

011. Results of Intensive Weight Loss Program (IWLP) (non-surgical) in a primary care office. Comparison of IWLP and CDC Diabetes Prevention Program (CDC DPP)

Friday, October 26, 2018

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Purpose

Patients and Primary Care Physicians (PCP) face difficulties in knowledge, motivation, expectation, appropriate setting, and affordability of services for a user-friendly effective weight loss and maintenance program in a primary care office. The key concepts of weight management such as behavioral, nutritional, physical activity and pharmaceutical interventions requires resources which is challenging for the primary care office. It is well established that ten percent weight loss helps in reduction of cardiovascular risk. Health insurance coverage for nonsurgical obesity care is inadequate nationwide. Individuals in CDC-DPP program is a national program was able to achieve only 5% weight loss in 35 percent of participants. Our poster provides data from an individualized Intensive Weight Loss Program (IWLP) to incorporate behavioral, nutritional, physical activity and pharmaceutical interventions to achieve weight loss in a user friendly, medically safe environment in an employer based primary care clinic with one provider and two support staffs in Ohio. Biometrics and labs values and CVD risk were calculated and shows improvement in all parameters with weight loss and maintenance.

Methods

Patients were selected who were willing to participate in weight loss program and have BMI>30 or BMI>27 with comorbid conditions such as hypertension, diabetes, prediabetes, hyperlipidemia, sleep apnea, GERD and arthritis. Patients were not eligible to participate who had BMI< 25, was pregnant or actively trying to get pregnant, and patients with active cardiac diseases, major surgeries, gout, or cancer, psychiatric issues not controlled by treatment, current use of illegal drugs and history of dependence on alcohol, narcotics and controlled substance.

Behavioral components of IWLP include daily body weight check and changing eating habits to 3 meals a day with an adequate amount of water. Nutritional components include either a low-calorie diet (<1200 calorie/day) or reducing carbohydrates to 60 gram/day and adding an adequate amount of protein (30 gram three times/day). Physical activity goal was 150 minutes per week (30 minutes/day for 5 days) or doubling up the daily step count from the baseline. Pharmacological components include multivitamins, Vitamin D and Fish Oil. Metformin, Phentermine (3 months only in Ohio) and Topiramate were used in selected patients with insulin resistance, binge eating and eating disorder respectively.

The initial goal of IWLP was a 5% to 10% body weight loss in 3 to 6 months and to maintain the lost weight. Participants were required to see the physician monthly, starting with an initial H & P and coaching. They were offered an optional

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weekly or biweekly visit with the nurse for weight and vitals check for 3 months After finishing the 12-week program, further goals and appointments were individualized according to patient's need. Patients were advised to keep their daily weight, exercise and food intake logs.

Results

Weight loss data from 78 adults (51 female, 27 male, 23 to 63 YO) in a 7 to 92-week period (Average participation 41 weeks) is presented. Body weights presented here are initial, lowest and nal body weight with corresponding weeks in each individual participant.

"High risk group patients" (Male#18 Female#38 Total 56) were classified by using following criteria; Waist circumference, BMI, HDL, HbA1c. and Triglyceride (At least 3 out of 5 criteria).

Maximum weight loss ranged from 7.2 to 130 pounds with average weight loss 30.3 pounds, corresponding to 4.6% to 35.7% weight loss with average 12.5% weight loss. Final weight loss ranged from 1.6 to 130.4 pounds with average weight loss 24 pounds, corresponding to 0.9% to 35.7% weight loss with average 9.8% weight loss. Our data shows that 43% of participants lost more than 9.9% of body weight and maintained. 83% of participants lost more than 4.9% of body weight and maintained. 17% of participants lost less than 4.9%. None of the patients regained all the lost weight. Average waist circumference, HbA1c, Total cholesterol, TG, LDL were reduced, and HDL were elevated with weight loss. "High risk group" showed similar changes with weight loss. Average Framingham scores were reduced (7.7 to 4.8) =38% and (1.8 to 1.5) =17% in male and female group respectively. Average ACC-AHA scores were reduced (11.4 to 8.6) =24.6% and (4.2-3.4) =18% in male and female respectively. "High risk group" lost average 30.9 pounds (10.6%) in male and 32 pounds (13.5%) in female groups. Average Framingham scores were reduced (7.88-5.85) =25.8% and (1.6 to 1.41) =11.9% in male and female group respectively. Average ACC-AHA scores were reduced (11.72-11.37) =2.9% and (4.27-3.58) =16.1% in male and female respectively.

IWLP were compared with CDC DPP as follows: Average weeks 41 vs. 208, number adults 78 vs 14,474, # of visits 1 visit/30 days vs. 1 visit/12 days, # of participants achieved >4.9% weight loss 83% in IWLP vs. 35.5% in CDC DPP. Average weight loss was 9.8% in IWLP vs 4.2% in CDC DPP.

Conclusions

This poster demonstrates that a primary care physician with current knowledge in obesity management using Obesity algorithm Obesity Medicine Association should be ready to offer individualized cost-effective program for weight management with minimal support staff and equipment. There was improvement in biometrics (Body weight, BMI, Waist circumference); labs values (HbA1c, Total cholesterol, Triglycerides, HDL, and LDL), Framingham score and ACC-AHA risk scores, thus in overall health and wellness.