Intensive behavioral therapy and liraglutide 3.0 mg show positive results for weight loss

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Intensive behavioral therapy (IBT) combined with liraglutide 3.0 mg (Saxenda) can produce clinically-meaningful weight loss in patients who receive the treatment in predominantly primary care settings, according to a study published online in *Obesity*, the flagship journal of The Obesity Society. The study is the first multi-site evaluation of the efficacy of IBT based on a treatment visit schedule covered by the Centers for Medicare and Medicaid Services (CMS).

"This is an impressive outcome, given the brief duration (15-minutes) of the counseling visits and the fact that participants were treated in a primary care setting, without the need to enroll in a group weight loss program at an academic medical center or another setting," said Thomas A. Wadden, Ph.D., professor of psychology in psychiatry, at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia. Wadden is the corresponding author of the study.

A total of 282 adults with obesity enrolled at 17 predominantly primary care clinics in the United States. All participants received 23, 15-minute, individual counseling sessions of IBT during a period of 56 weeks. The sessions were delivered by registered dietitians following a detailed treatment protocol.

After the first 28 weeks, participants assigned to IBT plus placebo lost an average of 5.4 percent of initial body weight, compared with a significantly larger loss of 8.4 percent for those who received IBT and liraglutide 3.0 mg; 44.3 percent and 69 percent of these participants, respectively, lost 5 percent or more of initial body weight—a common criterion of clinically-meaningful weight loss. At week 56, both groups regained a small amount of weight (from week 28) such that the mean weight loss for IBT plus placebo was 4 percent, compared with 7.4 percent for those treated by IBT and liraglutide 3.0 mg; 38.8 percent and 61.5 percent of these participants, respectively, lost greater than or equal to 5 percent of initial weight.

"These two treatment approaches, IBT and medication, appear to have complementary mechanisms of action," said Jena Shaw Tronieri, assistant professor of psychology in psychiatry at the Perelman School of Medicine and a colleague of Wadden's at the University of Pennsylvania's Center for Weight and Eating Disorders. Tronieri co-authored the study.

Weight loss in both treatment groups was associated with improvements in quality of life, as well as measures of cardiometabolic risk factors including waist circumference, triglyceride levels and hemoglobin A1c, a measure of blood glucose control.

As approved in 2011, Medicare beneficiaries with obesity—defined by a body mass index of 30 kg/m^2 or greater—are eligible to receive IBT from a qualified health provider in a primary care setting. The CMS covers weekly brief 15-minute individual counseling sessions for the first month, and then sessions every other week for the next five months. Patients who lose 3 kilograms (6.6 pounds) or more are eligible for six additional monthly sessions.

Wadden encourages CMS to expand the range of practitioners who are eligible to provide IBT independently, which is currently limited to physicians, nurse practitioners, physician assistants and nurse specialists. At present, registered dietitians and other professionals may only provide IBT under the supervision of a primary care provider, such as a physician, who must be physically present on site when treatment is delivered.

"Registered dietitians, health counselors and other professionals could be trained to deliver IBT independently, which would help expand access to this critical intervention and, ultimately, help the millions of Americans who struggle with obesity and

its associated health complications," said Wadden.

"Although this study provides important data on the feasibility of a dietitian-lead IBT in a primary care practice, these services that are covered by Medicare are rarely covered by any other insurance plan and the cost of implementing such a program is prohibitive for most private practice primary care providers," said W. Troy Donahoo, MD, FTOS, associate professor in the Division of Endocrinology, Diabetes and Metabolism, Department of Medicine, at the University of Florida. Donahoo was not associated with the research.

Donna Ryan, professor emerita at Pennington Biomedical Research Center in Baton Rouge, La., who was also not associated with the research noted "what is good about this study is that it shows that other office personnel besides the doctor can play an important role in weight management by delivering IBT. It is really important that we find ways to improve weight coaching—the essence of IBT—in primary care offices."

Provided by The Obesity Society