Obesity Screening and Assessing Patient Readiness for Weight Loss

General Recommendations

A body mass index (BMI) above 25 is considered overweight and a BMI above 30 is considered obese. In addition, obesity can be further divided into three classes or extreme obesity in individuals with a BMI above 40 (see body mass index table). Most electronic medical records routinely calculate and display BMI for providers. Many patients are either unaware of what their BMI is or how it affects their health.

The US Preventive Services Task Force (USPSTF) updated its clinical guideline regarding the screening and management of obesity in adults (Grade B) (1). They not only recommend screening all adults for obesity, they also suggest that clinicians should offer treatment or referral of patients with a body mass index (BMI) of 30 kg/m² or greater to intensive, multicomponent behavioral interventions. The USPSTF suggest a team approach for all practitioners.

Multiple behavioral management activities may include (1):

(1) Group sessions
(2) Individual sessions
(3) Setting weight-loss goals
(4) Improving diet or nutrition
(5) Physical activity sessions
(6) Addressing barriers to change
(7) Active use of self-monitoring and
Strategizing on how to maintain lifestyle changes.

The American College of Obstetricians and Gynecologists (ACOG) also recommends that routine medical examinations include an assessment of the patient’s weight and BMI and that physicians consider a team approach to overweight and obesity management. Referral for further evaluation and treatment is indicated if the management team does not have the appropriate resources to meet the patient’s needs, the patient has a BMI of 40 kg/m² or greater, the patient has a BMI of 35 kg/m² or greater with comorbid medical conditions, or the prior appropriate treatments have been unsuccessful (2, 3).

Role of the Obstetricians-Gynecologists

In their Committee Opinion on “Challenges for the Overweight or Obese Woman”, ACOG provides several recommendations for how Obstetrician-Gynecologists can be engaged in promoting healthy lifestyles such as discussing healthy lifestyle behaviors at each visit, advocating for sponsorship of a free exercise or wellness program at their hospital/medical organization, partnering with the hospital’s community liaison office to advocate for safe accessible outdoor recreational areas, and encouraging patients to shop at farmers markets (4).

Surveys of ACOG members reveal that 37% of their nonpregnant patients with private health insurance rely on them for routine primary care. 54.7% of ACOG physicians counsel their patients most of the time about appropriate physical activity; 75.8% counsel their patients about weight control most of the time or often, and 52.9% referred obese patients to a behavior modification or therapy program for weight management at least sometimes (5, 6).

Given the USPSTF recommendations and information on clinical practices, the obstetrician-
gynecologist has a responsibility to identify and treat obesity in their daily practice. Many studies show that health care professionals can play a pivotal role in motivating patients to adjust their behaviors and to lose weight.

**Preconception Care**

Entering a pregnancy with an elevated BMI increases the risk for gestational diabetes, hypertensive diseases, stillbirth, macrosomia, and cesarean delivery. In addition, the fetus is at higher risk for birth defects and childhood and adult obesity (7). ACOG fellows should engage patients in a weight loss plan that recognizes the importance of the risk of obesity in pregnancy or should refer to providers who will support and treat the patient before pregnancy. Data support that pharmacotherapy and bariatric surgery are safe prior to conception. However, medications for weight loss are not recommended during pregnancy. Pregnancies that occur after bariatric surgery require a more intense evaluation of nutritional status.

**Successful Screening and Management of Obesity**

At least three factors are necessary for successful treatment of overweight and obesity, regardless of provider subspecialty (8):

(1) Recognition of obesity as a medical problem

(2) Willingness to provide counseling and

(3) Adequate skills and resources to do so.

Although many health care professionals recognize the obligation to treat overweight and obesity, surveys show that this is not routine largely because many do not feel qualified to treat
overweight and obese patients in their own practices (8-11). Reasons for avoidance include (11-22):

1. Inadequate training to knowledgably discuss weight and healthy behaviors
2. Discomfort in discussing sensitive issues
3. Lack of time in routine annual exams
4. Lack of compensation for preventative services
5. Lack of access to guidelines
6. Perceived inability to change patient behavior
7. Negative attitudes towards obese patients
8. Lack of access to appropriate support services
9. Disbelief in the importance of preventive counseling
10. Perceived lack of patient concern and
11. Provider’s conflicted feelings about their own body weight and image.

We recommend that this discussion be considered the most important “teachable moment”, a naturally occurring health event or circumstance that leads individuals to make health behavior changes (23). Patients successful at losing weight reported that the initiating event was either an explicit warning from a doctor or the discovery of a risk factor during a provider’s routine screening (24). Physician advice can influence a patient’s self-efficacy, weight loss efforts, and their motivation (6, 25). National Institute of Health (NIH) guidelines highlight the importance of the provider in a multidisciplinary team for the assessment, treatment, and follow-up during weight-loss efforts (26). If providers do not feel comfortable discussing obesity with their patients or lack the knowledge to do so, the downside is that an inconsistent message may be
given either by ignoring the issue or providing incorrect information.

In order to screen for overweight or obesity, BMI (weight in pounds multiplied by 703, divided by the patient’s height in inches squared) should be calculated. Several charts, wheels, online calculators, and electronic medical record systems are available that easily calculate BMI. A patient’s waist circumference, measured at the iliac crest parallel to the ground, may be more predictive of risk than peripheral fat and is very helpful in screening for obesity. Based on BMI, waist circumference, risk factors, and readiness to lose weight, the patient should be offered intervention or should be referred for further treatment including nutrition and physical activity advice (lifestyle therapy), intensive programs, pharmacotherapy, and/or or weight loss surgery. (See Algorithm)

The practice of motivational interviewing is emerging as an effective and efficient catalyst for behavior change (27). This approach encourages patient participation through active exploration of uncertainties and listening. In the end, the goal is to allow the patient to choose a healthy path. Many studies have demonstrated that motivational interviewing prepares patients to be more ready for weight loss. Techniques surrounding this type of interviewing can be learned through didactics or videos.

If a patient is not ready to begin weight loss treatments, education on the risks of obesity should be provided and the topic discussed at the next visit. Discussing obesity prevention with patients with a healthy BMI is appropriate.
References


