Obesity Care: Real-World Tactics to Address Health Inequities

CMEO Podcast Transcript

Monica Peek, MD, MPH, MS, FACP:

Hello, and welcome to a very special BriefCase that is part of a series I am leading on diversity, equity, and inclusivity with CME Outfitters. Today's CMEO BriefCase is titled *Obesity Care: Real World Tactics to Address Health Inequities*. This activity is supported by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Medicine in the section of General Internal Medicine at the University of Chicago. There, I also serve as the Associate Director at the Chicago Center for Diabetes Translation Research. I'm also the Director of Research at the MacLean Center for Clinical Medical Ethics, all, again, at the University of Chicago in Chicago, Illinois. I'm very excited to be joined today by my distinguished colleague, Dr. Ricardo Correa. Ricardo, if you could just introduce yourself for the audience today.

Ricardo Correa, MD, EdD, FACE, FACP:

Thank you so much, Dr. Peek. It's a real pleasure for me to be here. My name is Ricardo Correa. I'm an Associate Professor of Medicine and the Program Director for the Endocrinology, Diabetes, and Metabolism Fellowship, and the Director for Diversity in Graduate Medical Education for the University of Arizona College of Medicine in Phoenix. Also, I work as the Health Equity Director for the fellowship at the Creighton School of Medicine in Phoenix, Arizona.

Monica Peek:

I hear that you've just recently relocated. Do you want to tell us about your new position?

Ricardo Correa:

Yes! I'm in the process of transition, so I will be working as the Endocrine Fellowship Director and the Health Equity Center Director for Endocrine and Metabolism Institute at the Cleveland Clinic in Ohio.

Monica Peek:

Congratulations. That's very exciting.

Ricardo Correa:

Thank you so much.

Monica Peek:

So very honored to have you today. I do a lot of work in diabetes, but it's always great to have a diabetes specialist with us and to talk about our discussion today. So, let's just dive right into our first learning objective, which is to identify the impact of health inequities on obesity care. I want to remind our audience that this CMEO BriefCase is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these important issues, and today's activity continues the discussion in, specifically, obesity care. The titles of the activities in this series are on the slides, and the links are in the images. You can simply click on the images to review any of those programs. If you participate in at least three of the programs in our D&I Hub, you will also be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity, and inclusivity.

So, before we begin to address disparities in obesity care, I want to review some of the foundational points regarding historical racism that remind us all how we got here. We've done previous programs that cover these topics in depth, and those programs can be found in our D&I Hub. I encourage everyone to participate in our foundational programs so that we can learn and do better. We'll start by beginning to talk about systemic inequities, structural inequities, that are due to race, and we call that systemic racism. What that means is the differential access to goods, services, opportunities, and risk. And so, what that means, for example, is that the social determinants of health that we think about a lot, as far as poverty, crime, food security, stable housing, access to educational opportunities – those aren't randomly occurring in society. They are disproportionately burdened by racial and ethnic minorities and the populations and communities in which they live.

Those physical communities are also more likely to be harmed, not only by the social environments, but also by things that are physically built in those neighborhoods and things that are occurring in the natural environment, in the air, the water, the land, that's occurring. So, for example, those communities are more likely to be located next to a landfill or to an industrial complex that is polluting the air and increasing the rates of asthma. We also know that within the healthcare system, there are providers that are more likely to hold implicit biases that we know can impact how they think about, and how they act towards, racial and ethnic minorities. These are manifestations of systemic racism that have indirect effects. So, we know that within the healthcare system, like I was just mentioning, that providers who are affected can deviate from what we call standards of care, which means that they will deliver disproportionate or different kinds of care to racial and ethnic minorities.

We know that the chronic stress of being exposed to racism, of being exposed to poverty, and the things that are accompanying these structural inequities, changes your body. It changes your pathophysiology, it increases your stress levels, and those go on to put people at increased [risk] for chronic diseases. It also increases people's current stress and increases your risk for things like depression, anxiety, PTSD, etc. And we also, then, want to think about the long-term effects of how people are engaging with institutions that have been affected by structural racism, whether or not they are willing to engage in those systems of care if they are healthcare systems, and what, again, this sort of pro-inflammatory state that people's bodies are in. So, racism changes people's bodies such that they are more likely to have diseases, more likely to need healthcare systems. But those systems are built in such a way that they're providing worse care to the very people who need them most, and who then become less likely, or more mistrusting or distrusting of those care systems. And so, we have to think about all of these factors, the sort of larger context for us thinking about any disease where there are racial disparities in care and/or outcomes.

Monica Peek:

And so today, we're going to dive into obesity care, but that's the larger framework in which we're operating. So now, we're going to turn to the patient case that we're going to be discussing today. Ricardo, if you can talk about the patient case, and the patient's name is Maria, and if you can tell us about her.

Ricardo Correa:

Yeah, thank you so much. So now we are going to dig into this case so we can put into perspective what Dr. Peek mentioned before, about all of the structural racism, all the influences that all social determinants of health has on the health of a patient. So, our case is Maria, her pronouns are she/her/hers. She's a 52-year-old female of Mexican descent. Her BMI is 34.5. She has a family history of cardiovascular disease and hypercholesterolemia. Her last appointment was two years ago, and at that time, she was diagnosed with type 2 diabetes. Her A1C at that time was 7.3, and her fasting blood glucose was 137. She was prescribed with metformin, 500 milligrams twice a day, and she was advised via the clinician for lifestyle modification.

As per what Maria mentioned, the clinician mentioned that she really needed to focus on her weight and improve her diet and exercise habits. Then, she lost to follow up. She felt at that time that she was judged for her weight, and that's why she didn't return. She stated that the receptionist was rude with her because of her accent and appearance. And when the lady at the front desk rolled her eyes at her, she didn't want to [return] because she felt unwanted.

Maria took the metformin as prescribed for one year and tolerated it well, but she was unable to refill without a follow-up appointment. So, she has been unmedicated for the last year. She decided to try a new clinician who restarted the metformin and counseled her to modify diet and increase her exercise. The clinician implores Maria to be adherent to her medication and behavioral modification. This clinician mentioned, “losing weight requires a lot of willpower, and it will be up to you to stay on track and keep yourself motivated.” A follow-up appointment was scheduled for three months later.

Monica Peek:

So, thank you for setting up this case, Ricardo. There is a lot of stuff packed in there. And so, before we continue, I have an audience question. That question is: How familiar are you with health inequities in obesity care?

Okay. So Ricardo, what can you tell us about obesity-related stigma and disparities?

Ricardo Correa:

Yes. So, as you mentioned, this case has a lot of components of what we call obesity stigma in what the healthcare system and the healthcare providers are doing to the patients. So, we need to know that obesity is one of the most often disease that receives stigmatization. We see this not only in the healthcare system, but outside the healthcare system. If we look at what is the standard model for the society, what you see on TV, what you see on banners when you're in the street, are people that are thin. So, this causes an unconscious, and sometimes conscious, bias of what society should look like. We know that judgment of appearance is very common outside and inside the healthcare system, and we know that clinicians tend to spend less time on patients that suffer from obesity or overweight because of how they look.

It's very important to understand that many times, these clinicians feel that all of the diseases that a patient is complaining of are blamed to the obesity, and this is what they tell the patient. There is an unconscious, as I mentioned, bias and a stigma in education, so we know that the way that we teach medical students and other trainees definitely has some burden on this bias that have been established. And there is a stigma in social media. We talk about some banners on TV news, but also in the social media, of what a "normal-considering" person should look like. Obesity disproportionately affects community of colors. We know that for multiple components, and we are going to talk a little bit about that - climate change, climate justice, social determinant of health, all of these affect communities that are more underserved than the communities that are not underserved.

Weight and race and ethnicity create conscious and unconscious bias. This is what we have been mentioned. So, people that are obese and are from underrepresented minorities are double or triple times more discriminated, and this is an intersectionality of weight and race/ethnicity where these people suffer the most. So, this is very important to have into account whenever we see a patient and we realize that it's not just a physical problem, but it's all the components that this problem bring into the table when we are seeing this patient in the clinic.

Monica Peek:

That is so important. And one of the things I think was interesting about this case is that her first experience of stigma was not with the provider. It was with the person at the front desk, rolling her eyes and already making her feel less than welcome and less than fully human. We have talked about that in this program a number of times, that people's patient experience begins as soon as they step foot on the campus, as soon as they're in the parking garage, way before they get to see the healthcare provider. And so, we may think that it's all about them seeing us, but they have stacked experiences way before they get to see us. Everybody on the team has to be on board in engaging patients in their full humanity. Understanding how someone's lived experience has created the circumstance for them to be manifesting the kinds of diseases that they have, including obesity, and being sensitive to those things.

Ricardo Correa:

Yeah, and just want to add a little bit. It's also the environment where they arrive. So, if you arrive to a waiting room where all the chairs are standard and they don't have a bigger chair, then you feel already insulted or that they are not taking you into account. If you enter and the weight that you have is a weight that is for certain amount of people and not for a little bit bigger people, then also that is. So, it's besides the interaction with the different components of the healthcare system. It's also how the environment where you arrive to a clinic looks like.

So, just going back again to the patient. So, three months later, she has a follow-up with you and the A1C is now 7.1, so it went down from 7.3. Her fasting glucose moved now to 104, coming down from 137. She gained eight pounds since her last visit. What she mentioned was that it is hard for her to exercise due to her work schedule. Plus also, the neighborhood is not so safe, and it's always hot outside, so she cannot walk around outside.

Monica Peek:

Okay, so this is a great point to stop and ask a few questions. So, we're going to go back and, actually, since we've discussed a bit of this, ask one of the questions that we asked initially before we started the clinical case, which is how familiar people are with health inequities and obesity care, so we're going to ask that again.

And then we're going to ask a second question for our audience, which is how often do you consider social determinants of health when developing individual treatment plans for obesity?

All right. So Ricardo, can you tell us about some of the clinical interventions for obesity and the impact of social determinants of health before we go back to our case?

Ricardo Correa:

Yes. So, the clinical intervention of obesity has been divided into three main areas. One is lifestyle modifications, and that includes diet and physical activity. The second one is medical treatment, where there is some medication that has been approved by the FDA for the management of obesity. And the third area is surgical treatment, that there's certain surgical procedures that has been done for the management of obesity. But as you are aware, this is very important, because sometimes, one focus in one area and the other, and not too much in the other. For example, we always think that the first thing that we have to tell the patient is, "Oh, you have to modify your lifestyle modifications," and then we focus on that. And probably, we don't do culturally appropriate lifestyle modification instructions so the patient will not do it, and then we do not progress to the next step that can be medical or surgical. And then the patient gets all the consequences of obesity complications. We need to be very aware that this is not a step-by-step process. Sometimes, we need to be using one mechanism instead of the other.

Ricardo Correa:

Here, also, in that appointment, it's sitting down with the patient and understanding what are the social determinants of health of the patient. For example, in this case, Maria has limited access to physical activity outside home. There is a climate justice problem. Outside is hot, also is not a secure zone. So, we need to understand that so we can provide another option for her so she can address this issue. Also, she lives probably, you mentioned this, in an urban area with a lot of industrialized activities, where the decrease of fresh produce happen. So we need to understand the community and say, "Okay, you live in a food desert. How can we bring some fresh produce to you or some healthy products to you?" If there's a fresh market near, what is the cost? All of that we need to understand when we address these kinds of interventions.

Also, the population where she is surrounded, because there's some unconscious bias in the population. For example, assuming that she's obese because she's lazy, she doesn't try enough, lack of willpower, and this includes family. And if we focus on Maria, Maria is from Latin descent, so this means that usually family will be very involved in all the decisions that she's making. And if family thinks that, for example, there is lack of willpower and that's why she's obese, she will be affected for that. So, in our clinical intervention, we need to take into account everything and, sometimes, for the Latinx community specifically, bring the family to the appointment so they can understand what the patient is going to go, what is the treatment, and what is the next steps for that.

Monica Peek:

One of the things I was just going to mention is that I appreciate how you are not only bringing in the social determinants of health as we normally think about them, but climate change. And a lot of people haven't necessarily linked climate change and climate justice to health disparities. We've been hearing more and more about how there are these literal hot spots in urban areas where, because of the increased amount of just concrete and lack of trees, that it's dangerously hot and so it is harmful for the city, particularly harmful for the residents. And of course, these are areas where it's more likely to have racial and ethnic minorities living in those areas. It's part of city planning to sort think about planting more trees, etc. But because of that, people are having to stay more indoors during the summertime because it's harmful for their health. I'm adding that as an extra component, of thinking about another environmental contributor to obesity I think is really important.

Ricardo Correa:

So this just is a perfect transition to our next slide: Climate Change and Obesity. We know that when there is problem in the environment, when there is high contaminant or when there is endocrine disruptors, chemicals, they affect the adipocyte, the cells that keeps the fatty tissue. And that affection include that it's more difficult to kill them than before. So when we put climate justice, it's very important to understand that it's not just affecting many people's focus on other chronic condition like asthma or lung disease, but also affecting conditions like diabetes, or obesity in this case. So we are trying to make a point that climate is part of the social determinant of health. At the level of the American Medical Association, there's a big movement on determining that climate is really part of the social determinant of health. Some resolution has passed, and we are moving in that direction because there are events that happen in certain communities due to climate change that affect their chronic conditions and that can predispose these communities to have more dangerous chronic conditions.

Ricardo Correa:

And we understand that these patients are the ones that usually live in urban areas, industrialized areas, that are most likely underserved communities. When we look about what happened to the agriculture, food, and all of this, there's an impact directly in obesity. Patients have less access to fresh produce, as Maria mentioned in her statement. They are a lot of high-concentrated carbs diet because this is what they only have access to, and corn syrup being one of the most used, so they're very, very important. And also, patients decrease their activity just because they cannot go out. Some of the farm workers need to move to other zones because there is dying of the farms because of the climate. So, all of this we need to put into perspective, not just focusing on the common social determinants of health that we know, but also adding this part of the climate justice.

Monica Peek:

Absolutely. Thank you so much, Ricardo. I actually want to talk a little bit about some of the limitations or shortfalls of the clinical education of providers on the disease of obesity. When we talk about health education, we're mainly thinking about patients, but we haven't really done enough to adequately provide sufficient and comprehensive education for clinical providers, particularly in the ways that there is a dysregulation of appetite and the processes that stimulate weight gain. There is a shortage of clinicians who are really trained in the comprehensive approach to managing the disease of obesity, including the use of appropriate medications. And so, while we all know and think about lifestyle and exercise, there really is a smaller subset of us who can manage the medications. And the amount of science that has gone into understanding how obesity works has exponentially grown since I've graduated from medical school.

Our understanding of the pathophysiology of obesity is so much more than we knew when I was coming up. And so, this sort of subpar obesity training that we either received, or that is still being taught in medical education, is really a limitation because we're on the front lines of treating obesity, and also because obesity is a main driver for so many of the chronic diseases. I'm an internist, so I treat most of the chronic diseases. It's a significant issue, and particularly because obesity, overweight, and chronic diseases disproportionately impacts racial and ethnic minorities, underserved populations. And some studies have shown that nearly 80% of the prevalence can be seen for some of these conditions in Black women, and obviously correlate with obesity. So, treating the disease of obesity can obviously address some of these other underlying conditions.

I think now would be a good time to revisit – we always do an audience response question one time and then we do it again. So we're going to now ask one of our questions again about addressing the social determinants of health when developing individual treatment plans for obesity. So now, thinking about your practice going forward, how often will you, audience members, consider social determinants of health when developing individual treatment plans for obesity?

Okay. So Ricardo, I'm going to hand it back over to you for you to tell us what happens next with Maria.

Ricardo Correa:

Yes. So in the same three-month follow-up, Maria expresses some frustration due to low self-esteem. And this is very common if we are in a healthcare system that is not supporting our patient. Right now, the one component that is the physiological part of the obesity is also affecting the other component that is the mental health. So she mentioned that she feels like a failure. She almost didn't come to this appointment because she was ashamed about her lack of willpower. Also, she mentioned that she wants to improve lifestyle choices, but she didn't know where to start and she felt overwhelmed by all of it. And also, she mentioned that there is a lot of information out there about different diets and exercise and that she doesn't know what is right, and sometimes they contradict one and another.

Monica Peek:

Yes, so we're at a challenging juncture with our patient. So, let me ask our audience: What would be the most effective action to take working with a patient with obesity who's experiencing feelings of shame or low self-esteem?

So Ricardo, in the disease of obesity, empathy and support are particularly important. And you talked about this a bit earlier, but can you talk a little bit more about why?

Ricardo Correa:

Yeah, so very important to understand. Remember that when we talk about chronic condition, it affects multiple areas in our body. Not just the physiological part, but also the other components, in this case, mental health. So, starting on empathy and establishing empathy with your patients, and make it culturally sensitive without language barrier, that conversation will help a lot the patient in understanding their disease and understanding where do you want to take the patient later on and preventing the complication. In this case, the example is obesity. So, we know that patients try to lose weight and then they have a lifestyle modification including some of the intervention that we talk. But we don't know the rest of the components and how to achieve that goal, and that's why it's very important in every one of us that treats obesity is understanding the community where the patient is coming, and what support they can find in the community and what support we can provide from the healthcare system.

This will prevent low self-esteem, depression. They will prevent anxiety. And definitely, all of this will prevent the discouragement of the patient, when they have obesity as a disease, that they don't want to continue their own treatments. So it is very important not only addressing the physiological part, going back again to the same, but also addressing all the social and mental health components of this disease.

Monica Peek:

How do we overcome stigma with our patients who have obesity?

Ricardo Correa:

Yes. So, there are multiple levels that we can overcome the weight stigma that patients that suffer from obesity can have. One of them is, we know that stress, and constant stress, and stress caused by structural racism, cost of living, behavioral activities ... We know that binge eating is one of the components of this toxic stress that is happening in the patient, and then just translated to gain more weight. This is like a cycle. So if we don't address the stress that is happening in the patient, the patient will get more stressed. More stress translates to more binge eating, binge eating into more weight gain, so we will never stop the cycle.

The other is the physiological reactivity. For example, we know that stress also have an internal component, raising cortisol into supraphysiologic levels that can cause, also, increase in adipose tissue, increase in glycemic problems. So all of that, gaining more weight, and then making this vicious cycle. We have to address this stress in the patient that comes, and addressing this stress is addressing the psychological health distress. So we address the mental health problems that the patient have, depression, anxiety, we address that. That's why it's very important to have a multidisciplinary team when the patient comes. We call it a one-stop shop. So where they come, they see the clinician, but also they see the mental health provider, they see the nutritionist, they see the physical therapist.

If you are allowed to have that, that's a very good approach. If not, well, you can find some resources in the community. For example, working in a community center where we start some physical activity programs. We have a consultant that is a mental health consultant that comes once a month, and then we put all of our patients in that track so they at least can see them and they can see the physical therapist and occupational therapist sometimes in a month. The very important thing in all of this is understanding the community. Back again to the same concept, because the community can provide a lot of resources. Some communities have YMCA that are very active and they can use that. Other communities have other resources. Other communities have fresh market that can collaborate with you.

And one of the things that we figured out in one of our communities in Phoenix was the same issue as Maria. A lot of difficulties in physical activities, a lot of difficulties because of the zone where she lives. So we start a program where in the community center on Friday nights, we have a physical therapist that comes and do some Zumba classes. So with that, at least it's an activity that the community didn't have in the past, and we are using the community center to help the community. So, things like that will decrease some of the stress that is partially imposed by society, partially imposed by environment, by multiple other components. But we are trying to break that by helping them in their own needs. This is a way of overcoming weight stigma. Patients get more interested. Patients know that you are helping them. And then definitely, patients will break that cycle that is caused by this toxic stress, all the components, and then more weight gain, and then more obesity and complications of it.

Monica Peek:

Excellent. Yes, yes. Breaking the vicious cycle is super important.

We're going to come back to that audience response question. And so now, what would you say, audience members, is the most effective action for a clinician to take when working with a patient with obesity who's experiencing feelings of shame or low self-esteem?

All right, so now we're going to move on to our second learning objective, and that's how to individualize a holistic treatment plan for obesity to improve patient outcomes. So Ricardo, what's next for Maria?

Ricardo Correa:

Yes, so the next step is the shared decision making. Maria received dedicated counseling on treatment options, including lifestyle intervention that is exercise and nutrition. She is offered a referral to a Registered Dietician. Also, she had some discussion of medications. Remember, she's a patient that also suffers from diabetes, so there were some options of medication that can treat both the diabetes and the obesity, like GLP-1 agonist. She also was offered some other medication, SGLT2 inhibitors, insulin and that. And also, in doing that visit, she was offered for bariatric surgery as a secondary option in her case.

Monica Peek:

Okay. And I think it's really important because a lot of people are struggling. We know that insulin can cause weight gain, but we need to sort of make sure that their diabetes is controlled as a primary focus of reducing diabetes complications. Yet at the same time, we need to think about weight reduction because we know that also weight, in and of itself, is driving some of the diabetes for people who have type 2 disease. And so, having these additional medications that can both treat the diabetes and infer some weight loss is great if they can be effective for people who don't require insulin.

So, our last audience response question is based on the 2022 ADA guidelines on pharmacologic treatment of hyperglycemia and type 2 diabetes. Which of the following is preferred for patients like Maria who need to minimize weight gain or achieve weight loss?

All right. So Ricardo, can you tell us a little bit about the ADA guidance around these medications?

Ricardo Correa:

Yeah, so definitely. There's two components here that I want to mention. One is what the guidelines will recommend what is the best treatment, but also, is the best treatment need to be applied to our patient. Many of our patients will not be able to afford some of this medication because they're so expensive. And even though they are so helpful in preventing complications, and decreasing also obesity, some of them are very expensive for the patients. So, if we look at the ADA guidance for the management of hyperglycemia, we can see that there is some medications that they classify in the group that minimize hypoglycemia, and these include the DPP-4, the GLP-1s, the SGLT2s, and the thiazolidinediones. They make a clarification where sulfonylureas, the ones that we use because, of course, the health equity issue, our basal insulin ... They are considered agents that can increase the risk of hypoglycemia.

And definitely, if A1C is above target, we have to incorporate additional agents. So the way of start management of this patient is based if the patient was on metformin already. Even metformin is not any more classification than first line therapy, but for many of our patients that we see with this part, metformin will continue to be the first line therapy because it's a medication that is not so expensive. Then, we can start adding more medications. The recommendation is try not to add sulfonylureas because of the risk of hypoglycemia. In many cases, this is not completely a reality because then if we look at the comparing sulfonylureas with the others, we will see that the next best option, economically, will be sulfonylureas. An option that we don't think a lot, but it's very important to add that it's also not a high price medication, is thiazolidinediones, so try to think on that, also. That's the three drugs that we try to use in patients with low socioeconomic status that cannot afford some of the others, or underinsured/uninsured patients.

So if we want to think about the weight gain and the diabetes, definitely our best option will be the GLP-1 agonist, and the second option will be SGLT2s. The big issue that we have with these two medications is the cost. But if the patient have the ability to afford, or sometimes the clinics have the ability to provide these kind of medications, then that will be an option in a patient that suffers from diabetes and also suffering from obesity. And the third part, I think, that it's important from the guideline from the ADA that they add the cost and access to this medication. And if we look, the three drugs that we can afford more, the patient can afford more, will be thiazolidinediones, metformin, and sulfonylureas. So this is the algorithm that they put.

What I think that many of the times is conversation with the patients, some patients can find ... So if you have a social worker that can deal, sometimes there is things that you can find that can help the patient, some resources that can help the patient. Recently, I know, for example, for patients that need insulin, some of this insulin can be very expensive, but there is an organization called Type 1 and Type 2 Diabetes Beyond, that they provide insulin to the patient for a small amount of price for two years. So, trying to find in your community places or organizations that can help will help a lot of these patients manage their diabetes, and their obesity on top of this.

Monica Peek:

Excellent. So the ADA does actually mention cost and access, and these are really important considerations. In addition to thinking about how the medications work within the body, we have to also think about, can our patients afford them? Do they have access to them? Because some of these are new, and the price point hasn't made them ones that are fully accessible to patients in our communities, so your points are very well taken. These issues can influence whether or not our patients can get the medications. We may need to think about do we need to work to provide additional assistance having our patients access these medications? Because many companies will have special coupons and programs and patient assistance, other mechanisms for them to get them.

But we do know that inequities also exist for not just medications but for bariatric surgery, and so there are just a number of ... just always barriers. We have to keep in mind, because of cost, that there will be additional barriers for patients who sometimes need it the most.

Here is our follow up question for our last audience response question. So we'll ask again: According to the 2022 ADA guidance on pharmacologic treatment of hyperglycemia and type 2 diabetes, which of the following is preferred for patients, like Maria, who need to minimize weight gain or achieve weight loss?

So, of course, in any intervention and weight management, compassionate counseling is very important, and the six A's help us provide a helpful way for us to think about this. Those A's are to Ask, Assess, Advise, Agree, Assist, and Arrange. This is a slide that I want everyone to just take a photo of with their camera because this is something that we can do every day in our practice with a number of different kinds of diseases that we're thinking about, just that idea of Ask, Assess, Advise, Agree, Assist, and Arrange. But it's particularly helpful for weight management counseling. And so it's sort of an evidence-based approach that we can use for our patients. This is one of our key takeaways that I'd like for people to think about. Ricardo, do you have any additional resources that you would recommend?

Ricardo Correa:

Yes! So this slide, you can see a very good resource called Weight Can't Wait: A Guide for the Management of Obesity in the Primary Care Setting. You can see here all the list of all the major organizations that have endorsed this resource. It is a lot, so it's a very good resource. Very useful, very easy and friendly, that you can use in your clinic with your patients, so I highly recommend this.

So just finishing our case, because let's put a "What happened?" with Maria. So, on a six-month follow-up, Maria lost 19 pounds with the support of a multidisciplinary team: the nutritionist, the physical therapist, the clinicians, the mental health. She was able to make lifestyle modifications, and also, she benefitted from management of her diabetes in addition of the GLP-1 receptor agonist. And she controlled the two things, the diabetes and the weight loss, so we were able to find a good program for her with GLP-1 agonist, and she was able to obtain it.

Monica Peek:

Great! So happy ending! Thank you so much, Ricardo, for a wonderful exchange today. Thank you so much just for all your insight, your knowledge, and your emotional intelligence that you shared with us.

Before we sign off, I'd like to provide our audience with five SMART goals, and SMART stands for specific, measurable, attainable, relevant, and timely goals. First, emphasize to patients that obesity is a disease. It is not a behavioral character flaw. Second, educate patients about the role of medications and surgical interventions in a personalized way. Third, partner with patients in assisting them to find strategies that can help them with behavioral, mindset, and counseling goals. Fourth, recognize that patients may be adherent and still not lose weight. Adjust strategies according to possible biopsychosocial barriers. Acknowledge the complexity of contributing factors to an individual's health, including epigenetics, psychosocial, environment, etc.

And as a reminder, here's just some of the topics that we've covered so far, and we will be adding new content every month. We really want to hear from you, our audience, on what you need so we can make an impact on these important issues. Please email us at questions@cmeoutfitters.com with your comments and feedback. We really assure you that we read every email, and we really appreciate your feedback.

Don't forget the CME Outfitters also has a diversity and inclusion hub with a number of excellent resources to share with you and your patients.

And then last, don't forget to complete the post-test evaluation so that you can receive either CME or CE credit for today's activity. Thank you again, Dr. Correa, for joining us today, and thank you for our audience for participating. Please be safe and take care of yourselves so that you can provide the best care possible for your patients.

