



## **Introduction to Magellan's Adopted Clinical Practice Guidelines for the Treatment of Patients with Obesity**

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## Purpose of this Document

This document is an introduction to Magellan Health Services' (Magellan) adopted clinical practice guideline (CPG) for the treatment of patients with obesity. As with all CPGs, this adopted guideline and this Introduction are intended to augment, not replace, sound clinical judgment. As a matter of good practice, clinically sound exceptions to this practice guideline should be noted in the member's treatment record, documenting the clinical reasoning used in making the exception. Magellan periodically requests clinical files from providers in order to monitor compliance with adopted guidelines. Clear documentation of the rationale for exceptions to the guideline's recommendations should be present in the member's treatment record whenever there is evidence of deviation from the guideline.

Additionally, this guideline does not supersede Food and Drug Administration (FDA) determinations or other actions regarding withdrawal or approval of specific medications or devices, and their uses. It is the responsibility of the treating clinician to remain current on medication/device alerts and warnings that are issued by the FDA and other regulatory and professional bodies, and to incorporate such information in his or her treatment decisions.

## Introduction

The guideline Magellan has adopted to augment providers' clinical decision-making with members with obesity is the ***Position of the American Dietetic Association: Weight Management (2009)***.<sup>1</sup> The position paper published by the American Dietetic Association (ADA) also is endorsed by the American College of Sports Medicine. The following ADA position statement provides the foundation for their recommendations:

Successful weight management to improve overall health for adults requires a lifelong commitment to healthful lifestyle and behaviors emphasizing sustainable and enjoyable eating practices and daily physical activity.<sup>1</sup>

The ADA position presents a framework for the assessment of obesity, principals on the regulation of food intake and goals/recommendations for weight management. It also incorporates current evidence-based information on the following:<sup>1</sup>

- physical activity
- dieting
- behavioral interventions
- pharmacotherapy
- surgery
- developments in weight maintenance.

For additional detailed information on the perioperative management of patients undergoing bariatric surgery, Magellan encourages you to refer to the ***Medical Guidelines for the Clinical***

***Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient. (2008)*** developed by the American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic and Bariatric Surgery (AACE/TOS/ASMBS).<sup>2</sup> Clinicians who perform pre-operative mental health evaluations may wish to consult specific articles cited in the AACE/TOS/ASMBS guidelines that provide recommendations regarding the structure and content of these assessments as follows: (1) Behavioral Assessment of Candidates for Bariatric Surgery: A Patient-Oriented Approach by Thomas A. Wadden and David B. Sarwer in *Obesity*, Volume 14, Supplement March 2006<sup>3</sup> and (2) The Boston Interview for Gastric Bypass: Determining the Psychological Suitability of Surgical Candidates by Stephanie Sogg, PhD and DeAnna L. Mori, PhD in *Obesity Surgery*. 2004; 14: 370-380.<sup>4</sup> Since publication of the AACE/TOS/ASMBS guidelines, The Boston Interview for Gastric Bypass has been revised and renamed as The Boston Interview for Bariatric Surgery (BIBS). Further information on the new instrument is available in the article: Revising the Boston Interview: Incorporating new knowledge and experience. *Surgery for Obesity and Related Diseases* 2008; 4:455-63 also by Stephanie Sogg, PhD and DeAnna L. Mori, PhD.<sup>5</sup>

### **Additional Recommendations Based on Recent Literature Review**

The Position of the ADA is based on a literature review through 2008. Magellan conducted a further review of the clinical literature on assessment and treatment of obesity in March 2009. Key relevant recommendations from this more recent literature review are summarized here. Magellan encourages providers to be familiar with this information, as well as the information in the position statement.

### **Weight-Loss Diets with Different Macronutrient Compositions**

A large study (n=811) published in February 2009 by Sacks et. al., compared the efficacy of reduced-calorie diets featuring different macronutrient profiles.<sup>6,7</sup> Patients were randomly assigned to one of four diets:

- (1) low-fat, average-protein – 20 percent fat, 15 percent protein and 65 percent carbohydrates
- (2) low-fat, high-protein – 20 percent fat, 25 percent protein, and 55 percent carbohydrates
- (3) high-fat, average-protein – 40 percent fat, 15 percent protein and 45 percent carbohydrates
- (4) high-fat, high-protein – 40 percent fat, 25 percent protein and 35 percent carbohydrates.

Study participants were between ages of 30 and 70 years and had a body mass index of 25 to 40 kg/m<sup>2</sup>. Individuals with diabetes, unstable cardiovascular disease, or who were judged to have poor motivation on screening interviews were excluded from participation. Researchers maintained blinding of participants by the use of similar foods for each diet and reduced each participant's caloric consumption by approximately 750 calories per day. Participants attended three group sessions for diet counseling per month during the first six months of the trial and then every two weeks from six months to two years. Individual counseling sessions were held every eight weeks. The goal for physical activity was 90 minutes per week for all participants.<sup>6,7</sup>

The main outcome of the study was the change in body weight at two years, waist circumference, satisfaction with diet, and laboratory markers of cardiovascular risk. Study results showed that weight loss at two years was similar in *all* four diet groups. Mean weight loss among participants in the 25 percent and 15 percent protein groups was 3.6 and 3.0 kg, respectively. The mean weight loss among subjects in both the low-fat and high-fat groups was 3.3 kg. The level of carbohydrate in the

diet did not significantly affect weight loss. Additionally, waist circumference decreased by approximately 4 cm in all study groups. Most weight loss occurred in the first six months of the trial. After 12 months, all groups, on average, slowly regained weight. At two years, 14 percent to 15 percent of participants in each diet group had lost at least 10 percent of their baseline body weight. Laboratory findings showed that low-fat diets were associated with greater reductions in LDL cholesterol levels, whereas the lowest-carbohydrate diet promoted higher HDL cholesterol levels. All diets reduced fasting serum insulin levels, and blood pressure decreased modestly with all diet interventions. Also important to note is that craving, fullness, hunger and diet-satisfaction were similar at six months and two years among the diets, and that attendance at group sessions strongly predicted weight loss at two years.<sup>6,7</sup>

Sacks and the study team concluded that diets that are successful in causing weight loss can emphasize a range of fat, protein and carbohydrate compositions that have beneficial effects on risk factors for cardiovascular disease and diabetes. These diets also can be tailored to individual patients on the basis of their personal and cultural preferences, and may impact the chances of long-term success.<sup>5,6</sup>

### **Obtaining Copies of the American Dietetic Association (ADA) Position Paper**

Copies of the adopted *Position of the American Dietetic Association: Weight Management*. (2009) may be obtained through the American Dietetic Association at:

[http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy\\_516\\_ENU\\_HTML.htm](http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_516_ENU_HTML.htm)

and by obtaining this article as published in the *Journal of the American Dietetic Association*, 2009: 109:330-346 (doi: 10.1016/j.jada.2008.11.041).

### **Obtaining Copies of Referenced Guidelines and Resources**

Copies of the referenced guideline, *Medical Guidelines for the Clinical Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient*. (2008) may be acquired through the American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic and Bariatric Surgery at:

<http://www.aace.com/pub/guidelines> by obtaining this article as published in *Endocrine Practice* 2008 Jul-Aug; 14 Suppl 1:1-83.

More detailed information on the structure and content of mental health evaluations may be found in the following articles:

- Behavioral Assessment of Candidates for Bariatric Surgery: A Patient-Oriented Approach by Thomas A. Wadden and David B. Sarwer in *Obesity*, Volume 14, Supplement March 2006.
- The Boston Interview for Gastric Bypass: Determining the Psychological Suitability of Surgical Candidates by Stephanie Sogg, PhD and DeAnna L. Mori, PhD in *Obesity Surgery*. 2004; 14: 370-380.
- Revising the Boston Interview: Incorporating new knowledge and experience. *Surgery for Obesity and Related Diseases* 2008; 4:455-63 also by Stephanie Sogg, PhD and DeAnna L. Mori, PhD.

## Provider Feedback

Magellan welcomes feedback on our clinical practice guidelines. We take all suggestions and recommendations into consideration in our ongoing review of the guidelines. Submit your comments to:

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## References

1. Position of the American Dietetic Association: Weight Management. (2009). *Journal of the American Dietetic Association*, 2009; 109:330-346.
2. Medical Guidelines for the Clinical Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient. (2008). *Endocrine Practice* 2008 Jul-Aug; 14 Suppl 1:1-83.
3. Wadden TA, Sarwer DB. Behavioral Assessment of Candidates for Bariatric Surgery: A Patient-Oriented Approach. *Obesity*. Volume 14 Supplement March 2006.
4. Sogg S, Mori DL. The Boston Interview for Gastric Bypass: Determining the Psychological Suitability of Surgical Candidates. *Obesity Surgery*. 2004; 14: 370-380.
5. Sogg S, Mori DL. Revising the Boston Interview: Incorporating new knowledge and experience. *Surgery for Obesity and Related Diseases* 2008; 4:455-63.
6. Sacks FM, Bray GA, Carey VJ, Smith SR, Ryan DH, Anton SD, McManus K, Champagne CM, Bishop LM, Laranjo N, Leboff MS, Rood JC, de Jonge L, Greenway FL, Loria CM, Obarzanek E, Williamson DA. Comparison of Weight-Loss Diets with Different Compositions of Fat, Protein, and Carbohydrates. *NEJM*. Volume 360:859-873. February 26, 2009. Number 9.
7. Wood S, Vega C. Fewer Calories Equal Less Weight, Regardless of Carb, Fat, or Protein Content CME/CE. *Medscape Medical News*. March 2, 2009.