Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/clinicians-roundtable/leading-the-charge-on-obesity-management-the-endocrinologists-role-in-empowering-community-providers-to-join-the-fight/18078/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Leading the Charge on Obesity Management: The Endocrinologist's Role in Empowering Community Providers to Join the Fight

Intro:
Welcome to CME on ReachMD. This activity, titled *"Leading the Charge on Obesity Management: The Endocrinologist's Role in Empowering Community Providers to Join the Fight"* is Provided by Clinical Care Options, LLC and is supported by an independent educational grant from the Lily Group.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Bessesen:
Welcome, everyone. Thank you for choosing to spend a little time with us this evening. How's the meeting been for you? Maybe – I hope you've learned some stuff. It's an exciting time for obesity medicine and for treatment of obesity, and I think you can feel some of that excitement at the meeting here. And I wonder if you might want to take that home with you, some of that enthusiasm and excitement. Because I think what you're seeing here is the future. For so long we've not had effective therapeutics and now we're in a new era where there's so many new therapeutics coming along that are highly effect. But it brings with it some new challenges and I think you guys are on the front lines of where that's going to be. Uh, tonight we're going to be talking about leading the charge in obesity management, the endocrinologist's role, and empowering community providers to join the fight.

So, the purpose of this meeting is a little unique. We hope you'll gain some new information, but our primary goal here is to have you consider, what can you do in your own practice environment to bring this along? Because there's more obesity treatment that needs to happen than you and I can do. And so, I think, what as people who are interested in this area and invested in this area, what we hope you – you might consider tonight is, what do you want to do in your own environment to help the practitioners around you think more deeply about treating obesity. Because you guys are leaders in your own environment and this may be a responsibility that you don't necessarily want, but I think their advantages for you, and we'll talk a bit about that.

So that's me. I'm Dan Bessesen. I'm at the University of Colorado in Denver. And we have a terrific faculty this evening Jamie Almandoz who is at UT Southwestern, where he's the Medical Director of Weight and Wellness in the Division of Endocrinology, and Joanna Miragaya, who is an Endocrinologist at Wellstar Health Systems in Holly Springs, GA. So, they're going to be sharing their expertise with you tonight. These are our disclosures which were rolling before we started talking. We have these learning objectives.

Really, what we're going to do is we're going to talk about some of the challenges that primary care people feel in treating people with obesity. We tell you this because what we're going to offer you is kind of our perspective on how we talk to primary care people about weight management, and you'll have the slides that we're using, you'll have those available to you, you'll have some tools kind of written tools that you can use should you choose to interact with the primary care people in your area. We'll talk about new therapies both lifestyle, medications and then talk about strategies. How might you be engaged with your community to help the practitioners in your area think more deeply about this?

Let's just give kind of give an introduction here about the challenges to obesity management in community practice. Obesity is very common, look at your state. Um, this is data from the CDC using the Behavioral Risk Factor Surveillance survey, and obesity has increased gradually. Between 2000 and 2018, the prevalence of obesity increased from 30% of the population to 42%. And the prevalence of severe obesity increased from 4.7% to 9.2%, almost a doubling. And there's no sign that this is plateauing. So, despite all of our public health efforts, we're not making progress here. And certain groups are more affected by this problem than others with non-Hispanic white individuals – excuse me, non-Hispanic Black individuals and Hispanics being affected more than non-Hispanic white.

Now there's challenges about the BMI and how accurately it defines obesity, especially in Asian Americans where they tend to get health issues at lower BMI's than Caucasian individuals.

Well, let's think about a patient here. This is a 45-year-old woman with pre-diabetes who comes to see you for help losing weight. She reached a peak lifetime weight of 240 pounds a year ago and then went on a low carb diet and lost 12 lbs. But she had trouble sustaining the diet and regained back to baseline. She reports feeling hungry much of the time with cravings for carbohydrates. She's worried about getting diabetes like her mother and is asking you what you think about intermittent fasting. It's a typical patient you might see. Our primary care colleagues see these folks all the time. And it's challenging to deal with this problem in the brief time we have and certainly our primary care colleagues have a brief time in practice.

CCO did a survey of primary care individuals to see where they see their challenges in caring for obesity. It's a bit of a busy slide, but what they commented on were lack of access or trouble affording pharmacotherapy, lack of access or trouble affording behavioral health interventions, questions about motivation for losing weight people who couldn't afford surgical treatment. So, access and payment seem to be top-line items. Concerns that the treatments may not be effective, other medical issues that are higher priorities, treatments have too many side effects. A fear of offending the patient, not knowing how to start the conversation.

So, as you think about reaching out to your colleagues, think about how you take care of obesity and how can you help them more effectively deal with this problem.

What they highlight is there's challenges with understanding obesity as a disease. I think, still there's this idea in many of our colleagues that weight is something that people choose and may be a reflection of just poor diet, poor physical activity, or lack of information. Insurance and coverage is a challenge, and there's challenges with how we talk about this in a time efficient manner. And there's questions about patient motivation and treatment effective.

Let me just ask our panelists here for a minute. Jamie, first, do you have a sense of – that primary care people's challenges and what would you say to them about those challenges?

Dr. Almandoz:
Wow, when you're looking at the survey responses, I think kind of insurance coverage for any obesity medications and therapies is really something we get asked about quite a lot and I think it contributes to the inertia when there is a belief by many providers that medications aren't covered or they're not effective or there's a lot of work that goes into prior authorizations and other paperwork that people need to do in order to get access to medication. So, it's about guiding the conversation, how to verify coverage, and to manage patient's expectations around coverage and medication affordability.

Dr. Bessesen:
Yeah, that's great. It's such a challenge for all of you and for us as well. We don't have magic solutions, but we'll talk a bit more about, how do you have that conversation in a way that's productive for the patient given the reality of the environment we live in.

Joanna, how about you? Where do you see the challenges?

Dr. Miragaya:
So, one of the parts in the survey talks about the patient's lack of motivation and I think we need to assess that, and maybe the patient is tired of tired of trying or hasn't seen any results yet. So, we need to look into, is the patient experiencing some sort of, like, implicit weight bias, is the patient lacking motivation because the patient is frustrated without the failed attempts and looking for are their psychological facts that probably are leading to this lack of motivation.

Dr. Bessesen:
Yeah. If you feel like the person you're working with isn't motivated, it can be frustrating for them, it's frustrating for you. How do we have a conversation in that setting? Thank you.

Well, let's talk about obesity as a disease. I think increasingly, we recognize that diabetes is a disorder of glucose regulation, hypertension is a disorder of blood pressure regulation, and I believe that obesity is a disorder of weight regulation. This is a recent consensus statement that came from the Obesity Society, the Obesity Medicine Association, the Obesity Action Coalition, which represents people living with obesity, the Academy of Nutrition and Dietetics, which represents nutritionists, and the American Society of Metabolic and Bariatric surgery. These groups really came together to say obesity is a highly prevalent chronic disease characterized by excessive fat accumulation. That's the underlying problem, more distribution that presents a risk to health. So, it's not exactly about weight, it's about health, and it requires lifelong care, not temporary care. Virtually every system of the body is affected. Major chronic diseases associated with obesity include diabetes, heart disease and cancer. They go on to say that body mass index is used to screen for obesity. It does not displace clinical judgment. BMI is not a measure of body fat and social determinants, race, ethnicity and age, may

modify the risk associated with the given BMI.

BMI has been given a bad rap here lately, but nobody's really come up with an alternative that is completely satisfactory. So, BMI is worth talking about, but it's not the whole story. The consensus statement goes on to say that bias and stigmatization directed at people with obesity contributes to poor health and impairs treatment, and that every person with obesity should have access to evidence-based treatment. So, I think that's a consensus view of obesity treatment in 2023.

Now, what I believe is that weight – obesity is a disorder of weight regulation. This is a rat study; I always hesitate to show rat studies. But if you take a that's a long rat life there – and you measure a rat's weight, what you can see is that a typical rat gains weight through its whole life. And if you take a rat and you over feed it you put a tube in its stomach and give it more food it'll gain weight. But then when you stop that overfeeding, the weight goes back, not to where it was, but it goes back to where it would have been. On the other hand, if you take a rat and you put it on a diet, it'll lose weight, and then when you stop the diet, the weight goes back, not to where it was, but it goes back to where it would have been. So that's my understanding about weight regulation is that we tend to have animals, organisms in an environment where there's reduced physical activity and increased food intake tend to gradually gain weight through their whole life. And if you overfeed, you can gain weight, but the weight is regulated around not a set point, but a trajectory of gradual weight gain.

Some animals and some individuals are prone to a steeper curve of weight gain. Other people have a more gentle slope there. But this idea the weight is regulated around a trajectory of gradual weight gain I think fits with what we see in clinical practice. I typically ask my patients, can you draw a picture of what your weight's done and they'll say, well, you know, I went to college, and I gained weight. I got married and I lost some weight. I got pregnant and I gained some weight. I went on a commercial diet program – I'm dating myself here [laugh]. Stressful job, medication – there's an old-fashioned medicine for you – and I lost some weight. So, I think when I look at this, this is what I see. I have patients say I lost weight and then I gained it back and then some. So, I think patients actually have this underlying idea of this trajectory towards gradual weight gain, and this frustration with treatments that they look at as temporary, not sustaining the weight loss. So, I think that's the challenge. Is this a biologically regulated system and the treatments need to be chronic and sustained. It's difficult to treat this with lifestyle and willpower alone.

And that's because when somebody loses weight, goes from being heavy to being of a lower weight, the body reacts. Hunger goes up due to a change in a variety of hormones, there is increased hunger, less satiety, and less satiation with the meal. En – energy expenditure goes down for a number of reasons. The body mass is lower, so it just burns less energy, but the body becomes more energy efficient. So, these are the biologic reasons that it's hard to lose weight and hard to maintain it. Now, maybe the body just gets used to this and eventually the body will defend a lower weight.

Here's another rat study from a long time ago. Uh, if you take rats and put them in a world like ours, they'll gain weight. Now you can put them on a diet, and they'll lose weight, and you can sustain that because you can control their intake. The question is, if you let off this dietary restriction in a short time or a long time period, what happens? Did they maintain that weight? Did they just get used to it? And the answer is, no. The longer you maintain the reduced state, the farther the animal is away from its defended weight, which is this trajectory of gradual weight gain. So, no matter how long you wait, the body actually regains more quickly to a higher weight because that's the defended weight.

So, this is challenging, but this is the reality and it's a reality we have to describe with our patients. It doesn't mean it's hopeless, it just means it's challenging. I think the failure to see weight as biologically regulated and controlled leads to us blaming people for their weight in a way that we don't blame people for their blood pressure or their diabetes. We see these as biologic problems, but if we don't see weight as a biologic problem, then we tend to blame people for it. We also give people unrealistic views about what the treatment of obesity is. It needs to be sustained in long term. And the effect is, that we have this persistence and growth of a problem that's affecting the health of the country and the productivity of our workers.

So, I think the message we want to share with our colleagues is just like diabetes and blood pressure are biologic problems that we need medical treatment for, it is legitimate to use medical treatment for the problem of obesity. Some of this has to do with talking to people about this, and I'm just going to share some of my thoughts about this. You know, a lot of times, when we walk in the room with some patient who has a problem, I think we think it's our job to manage this problem. We think of ourselves as being in charge. We are accountable and responsible for that health problem. But if you think about somebody's weight, who's the manager here? Who's the boss? Who's in charge? It's not me. It's the person. They're ultimately in charge of what they do. And so, if that's the case, what is my role? My role is really to be a consultant or a coach. And think about the good coaches you've known in your lifetime, and how can we adopt some of those postures in the way we think about our conversations with patients. We hopefully are an expert, an advisor, somebody who acknowledges that we're not really in control, but we want to help this person make decisions about their health. And I must say, shifting my focus to this kind of a framework has really helped me not feel the frustration with the patient who's not motivated.

People are motivated, they're just motivated for different things. So, my question is, how can I have a conversation with this person that helps them understand their health better?

And that involves talking about these treatment options. And what I say when people walk in the room is, I say, you want to talk about your weight? And they say, OK. I say, well, the choices are, you could accept your weight where it is, you could try lifestyle things, we could talk about medications, or we could talk about surgery. These treatments go from not doing very much to doing a lot. But they go from not very expensive and not very costly to things that are more costly. What would you like to talk about today? Because it's hard to talk about all this stuff in any short period of time. But most people come in with an agenda. Unfortunately, a lot of people will say to me, well, I can't accept my weight where it is because it's too high, and diet exercise, I've tried that, that doesn't work for me. Medications, they're too expensive and have too many side effects. And surgery, oh my gosh, that seems too radical. And when they say that I usually say, well, I wish I had better choices for you, but these are the choices that we have. And so, do you want to talk about any of these? And if you don't, then maybe it's time – you can accept your way where it is, and we can think about it in the future. That's the way it – I'm not trying to judge what we're going to do here; I'm just saying what can we talk about in the time we have that's most effective?

Well, I haven't really talked to you about what those treatment options are and I'm going to give the podium over to Jamie. He's going to talk to you a bit about lifestyle and advanced interventions. Jamie.

Dr. Almandoz:
Thanks very much for that nice introduction to what we're going to talk about this evening, Dan. So, often when patients come to our clinic, they state that they want to lose about 30 to 50% of their current body weight and we start with the conversation of, well, why is that important for you? What would you gain from losing that magnitude of weight, and how could we measure your success on and off the scale? I think it's so important for us to have non-weight-based markers of success with our patients so that we can maintain engagement for what is really a lifelong chronic disease management.

When we look at the impact of weight reduction on health, as little as 3 to 5% weight reduction can start to see impacts on blood sugars, blood pressures and things that we know will improve our patient's health, but will it improve their outcomes? If we're looking at things such as fatty liver improvement on biopsy or AHI in our patients with sleep apnea, we're really looking at 10% or greater weight reduction. When we're in the space of looking at disease remission or mortality or sorry mortality or CV event reduction, we're really talking 15% or greater. And the question is how do we do that? So often we tell people, you know, if your weight was lower, I think you'd be healthier. And then when they what should I do? Well, have you considered walking 30 minutes 5 days a week? Have you considered eating less? And it's almost laughable that we're telling or asking of someone who's lived with obesity for decades to consider eating and moving. Hands up, if a patient has thanked you for telling them to eat less and move more in the last month, right? So, the question is, what do we do? Weight loss is beneficial for a variety of reasons, and we know that 10% body weight reduction is associated with about a 30% reduction in visceral adipose tissue. And we know that this kind of ectopic fat placement is associated with insulin resistance and a host of cardiometabolic risk factors that promote atherosclerotic disease and other factors that are important.

When we look at magnitude of weight reduction, we kind of talked about this kind of 10% being a very clinically meaningful cut-point, 15 and 20 being even better, until recently, we really haven't had effective options beyond bariatric surgery. And as Dan discussed earlier, when we're talking with patients about effective treatments, if this is our first go-round in talking about advanced or effective therapies and you mention surgery, the average person who's coming to a weight management or obesity medicine physician is almost saying, hey, surgery is not for me, what else is there? Older generation AOM's, we're looking at maybe 5 to 10% risk – oh, excuse me, weight reduction on average. Not that that's ineffective, it is effective, but is that what we're going for? Is that what we're actually recommending to our patients? And now with the social media popularization of highly effective therapies, is that what healthcare consumers are asking for? And I say that because I'm sure many of you are experiencing patients coming to your office and primary care providers within your system asking how do I get these very effective treatments for my patient? How do we do this?

We often start the conversation around weight management with physical activity. The challenge is, you know, these ACSM Guidelines of hey, moderate intensity physical activity 30 minutes five days per week are best for weight maintenance activities, and really don't help people to achieve the magnitude of weight loss that they're looking for. And I think it's important to manage expectations around those, because our patients will often cluster behaviors together where they say, well, I was going to change my diet, but the physical activity really didn't help with the weight loss. And it may seem kind of a little bit nonsensical, and you go, well, why would you lump them together? But it's important for our patients to understand that there are health behaviors and there are weight loss behaviors, and to not abandon things which are going to be helpful not just for their physical, but also for their psychological health. But they may not help them to achieve the magnitude of weight reduction that either they want, or that we're recommending to them.

We do recommend physical activity as part of weight management programs to help support preservation of lean mass as part of a the

weight loss journey, while also recommending nutrition factors such as, prioritizing protein intake and trying to eat a balanced diet. When we look at diet to help people lose weight, this is a – a nice study that kind of randomizes patients to kind of some popular dietary patterns if we imagine kind of low carb, low fat. But what it really shows is that when you vary the macro nutrients in diet, the weight loss is pretty much the same. But when you look at adherence, it's – that's what's important and that's what correlates most strongly with weight reduction. So, when people ask what's the best diet, I'm like, oh, the one diet that works for everyone? Yeah, I have it on this sheet – it doesn't exist. It's about, how do we find something that a patient is interested in doing and is sustainable to do. And it's about creating healthy patterns, not creating a restrictive attitude towards nutrition. And I think that's so important as we have highly effective therapies that help people to manage their intake, we need to move away from a restrictive mindset of nutrition and, you can't do this ever again. Because who wants to live like that? I don't, and I know our patients don't either. They've done that for decades. So, it's about how do we create healthy, sustainable patterns that provide your body with the fuel it needs in order to be healthy.

Simplification of calorie restriction is something that's effective not just for weight reduction, but also for disease remission. These are results from the DIRECT trial. There's now 5-year data, but this is a 2-year outcomes data for diabetes remission from the DIRECT trial, and what it shows is there's an association between magnitude of weight reduction with remission of diabetes. So, these are people who had 12 weeks of a very low-calorie diet, and then were followed out after 2 years. Those who had less than 5 kilograms weight loss, about 5%, diabetes remission, those who had more than 15 kilograms weight reduction, 70% diabetes remission. So, there's an associated between the amount of weight we lose, as a program like this, with remission of diabetes.

However, if we look on the right, those who responded, either those who had diabetes remission versus those who didn't, everyone lost weight. They had reduction in ectopic fat in their liver and their pancreas, but those who experienced diabetes remission had preserved beta cell function for insulin secretion. And all that to say is that obesity is a chronic and complex disease and just because somebody decreases their body weight, does not necessarily mean that they're going to have remission in obesity-related complications like diabetes. So, we need to manage expectations and help our patients and ourselves to understand what to expect from given interventions that we recommend.

Bariatric surgery is still one of the, if you will, kind of gold standards or benchmarks for weight reduction for our patients. It's been around for a very long time and so have the criteria used by most of our payers. So, these are the 1991 NIH Consensus Guidelines for bariatric surgery. So, for people who have a BMI of 40 or greater, or those with BMI of 35 to 40 with a weight-related comorbidity or complication, ASMBS and IFSO last year proposed new guidelines dropping these BMI categories by about five points. But that has not yet been adopted by payers. When we look at average weight reduction for the most common bariatric surgeries performed within the US and around the world, number one would be sleeve gastrectomy, so around 60 to 70% of people around the world average weight reduction at 2 years, it's about 20 to 25%. Roux-en-Y gastric bypass, about 25 to 30, adjustable gastric banding and biliopancreatic diversion are really the minority of – of surgeries which are performed now.

We know that bariatric surgery is helpful for remission and treatment of cardiometabolic disease. These are results from the recently published BRAVES trial, which is the first randomized control trial looking at bariatric surgery versus lifestyle or medical intervention for treating people with biopsy-proven NASH. And what it shows is that those who undergo bariatric surgery experience remission in their NASH in the order of 50 to 50 – sorry – 56 to 57%, depending on whether they underwent Roux-en-Y gastric bypass or sleeve gastrectomy. Average weight loss with gastric bypass in the study around 30%, about 25% with sleeve. In the medical or lifestyle arm, there was some use of liraglutide, some use of pioglitazone, just to kind of give you an example of what was going on.

When you look at fibrosis without worsening in NASH, there was improvement in fibrosis score in about a little over a third of people. When we look at this older French study, what it shows is that there is an association between the magnitude of weight reduction. So, on the left we can see BMI points. So, those who experienced more than 10 BMI-point rate reduction, there was more than 90% remission in NASH. So, there is a kind of, a dose response relationship relative to weight reduction, but also with time. So, this is a little bit difficult to follow with, kind of, the coloration here but F-0 – so going to a zero-fibrosis level, we can see that over time there's also an improvement in fibrosis. So, magnitude of weight loss plus time equals improvements in fatty liver.

What I want to highlight here is, with the magnitude of weight reduction and with the surgery we can see a significant improvement in liver outcomes for people who have biopsy-proven NASH, and they're kind of using this composite outcome here of progression of clinical cirrhosis, development of HCC trend liver transplantation or liver-related mortality. There's about an 80% - more than 80% reduction in this composite outcome, so people want to go bariatric surgery.

What FDA approved medications do we currently have for treating NASH? So, we're really focusing in on weight reduction or bariatric surgery or bariatric range weight loss to improve outcomes for our patients with NASH. When we look at diabetes and the impact of bariatric surgery, bariatric-range weight loss, we can see that remission 5 years out from surgery, depending on the type of surgery, in the kind of orange bar. There we have biliopancreatic diversion about 63% remission, relative to about 31 to 37, with Roux-en-Y gastric

bypass relative to about 23% remission with sleeve gastrectomy. So, this is still pretty impressive. Five years out from surgery to almost two-thirds of people, or almost a little under a quarter of people, depending on the surgery type, have remission in their diabetes.

What's important to point out, and this is a different study here looking at reductions in all-cause mortality and cardiovascular mortality for people with diabetes who undergo bariatric surgery. There're significant reductions in mortality and in cardiovascular events. So, we're not just, kind of, treating or putting the diabetes into remission, but we're also helping with associated cardiometabolic complications. These are randomized data from 10 years after bariatric surgery showing that there's recurrence in diabetes in 75% of people who underwent Roux-en-Y gastric bypassing, and 50% who underwent biliopancreatic diversion. But what it says is that there's still, with this magnitude of weight reduction, much better controlled diabetes. Mean A1C 10 years out was 6.7%. So, diabetes is easier to manage.

But if we look at diabetes related complications, in the lighter color here, we have microvascular for – and macrovascular in the darker color. This is the medical therapy group relative to those who underwent bariatric surgery. We see these dramatic reductions in diabetes related complications as a result of bariatric surgery and bariatric range weight loss. What else do we do in the clinic that helps patients to achieve these kind of outcomes and risk reductions when it comes to diabetes related complications? Not much. And not to do too much of a hard sell for bariatric surgery and bariatric range weight loss, these are data published last summer that showed the association between reduction in obesity related cancer risks, recording stratified by quartile of post bariatric body weight reduction. We see a nice dose-response relationship to the amount of weight lost after bariatric surgery and a reduction in cancer risk. What else are we doing in clinic that's decreasing cancer risk like this beyond asking people to stop smoking and be healthier? So, all this to say is that we have tools that can help people to lose weight and be healthier. Are we using them and are we using them effectively?

When we talk about anti-obesity medications, these are things that are underutilized currently. Within the US, less than 3% of people who are eligible for anti-obesity medications get treatment. One way to kind of look at how to choose one is by looking at contraindications and cautions. First, do no harm. So, for somebody, for example, who has a history of seizure disorder, maybe not choosing bupropion, which can lower seizure threshold. Or someone with a history of recurrent idiopathic pancreatitis, maybe they're not the best choice for an incretin. Comorbidities - can we treat coexisting food addiction or bingeing disorder with something like bupropion or lisdexamfetamine? What are the cues that are prompting people to have a positive energy balance using combinations of therapy the way we would address something like hyperlipidemia, diabetes, or hypertension? But the sticky situation for many is cost and coverage of anti-obesity medications, and I think this is something which will continue to be a challenge with access for patients.

There are several FDA approved anti-obesity medications. There's Or - orlistat, a gastrointestinal lipase inhibitor, a cellulose citric acid hydrogel, which is technically a medical device. There's the sympathomimetic phentermine which many of you are likely familiar with, which can be given also in combination with topiramate, which is one of the most potent oral anti-obesity combin – combinations. The combination of bupropion/naltrexone is something borrowed from the world of addiction medicine, which we often use to help people with alcohol use disorder but can be quite helpful for appetite and for those who have a hedonic drive for consumption. And then the currently approved incretin-based therapies for treating obesity, liraglutide and semaglutide, are GLP1 receptor agonists. There are many pipeline medications, and it almost feels like this slide is woefully out of date, given all of the developments this weekend. But to the far left, there's an off-label box here because those of us who work in the obesity medicine space have had to be very resourceful for many years given the challenges with coverage for anti-obesity medication therapies.

These are data from the STEP 1 trial, and I won't, kind of, go through everything because you'll have these, kind of, available to you. All this to say is, this is one of the most effective agents we currently have for treating obesity that's approved. Average weight reduction of around 15% with about a third of people losing 20% or more of their body weight, so in that bariatric range of weight reduction. When we look at tirzepatide, so dual GLP1/GIP receptor agonist which is under investigation for approval for obesity. And we saw the SURMOUNT-2 data for those with type 2 diabetes this weekend. What we have is an average weight reduction of greater than 20%, which if we recall prior, about a third of people losing 20% of their body weight. Here we have over 55% of people losing 20% of their body weight or more. So, what we're seeing are more effective agents with greater mean weight loss, but a greater proportion of people also achieving these clinically significant cut-points that we talk about when we talk about disease remission and improvement in health.

So, what we're seeing here is we kind of move through the landscape of older anti-obesity medications to what we're now calling next-generation or highly effective anti-obesity medications, such as semaglutide and tirzepatide. We're really seeing a closure of the gap between the eat-less-move-more lifestyle approach and the bariatric surgery magnitude of weight reduction that has kind of been the benchmark that we've been chasing for so many years. Again, slides like this are woefully out of date based on this weekend's meeting. But what we're seeing are greater and greater magnitudes of weight reduction and this is a combination of cagrilintide/semaglutide of the Phase 1b data, and then on the right here we have an Amgen molecule, which is, kind of, a Phase 1 data for something which is a GIP

receptor antagonist and GI – GLP agonist, which is given monthly instead of weekly. So, we're seeing alternate routes of administration, where instead of daily or weekly, perhaps monthly. We've seen at this meeting oral peptides and non-peptide medications which work on the incretin system. So, the space is rapidly evolving where there are newer and different agents which may meet the needs of the variety of patients we see who are living with obesity.

I put this up to highlight that pharmacotherapies are used in conjunction with intensive lifestyle interventions or lifestyle modification, and we can see that it augments the weight reduction that we see with intensive behavioral therapy alone, but also when we incorporate multi-component or meal replacement or things that facilitate neg – negative energy balance, we can potentiate the weight reduction that we see as a result – result of pharmacotherapy.

These waterfall plots just highlight the heterogeneity in terms of response. There will be people who do not respond to therapy, be it lifestyle, be it medications, be it surgery. But by using augmented therapies, and in this case it's bupropion/naltrexone, we can see that significantly more people are losing weight, but also achieving these clinically significant cut-points that we talked about in terms of helping with cardiometabolic health and other health outcomes beyond that, including quality-of-life. I think what we need to do is normalize the treatment of obesity the same way we have hypertension and hyperlipidemia. You wouldn't say, well, I would prescribe a statin, but I don't have a dietitian in my office to talk about saturated fat. You'd never say that. Yet there's so much inertia to treating obesity because we feel that we don't have the tools to help people to eat in the way that we believe is right for them. And so, what I want to do is make sure that we understand that we can treat obesity without having all of these moving parts. We need to start the conversation with our patients. We need to discuss evidence-based therapies. And we also need to socialize the idea that things are effective. We've seen all the efficacy data for medications and interventions, including surgery, but obesity is a chronic and very complex disease, and for example, if we discontinue medications that, well, the patient's in a healthy range BMI, we can stop the medication. We wouldn't do that if an LDL was a goal or if an A1C was a goal. Yet for some reason, we, or maybe the primary care provider in this situation, may think it's appropriate to discontinue medication. That's not evidence-based therapy, that's bias-based intervention.

And I think what we need to do is make sure we have a clear conversation that obesity is a chronic disease. And I think these data from the STEP 1 extension trial showing the nice decrease or reduction in body weight with treatment with semaglutide 2.4 milligrams weekly over 68 weeks. But what we see is after a year of discontinuing the medication and the lifestyle intervention, that there's recurrence in about two-thirds of the weight loss, regardless of the magnitude of weight reduction. And so, we can expect recurrence in disease once a highly effective intervention is this continued. So, what we need to do is make sure we're treating obesity as the chronic complex disease that it is. As endocrinologists and specialists, when we see patients within the clinic making sure they're on secondary causes is kind of the first thing. Are we prescribing them with sulfonylurea and a TZD that may be promoting weight gain? Are they on antidepressants or other medications which are promoting excess body weight? How can we create with the best of our abilities and our knowledge an integrated program that does focus on some nutrition, lifestyle activity and behavioral change? How can we incorporate pharmacotherapy, surgery or surgical procedures to help patients to achieve a lower body weight, knowing that there's a lot of inter-directionality between them. There are effective – there are data showing the impact of helping people after bariatric surgery, for example, to achieve a healthier body weight, to maintain weight, and to treat post bariatric weight recurrence. We need to look at this as a chronic disease where we're providing continual iterative interventions to help patients to approve – improve not just their weight, but their health and, most importantly, their quality of life.

So, thank you very much for your attention.

Dr. Bessesen:
Thanks Jamie. You know, yeah, there's a lot to absorb here, isn't it? And again, our purpose here is to provide you information, but some of this you may know. Uh, I think you could ask yourself, am I using this information in my practice given the frustrations there are? And then also, can I share this information with our colleagues? Who are your bariatric surgeons in your environment? Who are your obesity medicine colleagues? What's your access to medications? How can you help the providers in your community do this better? Because it's an – it really is a wild time.

Jamie goes over how the higher levels of weight loss has more health benefits, and we're really in an era where there's going to be multiple medications that give this higher level of weight loss. And yet, right now, things are expensive. They're not all covered by insurance, but that doesn't mean we can't start these conversations with our patients to help them think about obesity as a disease and think about what their choices are.

Joanna Miragaya is going to talk to us a little bit about, how do we have conversations with people around their weight. Joanna?

Dr. Miragaya:
Thank you, Dan, and thank you all for being here tonight. So, we'll talk a little bit about addressing the bias and how to initiate the conversation with our patients. First of all, I wanted to address that obesity is the most stigmatized chronic disease that we currently

have. The stigma and bias are the result of misconceptions and leading to suffering for patients with chronic diseases. It's discriminatory and it affects the patient emotionally, socially, psychologically, but also physically. Um, it's the result of negative ideologies that will affect the patient socially and eventually leading to social rejection and demeaning the patient. And this will lead to behavioral change and psychological changes to the patient, besides, as well health disparities. The media plays a big role into the negative role in the weight bias and stigma, and it's important for us as physicians to address the implicit bias and explicit bias. And the research has shown over and over that biases start early – early as in medical school, and it progresses throughout our training in residency, fellowship, and even in practice.

There are five obesity myths that have been somehow recognized. The first one is that calories in are calories out. So, if we think like that, so, it's usually around the energy output accounts for 30% of your total daily energy expenditure and 10% being your thermic effect, and around 60% being your metabolic rate. So, if we think that's actually calories in minus calories out and you should regulate your weight. So, this formula would only apply for athletes, not for most of our patients, right? So then definitely, that wouldn't work. And we need to account for other several variables besides the food, but also the energy of the food as well as the digestive enzymes, the microbiome, the medications. And gut hormones and neuro – neuroscience.

And obesity is primarily caused by voluntarily overeating and sedentary lifestyle. So, this is pretty much telling that we're calling our patients lazy and that's actually not the case. It actually would be discriminatory, and it would be a bias right there. And let's not forget that this will eventually lead to more negative impacts to the patient as well. So, we need to account for sleep deprivation, for medication, for epigenetics for other genetic factors, as well as and intergenerational factors.

Obesity is not a lifestyle choice. In fact, most of the patients that are coming, they're actually seeking help. And according to this ACTION study, more than two-thirds of the patients recognized that obesity is as important or is more serious than hypertension, diabetes or depression. So, they are looking for help. In – after all, they want to live longer as well.

Obesity is not a condition. Obesity is a disease. The WHO has recognized obesity as a chronic disease and should be treated as such. And treating as a disease would allow us not only for therapeutic options, but as well as for creating policies in place.

And severe obesity is usually reversible by voluntarily eating less and exercising more. Again, it pretty much applies to the same concept. That's actually not true, and as we heard earlier from our previous speakers that when you actually lose the weight, you decrease your energy expenditure, but then you become hungrier and decrease satiety, which in fact what – will make you regain the weight.

And the vicious cycle of the stigma in health care impacting health in several aspects. It starts with the patient, so the patient is less confident in their ability to lose the weight and in fact it plays a negative role, and the patient ends up eating more and exercising less because the patient now doesn't see any benefit of it. And would increase the cardiovascular risk, increase risk for diabetes and stroke. And it affects patients psychologically such as, depression, anxiety and binge eating disorders. So, this is a vicious cycle that perpetrates and eventually will cause some public health consequences to the patient, but also to our society. So, in regard to the society, the environmental contributions for obesity to the impaired obesity prevention efforts and to the increased health disparities and social inequities. In fact, this will eventually lead the to an increased morbidity and mortality.

So, you cannot address stigma and bias without addressing the social determinants of health. And to address that, we need to talk about socioeconomic status. So, education, occupation, income. So, those play a big role on weight stigma and bias. The areas of living, the housing, food choices, public safety, transportation, parks and recreational parks, there are several areas that patients end up not being active because of fear where they live due to crime rates or just not feeling safe.

We need to also address the endocrine-disrupting chemicals. More and more we have data to support how damaging they are to the endocrine system and as well as obesity. And other effects such as school ratings at the level of the school's crime rate and job opportunities.

The Joint International, as well as Obesity Societies, and recently ACE, has come up with statements to end the stigma for obesity. They all condemn the use of stigmatizing language, images or attitudes or policies wherever they occur, it could be in schools, jobs, or in any setting including healthcare settings. They do recognize all of them, the effect that this type of language, the weight stigma and bias, can affect patients with overweight or with obesity, and it can cause – it can be discriminatory and should not be used at all. And this applies to not only schools and jobs, but also to our healthcare system, which is unfortunately commonly seen.

So, this is just this is a slide just to say that not one-size-fits-all for patients and this not only applies for pharmacotherapy as well as surgical options, but also on how to address, how to initiate the talk with your patients.

So, here we have the three out of the 5A's that we usually use that – to start a conversation with our patients with obesity. So, the 5A's,

initially the model came from the smoke cessation that was initially used, and has been used then for chronic diseases. So, the first one is Ask. So, you need to ask for permission to discuss their weight, or even better, according to the new ACE consensus statement is, perhaps not focus on the weight, but on their diseases associated with the excess weight. And you can assess the health status and the complications, and you advise the patient the treatment options depending on the severity. And you have the option to refer and/or treat the patient, and that would mean you agree on assessment and plan, and you assist the patient on a model that is for a shared decision.

So how do you discuss that? The first thing that we have been approached for all chronic diseases is a patient-centered approach. We have to be empathetic. That doesn't mean you have to agree, but you need to show empathy. You need it's important to be unbiased and free of any judgment, shame or guilt and focus on health rather than the weight. The patients do know that they are suffering with either with obes obesity, or with overweight, so it's important for them to just hear more of the health aspect of it than focus on the pounds. And language is extremely important. We are – we have come a long ways from leaning from patient is, to patient with. So, it's very big component for all of us, and morbid obesity is a term that should no longer be used. And most importantly, for any motivational interviewing, you need to focus on the decision-making and providing a practical options to assist with the weight loss.

So, what's important is keep eye contact during the conversation. It doesn't take long, you don't have to be focused the whole time on the patient, but especially for the first one to two minutes, focus on the patient, good eye contact, head nodding, get close to the patient, lean forward, or affirmative nods and gestures. However, this can be a little bit challenging with telemedicine, which has grown in popularity, and we'll touch on a little bit at the very end.

Other things to consider is that, explain the importance of staying in the treatment with the patient. As Dan has mentioned earlier, this is a lifestyle or maybe it was Jamie. This is a lifelong therapy choice, right? So, it's not only lifestyle changes that are life-long, but also, if the patient has opted for medication or surgery, this is actually life-long. It's not something we're going to stop at any point and moment. Uh, set realistic goals with the patient, and expectations. You know, a patient might come to you and say, I want to go back to my weight during high school, and you need to set expectations that it actually might not be possible. So, let's set maybe a 5% or a 10%, but set expectation that the high school weight might not be an option.

Now, follow-up with regular basis. It's extremely important. Patients that are lost for follow-up, they are more likely to regain their weight. And titrate and discontinue the medications that have not worked for the patients or that have worked for the patients. But also, most importantly is address the comorbidities related to the obesity. So again, just – oh, did I go back? Yes, I did. Sorry.

So, it's shared decision-making. That's the number one part of any motivational interviewing. The patient is the center, but it's important to have that mutual relationship. Uh, talk about medication adherence. Maybe sometimes patient will stop because of side effects, but patients are not comfortable saying that because they are fearful that you might discontinue the medication. Be aware of any cultural differences or anything that might be being a barrier on your conversation with the patient. And self-monitoring for the patient, but also for yourself and how you're handling the conversation.

So, what is motivational interviewing? It employs the patient centered approach. So, pretty much you're empowering the patient to be there for the conversation. You're giving the patient a chance to talk and be involved in their own care. It uses intrinsic motivation to change the behavior and it focus on mutual understanding and achieves the idea from export to patient to a teamwork approach. And with that, hopefully empowering the patient, we can make some changes.

So, this is the OARS component of the motivational interview, the open-ended questions. So how do you start talking to a patient? You can start by saying, what would you like to address today? What would you like – what would you envision we can do today? So, as a start, it's not closed questions, but open-ended questions. And affirming the patient, like, I appreciate you being honest with me that you haven't been able to follow on, whatever you guys have agreed on last week or 3 months ago. And reflecting; so, reflecting, that means that you're not agreeing with the patient, you're just listening to the patient. So, the patient has felt that he's been heard. So, you don't have to agree with the patient, just listen and try to show some understanding.

And summarize and tell the patient at the end, like, well, let me summarize. Let me know if I have missed anything. And most importantly, set a goal at the end or the middle of your day. So, we've talked about a lot of different things, so tell me, pick up one of those items that you would like to work on, so that way you have an approach with the patient with one goal. And with that, it would be your SMART goal, which is Specific, Measurable, Achievable, Shows results, and Timely. So, you go from, I'm going to quit snacking, which it sounds like a little bit unrealistic, right? We all snack at least once in a while. So, change that to maybe I will not eat or drink anything but water after 7:30 for the next 4 weeks. So, this is specific. It's measurable. It's more achievable than the first option, and you're likely to get the results.

So, on your interviewing time, so then the first thing that usually we hear is just like, oh, that's a lot. Do I have to document all of that?

No. The most important entry in your medical record is going to focus on what would be your goals with the patient, what you have agreed. But the whole patient narrative you don't have to – um – to be part of your medical record, but it's good to listen to the patient so they can feel heard and valued.

The other pneumonic that can be commonly used is the I AM LATE pneumonic. So, it talks about Impression, Minute of silence, Listen, Acknowledge, Touch and Empathize. So again, I think I touch based on that already, it's the eye contact, the smile greeting. I in Georgia, so a lot of patients like to hug, so that's one of the things. Um, resist to interrupt your patient, at least in the first one to two minutes. A lot of your patients, when they're coming to you, they are already frustrated because they have tried so many weight loss options and they are not successful. So, just listen to them for the first one to two minutes and try not to look at your computer screen. It just doesn't take long. And that addresses the listen as well. And acknowledge any psychological factor that's playing a role. Um, do not – uh – don't underestimate the power of a touch. And understand the other point of view and try to walk in their shoe.

And I'm not going to go over this slide in much detail because it talks about the same things about the relationship of patient and physician, but it also gives some examples on how to use the language. You should also – all have on your hand out there.

In terms of telehealth it has been widely used since COVID pandemic. It has been a great resource for many patients, especially those patients that lack access locally, or patients that due to their job demands cannot make it. But it does have some limitations and can be a little bit some challenging time for some other patients because you're not able to apply motivational interviewing as we would like to. It has been adopted universally as we know. As for pros and cons, we don't have much data yet on it, but it does allow for better access, so it does carry some connectivity issues and you don't have the physical examination. So, it's good sometimes for your established patients but it can lead to some areas of the input that still need some improvement.

And the patient-centered care is what we talked about. It's about the patient. Give them the power to make the change with you. Let him be – him or her – be part of that decision-making. And that leads to our SHARE approach, which is seek your patient's participation. They need to be involved in their own health and their own care. Help your patient explore and compare treatment options, discuss side effects of the medications. Some patients are fearful of trying medications because they are afraid of the side effects. They might come to you, oh, my neighbor ended up in the hospital, so it's important to address those side effects with the patients.

Assess your patient's values and preferences. Some patients might describe to you what they think culturally, or other factors related to family values. And reach a decision with your patient. The two of you should be able to make a decision together. And you can develop several plans, a plan A or plan B. And evaluate your patient's decision and talk to him or her and see if that was realistic or not realistic. And I think I've finished here for this talk.

Dr. Bessesen:
Thank you. Thank you so much. Yeah, it's challenging, isn't it? Thanks for hanging in with us here. And I think, probably a lot of you do this with your patients with diabetes. Diabetes is such a challenging thing for people to live with, and I think a lot of you over time have come to use a lot of these techniques. So, you may be experts in this. I think some of your primary care colleagues may not be as used to doing this kind of thing. A lot of them may still be in this framework of, my job is to tell the patient what to do. The patient's job is to do what I tell them to do. So, I think there's a lot of great tips in here. And again, you'll get these slides to use should you choose to do that with your colleagues. Don't forget to put in some questions there if you have any. We've been pushing out a lot of information to you, but you've got your device, so if you have any questions please put them in there. And those of you who are online, you can ask your questions as well. We're getting close to the end here and we'll have some time to address those questions.

I'm going to start with Jamie. So, what do you think about this communication piece? It's a big part of what you do, I know. Do you have any thoughts about what Joanna said there?

Dr. Almandoz:
You know, I think Joanna brought up some really lovely points with regards to how to start a conversation with patients and how to set, kind of, realistic goals. As I kind of shared at the beginning, one of the things we do for engagement is kind of find out why would weight loss be important to this patient? So, patients come to us specifically for weight management. It's not that we're having a casual conversation for someone who's coming in for diabetes management or for another kind of acute issue. And so, we kind of have conversations that help to understand why weight reduction is important to them. I think society places such a high value on thinness, but sometimes it's important to determine what would the benefits for them be – what would they be? And then we could measure both on and off the scale with regards to, I would like to be off of insulin. I wish I didn't need CPAP anymore. And kind of working out how we can achieve these kind of goals together as a team.

Dr. Bessesen:
Yeah, that's really terrific. I think anytime you ask an open-ended question like that, I think there's a natural concern like, am is this visit

going to get out of control here, and we're just going to go down some road that I don't want to be on. But actually, as I listen to you say it, Jamie, I think that's the kind of open-ended question that adds – that gives information that's so deeply meaningful. I mean, again, I think Joanna said it really well. I don't mean to repeat it, but this is the algorithm I use in my head. I try to say, can I start everything with a question? I tend to want to push information out. I think, you know, I – let me tell you about the new medicines, let me tell you about what diet's the best diet for you, let me tell you about the pros and cons of surgery. Anytime I find myself wanting to push out information, I say can I turn it into information – turn it into a question? And I think Jamie's going, I'm going to use that as a question. I must say, I don't use it. I'm afraid it'll get me off track. But as I hear you say it, I think it's a great question. So why – why are you concerned about your weight? There's the question.

What you need to do is actually give time for the person to give an answer. And the person may say something completely surprising to you. They may say something out of the blue and you'll say, wow, what do I do with that? And that's that moment where this reflection statement comes up. If you're lost and you don't know what to say, and I'm in that position a lot, you know, I just reflect. And for me, reflection mean – it means really – so, say the person says, I really don't want to be on insulin like my mom was. OK, that's a simple answer, but there's a lot going on there. And so, the reflection statement means, say it back to the person what they just said to you and say, so it sounds like you're worried about being on insulin. You think losing weight is going to help with that. It sounds like you have real fear and concern about insulin based on your family. So, I just said it back to what the person just said.

But what by doing that it does three things. First, it lets the person know you're listening to them because they think we're not going to listen to them. The second thing is, the next words out of your mouth come from where that person's at. That's a – now a deeply informed conversation. We now know the heart of what this person thinks is important. And the third thing, though, is the person gets to hear their own words coming back at them, and sometimes that has a profound effect on the person. They realize, you know, I'm not my mother. I'm a different person, and so now we can have a real conversation about these deeply meaningful things. Empathize, because this is challenging, but at the end of the day, I think Joanna said this, we're here to do something. So, what do you want to do? Let's pick something that you think is achievable, it's specific, and measurable. So, I try to hold myself accountable for these steps.

Although, and our last thing, we're going to think about how can you help your partners in the community overcome barriers to providing the kind of care that really, I mean, imagine a world where people didn't have to struggle with their weight. What would that world look like? What health problems would be better if we actually had effective treatment, and we actually disseminated it? I mean, it would have a profound effect on healthcare, I believe. But how do we get there? I'm going to start with Jamie. How can we – how can we help – what are the key things to help our partners here?

Dr. Almandoz:
You know, I think this is almost a trick question. I think, I'm an endocrinologist and the majority of my colleagues aren't treating obesity. I think we need to start as a group treating obesity first and then we can start helping our colleagues do that by modeling behaviors by working in a consultative way with them. I think there's been such an inertia to treating obesity even amongst endocrinologists and diabetologist when we know that our patients would benefit, that I think we need to overcome that first.

Dr. Bessesen:
Maybe we're that – our own barriers inside ourselves is Joanna, what do you think?

Dr. Miragaya:
I'm going to second Jamie's words on diabesity , the new term nowadays. So then, a lot of our patients do come to us for diabetes and in our local communities or even academic places, and we see that those patients are still being treated with insulin or sulfonylurea and we don't see the new agents that can potentially be used that would help with the weight loss for some of those patients. So then, that's when the endocrinologist can play a big role and help those patients in our communities or academic centers.

Dr. Almandoz:
Yeah. And the bias and stigma can be so deeply embedded psychologically that we don't even acknowledge it. I think sometimes I feel just frustrated, like, how are we going to ever do this. Insurance coverage cost, prior authorization, they can get so frustrating that you think it's just not worth my time. And that frustration, I think, can really get in the way to engaging this. Does the frustration come in part from how we feel about the health problem of obesity that may be under – in the subconscious there. So the CCO folks asked our primary care colleagues about this, and how could you, as specialists and endocrinologists, help them be more effective? And these are some of the things that they said. They said develop a referral resource database partner with your primary care colleagues to care for patients, provide curbside consults for difficult patients, a lecture on initiating weight loss medications, sharing your expertise, share effective strategies and cost-effective treatments, establish goals that can be shared, practical approaches to getting meds approved.

So, this is some of what they said. I'm going to back to our panel. Have you had some success helping people in your area with their treatment, and maybe could you share some of the successes, Jamie?

Dr. Almandoz:
Yeah, we've been very successful. A group of us got together and created Dallas Obesity Society, which really kind of focuses in on how we can engage with our primary care and other colleagues in the community to provide them with evidence-based educational lectures, kind of like was suggested, on how to initiate obesity treatments. But then there's also a peer mentorship component to it, because we can give all the didactic lectures we want about obesity as a disease and how to treat it with medications, but to help someone understand how to navigate the process of prescribing medications, dose titration, managing the side effects in a real-world setting, really I think has been invaluable to a lot of our colleagues in the community on how to treat obesity more effectively.

Dr. Bessesen:
So, establishing a new organization, really advocating in the local environment for better care for people with obesity. Joanna, how about you?

Dr. Miragaya:
So, our healthcare system, they have a program that's called Center for Best Health that involves the treatment with a physician, but as well as a psychologist and exercise physiologist and dietician and, of course, the surgeon if needs to be. And with that, we were able to create several satellite clinics outside of Metro Atlanta to help those communities, those local communities outside of the Metro Atlanta area. So, reaching out to them.

Dr. Bessesen:
Great. You get a lot to do. You don't need more to do. On the other hand, if you channel that frustration, you sometimes feel, about the care you provide, into some sort of action, I think that may change the landscape. I've been fortunate enough to be able to talk to a variety of people, employers is one group, insurers as another. Actually, in a few weeks I'm talking to the Republican State Legislatures organization about the problem of obesity. I'm thinking what am – what am I going to say to that group that I'm trying to be a good advocate. I think – I think I'm going for the it's a national security issue that recruiting an effective military is a problem because weight is a problem. And also, the business case, but I don't know if that's going to fly. That's what I'm going to. [laugh] But I think I'm honored to have an opportunity to talk to the decision makers. And also, to bring in patients that I care for because nothing changes opinions like a personal story. And so, if you have patients who want to be vocal advocates here, get them in touch with the real decision makers. We're not where we need to be, but you can be agents of change, really, in your local environment, whether that's your clinical colleagues, with the insurers, or employers in your area.

Share the stories of your patients, because I think a lot of people don't understand the impact that obesity has on our patients.

So, in summary, obesity is a growing epidemic in the United States that does not affect the population equally. It's a chronic disease and we need to think of it and treat it as such. Modest weight loss of 5 to 10% is beneficial. More weight loss provides more benefit. Uh, anti-obesity medications are effective tools at helping people achieve significant weight loss. And even if you can't get the Ferrari medicine, I think to talk about the other medicines and give people the realistic options based on the realities of your practice I think that is actually so beneficial to people. Motivational interviewing and other counseling strategies can help healthcare providers be more effective at addressing weight management with their patients.

Well, that's what we have prepared for you. Happy to answer some questions now. If you have some questions that you put in, feel free to grab your device and let us know if you have questions. I'm going to grab my pad here and see what questions have come in. Those of you at home, feel free to type in your questions, too.

Jamie, guess what the first question is? How are you going to get medicines approved by insurance?

Dr. Almandoz:
I wish I had the answer for that. You know, I think there's kind of a belief amongst patients, or amongst non-specialist providers that if they send patients to us, we'll magically get them covered. It's like saying, well, if I send the patient to you, I'll get this specific insulin covered. That's not how insurance works, and I think helping patients to develop kind of a health literacy where they understand what is covered, what copays are what discount cards and things are available to them is a very important, kind of, skill that can be helpful for patients getting access to the care that they need and managing their expectations so they're not overly frustrated.

Dr. Bessesen:
Great. Thank you. Joanna, here's one for you. How do you handle the patient who does not want to talk about their weight?

Dr. Miragaya:
So, they're probably not ready yet to address. So, usually when I start the conversation, I don't try to focus on weight, but I ask their permission and see if that opens – they're open to listen or to start the conversation. If they're not yet, then I might say that it doesn't look like we're ready at this time. We can talk about this at a later visit. And we try again at another time.

Dr. Bessesen:
Yeah, great. Jamie, how often do you suggest following up with patients who are on anti-obesity medications?

Dr. Almandoz:
I think it all depends on kind of their level of health and where they're at on their journey. So, many of our patients will start off on multiple blood pressure medications. They may be on basal insulin, and they may have things that need to be adjusted as part of that. We want to check in with them for medical management dose titration of anti-obesity medications if they're on a specific agent that needs to be titrated. But also as part of that engagement piece, to be there to troubleshoot with them if they feel something isn't working. What can we change? Because change comes from change, and I think it's important to help guide patients and be that resource for them. Some people think it's about accountability. I like to reframe that, that it's about engagement and partnership to make sure that we're treating the disease together.

Dr. Bessesen:
Yeah. It's – the language is really telling, isn't it? You know, if the language is that patient-centered, it's kind of a buzzword, but on the other hand it's a frame of mind in some ways. I think you're good at this, Jamie.

Joanna most people are motivated to change but struggle with staying determined. Do you have any tips to help people stay determined?

Dr. Miragaya:
So that's a good one. I think that's why it's important to have regular follow up to check on bases. The patient wants to see results, they want to see that things are changing, so they look at numbers, they look at their weight. But when they come to you for follow up, you should look at the health. Is their diabetes improving, is the blood pressure improving, the LDL improving. And to show those numbers to the patients then, more than a weight standpoint, because sometimes they might not see much of a weight change and then that gets them discouraged. So, regular follow up does help you patients stay motivated.

Dr. Bessesen:
Great. It's hard, though. It's a chronic problem, and motivation goes up and down, or energy, energy, energy that the person brings to it. Jamie, how about the people who need an interpreter? Do you find it challenging to work with people who need an interpreter? You may have experience with that where you're from, or maybe you speak Spanish or no?

Dr. Almandoz:
I speak Spanish badly enough to know that the interpreter is not translating accurately. [laugh] So, I think, you know, patient engagement comes from a variety of different ways. I think one of the challenges is maybe not getting the story from the patient, but the other is communicating that empathy that's so important for creating that relationship with your patient. I think there's a lot that can be done through, kind of, nonverbal communication cues that helps the patient to understand that you're working with them and that you're there to help them to treat their obesity and their other complications.

Dr. Bessesen:
Do you think there's some cultural differences with some groups, though, in terms of this whole motivational interviewing approach? Do you find that some groups that it doesn't work so well, or what's your experience with that?

Dr. Almandoz:
We have a very diverse population in Dallas, and I think they're definitely some groups which prefer a more paternalistic style, and I think kind of checking in with your patient looking at their nonverbal cues and asking them what kind of relationship do you want, or what do you want from our relationship together? How do you like advice to be received? It can be very helpful in creating that partnership because you may end up with a patients for sure like, why are you asking me all these open-ended questions? Why don't you just tell me what to do? [laugh]

Dr. Bessesen:
Give me some advice here. Let's be direct. Joanna, do you have experience with that, too? Like, the cultural piece of this. And how do you negotiate that?

Dr. Miragaya:
So, that's actually interesting, because we do see the same conflict with some of the patients. They come and they are asking me what do they need to do. Um, I would say, especially with the Latino community, it's very common to see that in my area, that they actually expect you to come up with a plan for them and they will try their best to adapt to it. So, I try to change that model and say no, we need to sit down and talk together about how we're going to make this work.

Dr. Bessesen:
Yeah, great. Let me see. Jamie, what's the best method to reduce abdominal fat? My patient has a lean body except the belly.

Dr. Almandoz:
Wow, this sounds like something on the magazine cover at the supermarket, right? I think that's very challenging. The same way in which we don't choose where we store fat, the same way we don't choose how and where we lose it. And I think, you know, there are data that suggests that there may be certain bad types of physical activity that will promote visceral or adipose reduction, but I think it's all about creating those healthy, sustainable habits that decrease body weight, and kind of support health in general.

Dr. Bessesen:
Great. Joanna, there's a couple of questions about kids. I don't know if you see kids or if you have thoughts about this.

Dr. Miragaya:
I don't see kids. But.

Dr. Bessesen:
Yeah, well, maybe just add your thoughts here, because I think it relates to others too. One question is, I see adolescent patients for routine visits. We've – we have given them BMI handout at each visit. After this conference, I think I have to ask the people – the patient first - if they want to talk about their weight. What if they say no and yet their BMI is very high, what do you do then?

Dr. Miragaya:
Adolescents are hard, right? So, then it's a hard population just by being teenagers. I think those are the patients that you need to figure out what are the barriers? Why they don't want to talk about that? Is it because they are ashamed of the weight, or what's going on for them to not maybe want to talk about their weight? I think it's important to involve whatever family members close to them into that conversation, if the patient is open for that. And those patients, I think they require way more a multidisciplinary approach than adult populations. So then, those patients are the ones that definitely would benefit from a tertiary center from all the aspects to help achieve their weight loss.

Dr. Bessesen:
Jamie, do you have the – it's that opening question. How do you bring the topic up? What's the first thing that comes out of your mouth? You guys' kind of do obesity medicine, so, what would you general endocrine patients, so. So, do you bring it up as BMI or how do you actually – or do you say, can we talk about your weight? Or Jamie, what do you do you? What's your opening.

Dr. Almandoz:
So, everyone who I see is for weight management, so it's kind of, There will be the rare patient who says I'm not quite sure why I'm here. The sign on our door says Weight Wellness, so, you know, you kind of take that with a grain of salt.

But it's kind of I then explained well, here's what we do and here's what our expertise is. Do you think this would benefit your health? And I kind of focus it more around health, and a discussion about quality of life and health, particularly for people who don't believe that their weight is an issue for them. It's not that I want to kind of take away that belief, but I want to reframe how having a healthier weight may ultimately improve their quality of life for things that they want themselves.

Dr. Bessesen:
Yeah. I – my opening is sometimes diet and physical activity. I'll say something like how do you feel, do you feel like your diet's great? Any challenges with your diet? Anything you've ever thought about changing with your diet or the physical activity? So, it puts the focus on the behavior as opposed to the weight, so that's another strategy.

Here's one. I'll ask you for this one, Jamie, too. Actually, I'll ask both of you. Assuming tirzepatide is approved for obesity, how do you select between tirzepatide and semaglutide for patients who are good candidates?

Dr. Miragaya:
Oh, start first.

Dr. Almandoz:
You bring up a great question. You know, what – what I often kind of ask the patient as we talk about, you know, what kind of weight would you feel comfortable in maintaining long-term? Because what we're doing is we're setting the destination. What is it that we're working towards? And then we talk about all the different routes that we can take to get there. And we ask the patient, well, what do you think would be the best way to get there, and they may throw out some things which may be highly unlikely to help them get there. I'd like to try intermittent fasting again. I watched a Netflix documentary about plant-based diets. Things like that, that we say, well, that might be a healthful option for you, but what's the likelihood it's going to help you to get there? We then talk about the available

therapies and say, well, what is the average, or kind of likelihood of you getting there with the specific therapy. But then we have to talk about the practicality of, let's look and see what's covered by your insurance.

Dr. Bessesen:
Great. Joanna, yeah?

Dr. Miragaya:
Absolutely the same approach. Usually, I go down with all the medication options that I have for the patient, and I describe what's the likelihood of weight loss with each medication, as well as the side effect and insurance coverage. And then we decide on a plan based on that.

Dr. Bessesen:
Yeah. I must say, I too, don't give up on the older therapies because sometimes, you know, if neither of those are covered, you say, well, sorry, nothing. Say, no, there are other options as well. We can see how things evolve over time, but I can help you with other ones. And we talk about the parameters of other medicines as well.

What if a person doesn't tolerate incretin therapies? Jamie, you want to take that one?

Dr. Almandoz:
Yeah. And they're going to be people who don't tolerate. And I think it's important, you know, to understand kind of what's going on with that person, what is not tolerated mean? Typically, it's some kind of gastrointestinal side effect. Is it that the person was started on an appropriate dose? Is it now that they are, for example, feeling very still full from dinner the night before, and now they're not eating breakfast and taking their metformin on an empty stomach? I think this is something we commonly see in kind of a clinical setting. And when we hold the metformin for a while, the GI symptoms get better. So, I think it's understanding what does intolerance mean? Does it mean we can adjust what we're trying to do, knowing that, for example, for our patients with diabetes, there may be cardiovascular or potentially other benefits from being on this therapy beyond weight reduction. So, we can have those conversations. But if not, we try alternate therapies. Like you said, there are other treatments for weight management, and so it's important to kind of look at what else we can give them.

Dr. Bessesen:
Joanna, do you ever treat the side effects? If somebody's got bad nausea or diarrhea, do you ever treat that and keep them on therapy?

Dr. Miragaya:
So, likelihood, no, and short answer is no. So, if I have to keep someone on one of the incretins and then Zofran on a daily basis understanding on a daily basis, I probably wouldn't do that because I don't think that's the right approach for any patient. Any antiemetic medication, I should say, should not be done on a daily basis for any patient because of a side effect. But I think it's important to also address the diet of those patients, right? So then sometimes they are still having foods that are reaching in fat and that's probably causing the nausea as well, or there are other medications, as Jamie has mentioned. But once you get to that point that the incretins is not an option, then you either go back to some of the older medications that we use to use, or maybe it's time to talk about surgery as the option.

Dr. Bessesen:
Great. Jamie, how do we monitor therapy and what's the target of therapy? What's the goal?

Dr. Almandoz:
That's a trick question, you know. So, we talk about, kind of, weight management is about treating obesity, but it's also about treating the complications, and that's kind of where it comes in to asking patients how we're going to monitor our progress off the scale. Is it that it's to do with the functional, kind of, outcomes such as, I'm able to walk or get up off the floor without assistance. And I think, you know, it's easy to say, well, weight is out outcome, and we're seeing people back or having them report, or we have some kind of remote patient monitoring where we are looking at data from a body weight scale. But I think there's so much that goes in to, kind of, patient-reported outcomes and quality of life that's important to incorporate into that. So, I think everyone's going to be different and that's why we can't create this one-size-fits-all, as we call it, approach to treating obesity.

Dr. Bessesen:
Joanna, this somebody asks, weight loss often is visceral adipose tissue. Can you use waist circumference to decide treatment, or their body composition things? Do you use either of those in your practice, or what's the value of that?

Dr. Miragaya:
I use the waist circumference. I think that helps with some of understanding of the visual fat, and again, patients like to see numbers and

measurements. They like the data, so then, I think that helps to address with them their plan and therapeutic options.

Dr. Bessesen:
Great. Well, we're out of time here. Thank you all so much for hanging in here after a long day of learning. I hope you get something useful out of our session tonight. We'll stay up here for a few minutes if you have some questions you want to ask individually. Thank you again, and good luck as you think about helping your colleagues treat the problem of obesity. Goodnight.

Outro:
You have been listening to CME on ReachMD. This activity is Provided by Clinical Care Options, LLC and is supported by an independent educational grant from the Lily Group.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.