm sure everyone around this table is equally busy, but, you know being a busy person, I like to get double, you know, the bang for my buck whenever I'm doing something. So sometimes I'll share with my patients some strategies that might be helpful. You know, for, like non- exercise activity, I have a two minute timer on my electric toothbrush. And my husband knows to get out of my way because I'm going to be pacing all over the house, going up and down the stairs. During that entire two minute time, I'm brushing my teeth, and that gets me two more minutes of steps per day, as opposed to just standing in front of my mirror. I am a caffeine addict and I will stand in front of my coffee maker in the morning and I will do squats. When I do that, It's not that many squats, but again, it's better than just standing or doing nothing.

[00:37:40] In terms of increasing resistance training, a lot of times I'll ask patients, what do you think about getting some hand weights or some wrist weights, they're not expensive, and adding them on.

Maybe you do this while you're out running errands. Maybe while you're at the grocery store, you have some ankle weights on and that's helping you increase the resistance of that activity.

[00:37:57] So I think habit pairing, if you can find when a patient has time when they're either doing nothing, where they could throw in some easy activity, or when they're already doing activity, but maybe amp it up a little bit. That can help patients start to see That they can be as creative as they want. And really, the sky's the limit, and it doesn't have to be the dirty e word the dirty g word, which would be gym.

[00:38:16] **Christopher:** Here at OSU, do we have any specific resources that we can help with these patients, because I do feel that sometimes you can talk about these things, but some patients are just reticent, and may need extra help. They need professional help to actually like, show them how to do the things, or at least be there to coach them, and sometimes I worry about sending a patient to a retail gym like Planet Fitness, I don't know who these trainers are. Are there ways to vet these trainers or are there other programs which they can turn to?

[00:38:44] **Sara:** So actually at OSU there is a referral to "Exercise is Medicine" that any primary care doctor can place in the electronic health record. And then it's actually amazing. There's multiple sites and I practice in New Albany.

[00:38:56] So there's a New Albany site, but it's throughout the central Ohio kind of region. And then they get three one- hour, one- on- one sessions, and 16 group sessions. And I think it's, I forgot, maybe a 20-week or so program. The only thing is the primary care physician has to vet that the patient that you sent to this program is capable of exercising.

[00:39:16] So basically, you need to clear them to join this program. They don't bill insurance, so it's $200, so your patient will need to be aware of that. But, the trainers through these programs have completed the I believe the sports medicine...

[00:39:30] **Allison:** ...they're exercise physiologists, so they have a master's in exercise physiology.

[00:39:35] **Sara:** They also have a certificate in exercise in medicine. So they are really trained in the exercise for chronic medical issues like obesity. So it's a fantastic program. The patient starts with an intake visit for one-hour, then a second one-hour visit to follow on the progress. And then there's like a 16 weeks long where you do group activities with the final wrap up one hour session.

[00:39:56] **Christopher:** And what I know is actually I've sent some patients with sarcopenia there. If they're part of the program, then they have access to that site without needing to necessarily be a member of the site while they're in the program. Is that correct? So maybe that might offset some of that cost.

[00:40:10] **Sara:** That is correct. And I actually, I think I, one of my patients told me, and I've read recently, that if you are part of that program, you get access to the OSU gym. Oh. The undergrad gym.

[00:40:19] **Allison:** Dr. Li, will you refer me? I'm just kidding. One of the strategies that I've also used for patients that are worried about out of pocket cost. I refer so much to physical therapy. If patients are in again, "Exercise is Medicine", get that dirty E word in it. But a lot of times what I will tell my patients is, look, if you're scared to move, you have a history of an injury. When was the last time you did PT for your low back pain? When was the last time you did PT for your knee? And I can keep patients pretty much in physical therapy year round for different body parts that hurt them or ache. And that I think is also really good for structured exercise because physical therapy will prioritize that resistance training with patients.

So again, I think working with your patient's current insurance benefits in addition to, again we're so lucky at OSU to have this “Exercise is Medicine” program, but physical therapy hopefully is accessible for most of our patients.

[00:41:06] **Sara:** And also OSU has aquatic therapy that you can refer patients to. So that's actually under physical just regular physical therapy referral, but you have to select specifically for aquatic therapy for patients with any kind of joint issues.

[00:41:19] **Christopher:** One last question, for patients only doing lifestyle changes specifically, do you set goals of weight loss? Do you say, I want you to lose one or two pounds by the next time, or is that something that you definitely stray away from when you're talking to these patients in this sort of scenario?

[00:41:38] **Sara:** I don't know how Allison does, but I will, I want to set a kind of realistic goal for the patient. Because a lot of my patients are actually hoping for more weight loss than I am hoping for the patient. I tell them, if you can lose a half a pound a week, I consider that a victory. And if you lose one pound a week, that's golden. But if you don't need to lose any more than that, then I'm not expecting you to. If they're coming back to see me in three months, if they can lose half a pound a week, then I say that's a great goal.

[00:42:05] **Allison:** I think that's very realistic. When a patient's seeing me and one of the requirements that I have for patients to see me is that they are really ready to work consistently towards lifestyle change. This is going to be a major priority for them. I don't ever set a clear goal with my patient. A lot of times I do not, but I always ask them if they have a weight goal or a size goal. And I just keep that in the back of my mind, but sometimes in follow up visits, patients will say, did I lose enough weight? And I tell them, on average and for women that have lipedema, losing a pound a week is great. For other individuals that are just struggling more with insulin resistance, about two pounds a week is considered good weight loss. One of the things that I'm hoping to be able to introduce in my clinic soon enough would be a bioelectric impedance analysis scale.

[00:42:48] This was something I had at my last practice and what it allows is an on the spot calculation of a patient's lean body mass and their body fat percentage. And, one of the things that is really important, especially with the advent of GLP one agonist. which cause loss of lean muscle mass in patients if they're not actively performing resistance training is, You don't want your patients to develop sarcopenic obesity, meaning that their body fat percentage is the same or going up and they're losing muscle mass. And, this can happen when patients cut their calories , they actually lose muscle mass, and so they are damaging their metabolism and setting themselves up, actually, for probably, not only weight regain, but fat regain and sequentially an increase in their body fat percentage over time. So, when I have access to a bioelectric impedance analysis data, what I like to do is talk to my patients about what's happening to their body fat percentage, what's happening to their lean muscle mass. And that I think gives a much more clear direction for how they're progressing than just pounds lost because sometimes. If you go to the gym more, you could be putting on muscle, and you could gain weight. Or maybe you're losing fat, but you're also gaining muscle, and so your weight's totally stable. I really do wish that we could have access to this in every single primary care clinic.

[00:43:57] **Christopher:** Thank you so much for spending time with me today. Any closing thoughts before we sign off?

[00:44:02] **Allison:** If I have very limited time in a visit with a patient, I think some of the really high yield areas to focus on in terms of stress, making sure you're inquisitive with the patient. And exploring the connections between food and stress and helping them identify where they are making those connections in their life and helping them to find replacement activities. For example, this is actually from my own life. I

don't know why, but I just love sticking a spoon in a peanut butter jar and eating directly out of the jar, even as an obesity medicine specialist. And I know how many calories are in that unmeasured, high caloric density food, but it's just so good. And when do I stick my spoon in the peanut butter jar? Typically after a stressful day in the clinic. Helping your patients understand that they like Dr Rhodes can choose replacement activities other than eating peanut butter from the jar can be helpful. I think the other thing that's really high yield is normalizing working with a therapist. I always frame working with a therapist like a life coach, and I tell my patients, even professional athletes like Serena Williams, they have a coach. And, working with a therapist doesn't mean you're broken, doesn't mean you have a disorder. It really just means you care about figuring out how you can optimize your well being, from a mental and physical standpoint. really try and focus on positive normalization about helping the patients, reach their peak performance, almost like a coach would be helping an elite athlete.

[00:45:24] In terms of sleep I tell my patients if they're going to focus on one thing at all, it's actually sleep So I say sleep is the foundation, and the reason why is because without good sleep, we have higher stress, we have less energy to move our bodies, and we tend to crave sugar more.

[00:45:37] So if you're not getting enough sleep, if you're getting unrestful sleep, then it really does make all of the other behavior changes just more hard and more challenging, and so I actually tend to focus on that on my first visit. One other thing that I really like to counsel my patients about is the one hour, no electronic wind down time for their nervous system.

[00:45:57] The analogy I use is I tell my patients, your nervous system is a dimmer switch, not a light switch. So most of us have a morning routine, right? Most of us don't just jump out of bed, get in our car and drive to work and start seeing patients. We tend to wake up, brush our teeth, and brew some coffee. me, I'm squatting in front of my coffee machine, all those things. And so at night your body needs it. the same time to wind down, just like, it needed in the morning to wind up.

[00:46:19] And I find framing that for patients, because I think a lot of them feel like they can just go. And then just drop into their beds and their heads hit the pillow. And then it's like, all right, it's time to be lights out. But, framing that, Hey, that blue light from your phone, that's actually telling your pineal gland to not make melatonin. That's actually telling your brain it's time to wake up. And then you were just running around doing a bunch of stuff. No wonder your brain won't fall asleep. You've given it all these confusing signals. In terms of nutrition, I think a lot of people just don't drink enough water and helping them strategize. How do you make hydration accessible? an example from my own life. I had a horrible time drinking water during the pandemic when I was first in practice.

[00:46:56] Just because the masks and I didn't have water with me, and then I actually started carrying around a water bottle literally with me in my pocket and my white coat, and it had a straw, and that was a game changer for me. And so it wasn't that I didn't know I should drink water. It wasn't that I wasn't thirsty, but really, it's about what creative ways can you make it accessible? In terms of nutrition counseling, that's basic that primary care doctors can employ. If you can counsel your patients to order their food, I find it's very helpful. A phrase that I have to attribute this to a dietitian named Ilana Muhlstein , but she says, water first, veggies most.

[00:47:27] And really, reminding them to hydrate and then Just fill up with veggies and then go to their protein and then enjoy their higher sugar carb at the very end. That is really the key to success. So it's not about necessarily avoiding foods or not eating foods, but just optimizing. Like, how are you nourishing your body?

[00:47:43] And the most nourishment is really going to be from those fiber rich veggies in terms of activity. Another really high yield recommendation is 10 to 15 minutes of movement after meals. And when I'm first starting to talk to my patients, this is actually what I prioritize with them. I want to know, what are they

doing immediately after their meal? For example, if they are eating breakfast and then sitting in the car and commuting for an hour, maybe we can reorder their breakfast time. Maybe they actually eat in the car and they eat their last 10 minutes of their drive and then they park further away and then they walk to their office. And so sometimes it's just about reordering things to maximize the bang for their buck.

[00:48:17] As you're working with your patients. I think acknowledging frustration and reframing the things that they may feel like they're not being successful at as learning and growth opportunities is really key. So if a patient comes in and they haven't lost a single pound, that is just a learning opportunity.

[00:48:31] It is just a learning opportunity to know what didn't work and try again. And I think being your patient's cheerleader, always encouraging every single step that they take, is really going to be able to help them learn to do that reframing on their own, which will guarantee their long term success.

[00:48:47] **Christopher:** Awesome.

[00:48:48] **Sara:** Just want to add to that because that's a really great thought. Try different things. So, Don't give up.

[00:48:51] **Christopher:** Thank you guys so much.

[00:48:53] **Sara:** Thank you. Yeah.

[00:48:53] **Allison:** Thank

[00:48:54] **Sara:** you,

[00:48:54] **Allison:** Thank

[00:48:54] **Sara:** Chris..

[00:48:54] **Allison:** Thank you. I want to be your patient now. Can you help me with my peanut butter struggles?

[00:49:00] **Christopher:** That brings us to the end of this episode on the evaluation and management of patients with obesity. Please tune in next time when we will go over medications you use in obesity management. Thank you again for listening to another episode of Everyday Medicine, a podcast from OSU's Division of General Internal Medicine. Please consider subscribing to our feed on your favorite podcasting platform, so you don't miss out. You can also get our show notes and transcripts soon from our Division webpage at http://medicine.osu.edu/gim. Have a good day.

[00:49:30] Bye.