How to Deliver High-Quality Obesity Counseling in Primary Care Using the 5As Framework

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ABSTRACT

• **Objective:** To review the content of the 5As of obesity counseling for primary care physicians as well as strategies to efficiently address the 5As during a typical 20-minute visit.
• **Methods:** Review of the literature.
• **Results:** Obese patients are evaluated in the primary care setting for multiple weight-related comorbidities and often seek help from their primary care providers to lose weight. Several studies have suggested that physicians and other providers do not adequately counsel obese patients about their weight because of barriers such as poor reimbursement, lack of obesity-related counseling skills, and lack of time. The 5As (Assess, Advise, Agree, Assist, Arrange) is an evidence-based, behavior-change counseling framework endorsed by the Centers for Medicare and Medicaid Services and the United States Preventive Services Task Force.
• **Conclusion:** With the recent announcement that Medicare will now cover intensive behavioral counseling for obese patients, more providers may be interested in gaining the necessary skills to provide high-quality weight management counseling.

Approximately one-third of the US population is obese, and that number has grown over the last 20 years [1]. Several large trials of lifestyle interventions have shown that sustained weight loss is achievable and that even modest weight loss (i.e., 5% to 10% loss of body weight [2]) is clinically beneficial. Primary care physicians are ideally situated to promote weight loss via effective obesity counseling. They have longitudinal relationships that enable rapport building and behavioral change management with a large percentage of the population, and are experts in managing chronic diseases and health conditions. The United States Preventive Services Task Force (USPSTF) recommends that primary care providers screen patients for obesity and offer intensive behavioral treatment [3]. However, the literature reveals that primary care physicians may lack confidence and competence in managing obesity [4], largely due to lack of systematic counseling skills [5], negative attitudes [6], and lack of time [7,8].

In addition, lack of reimbursement has been an obstacle to providers in counseling obese patients [9]. Luckily, compensation for such interventions is changing: the Centers for Medicare and Medicaid Services (CMS) recently announced that Medicare will now cover intensive behavioral counseling for obese patients [10]. Specifically, primary care physicians will be reimbursed for weekly visits for the first month and then every other week for months 2 through 6. Given the efficacy of weight loss interventions and the potential remuneration for frequent visits, primary care physicians should be comfortable providing basic weight management counseling for their patients.

The purpose of this paper is to guide providers on incorporating obesity treatment into their practice using the 5As model for obesity counseling. This model guides the provider to assess risk and readiness to change, advise specific behavior changes, agree on specific goals in a collaborative manner, assist via addressing barriers (motivational interviewing), and arrange to follow-up or refer the patient for further treatment. Both the USPSTF and CMS have advocated using the 5As model for obesity counseling [10]. The 5As model, initially found to be effective when used by primary care physicians to promote smoking cessation [11], has since been adapted for use in obesity counseling training for primary care physicians and has been found to promote physician obesity counseling competence [5,12–14]. The model is also useful as...
a clinical reminder in an electronic medical record [15] and may impact patient outcomes in physician training in graduate and continuing medical education [13,16,17]. There are few studies that have examined the efficacy of using the 5As for weight management in patients. In a pilot study examining the use of 18 counseling practices related to the 5As, obese patients (n = 137) reported on the use of the 5As by primary care residents (n = 23). Each additional 5As counseling practice was associated with higher odds of being motivated to lose weight (odds ratio [OR] = 1.31, 95% confidence interval [CI] 1.11–1.55) and intending to eat better (OR = 1.23, CI 1.06–1.44) [13,18]. A larger study where researchers audiotaped primary care encounters between 40 physicians and 461 obese patients and followed patients for 3 months showed higher confidence to lose weight in patients where the physician “assessed” and “advised” them to lose weight, lower fat intake when the physician “assisted” and “arranged,” and higher weight loss when the physician “arranged.” This study examined a slightly different 5As framework, and thus did not evaluate the impact of “agree.” We know of at least one ongoing study that will examine the impact of using the 5As of weight loss outcomes, but the results have yet to be published.

We believe that the 5As is a useful model that highlights the skills needed to provide high-quality, behaviorally based obesity counseling. Here we will outline the content of each of the 5As as adapted for obesity counseling skill development. Furthermore, we will discuss how to complete the 5As in a time-efficient manner while recognizing that in a busy primary care practice addressing all the “As” can be done over several visits.

**ASSESS**

For a patient seeking treatment for obesity, there are many areas to assess. As outlined in the “assess” section of Table 1, the health care professional’s initial task is to evaluate obesity risk, motivation to lose weight, history of weight loss efforts, current dietary and exercise behavior, and current expectations of medically supervised weight loss. For a continuity visit, the past medical history and active comorbidities are usually known; the body mass index (BMI) can be calculated at triage.

**Risk Assessment**

The first step is determining who should be counseled. This starts with calculating the patient’s BMI using his or her current height and weight. Overweight status is defined as a BMI in the 25–29.9 range and obese status is 30 or greater [19]. In general, weight loss should be recommended to all patients with a BMI greater than 30 and those with a BMI 25–29.9 who have 2 or more risk factors for cardiovascular disease. For overweight patients without risk factors or those who cannot undergo weight loss, efforts should be focused on weight maintenance or prevention of further weight gain [20]. Obesity risk includes the patient’s obesity-related risk (including BMI and/or waist circumference), cardiovascular risk factors (hypertension, diabetes or prediabetes, dyslipidemia, family history of early myocardial infarction, tobacco use), and obesity-related disease (eg, diabetes, osteoarthritis, obstructive sleep apnea, fatty liver disease, stress incontinence, polycystic ovarian syndrome.) Using this information, the physician can later explain the risks and benefits of weight loss tailored to the individual patient. It is often helpful to initially ask for permission to discuss a patient’s weight. This technique will make any resistance readily apparent on a potentially sensitive topic: “Is it OK if we spend a little bit of time discussing your weight, exercise, and dietary habits?”

**Weight Loss History**

Before assessing current diet and exercise behavior, the provider should ask the patient about history of weight loss attempts, successes, and circumstances. This conversation may elicit many of the patient’s ongoing barriers to weight loss. Anecdotally, many patients who have attempted to lose weight using fad diets or extreme caloric restriction may initially be successful but then often regain the weight several months later. This observation can be pointed out to the patient later on as a way of supporting the idea of sustainable, gradual weight loss.

**Readiness for Weight Loss and Expectations**

Finally, readiness to lose weight is guided by assessing interest and confidence in weight loss on a scale of 0 (no interest/no confidence) to 10 (very interested/very confident) and considering the patient’s stage of change, which may be defined as pre-contemplative, contemplative, preparation, action, maintenance or relapse [21]. It should be recognized that certain major life events (recent move, new job, divorce, recent loss) might preclude commitment and attention to weight loss.

Finally the provider lays the groundwork for setting realistic expectations by asking “How much weight do
you want to lose?” and “How long do you expect that it will take you to lose this weight?”

**Current Behaviors**
In the next part of the assessment, the health care professional elicits information from the patient regarding current dietary and exercise habits. There are several possible approaches. One option may be to ask the patient to recall everything he or she ate in the last 24 hours, including drinks and condiments. While this might not reflect what the patient typically eats, it does provide a detailed starting point for further discussion.

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**Table 1. The 5As of Obesity Counseling**

<table>
<thead>
<tr>
<th>Assess</th>
<th>BMI</th>
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<tbody>
<tr>
<td></td>
<td>Comorbidities (metabolic syndrome, diabetes, high cholesterol)</td>
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<td></td>
<td>Family history (including family history of obesity)</td>
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<td></td>
<td>Psychiatric history</td>
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<td></td>
<td>Current depressive/anxiety symptoms and coping mechanisms</td>
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<td>Medications</td>
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<td></td>
<td>Previous weight loss attempts</td>
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<td></td>
<td>Dietary behavior</td>
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<td></td>
<td>Exercise</td>
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<tr>
<td></td>
<td>Stage of change</td>
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<td></td>
<td>Social history and interpersonal barriers to weight loss</td>
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<tr>
<th>Advise</th>
<th>Weight loss: specifics! 5%–10% over 6 months</th>
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<tbody>
<tr>
<td></td>
<td>Review patient’s weight loss goals</td>
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<tr>
<td></td>
<td>Suggest changes to diet</td>
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<tr>
<td></td>
<td>Suggest changes in physical activity</td>
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<td></td>
<td>Discuss treatment options for psychosocial co-morbidities</td>
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<td></td>
<td>Give information about treatment options: (1) Medication pros and cons when appropriate; (2) Surgery pros/cons when appropriate</td>
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<td></td>
<td>Address patient’s concerns and answer questions re treatment options</td>
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<tr>
<th>Agree</th>
<th>Clarify patient’s preferences about behavior change options that you advised/discussed with the patient</th>
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<tbody>
<tr>
<td></td>
<td>Allow patient to help choose 1–3 mutual behavior change goals</td>
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<td></td>
<td>Give written exercise /diet prescription based on the goals</td>
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<tr>
<td></td>
<td>Make sure the goals are SMART (specific, measurable, achievable, realistic, and time-bound)</td>
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<td></td>
<td>Make it clear when you will check in again with the patient to monitor adherence to these goals</td>
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<td></td>
<td>Make sure that these goals are revisited and revised during subsequent visits</td>
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<tr>
<th>Assist</th>
<th>Address barriers to change</th>
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<td></td>
<td>Help patient reflect on support systems</td>
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<td></td>
<td>Verbalize your support for patient’s goals, be empathetic</td>
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<tr>
<td></td>
<td>Describe services that can offer patient support (group therapy, nutritionist, CBT therapist, etc)</td>
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<td></td>
<td>Prescribe medications and/or refer to bariatric surgery</td>
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<tr>
<td></td>
<td>Apply motivational interviewing skills to stages of change/transtheoretical model to help move patient further in their stage of change and activate the patient to change behaviors</td>
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<tr>
<th>Arrange</th>
<th>Frequent follow-up</th>
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<tr>
<td></td>
<td>Referral to weight-management clinic</td>
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<tr>
<td></td>
<td>Referral to community resources/commercial programs</td>
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<tr>
<td></td>
<td>Bring family members/social support in weight loss plan to future visits if applicable</td>
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Another approach might be to have the patient describe a typical day, with attention to typical foods chosen for each meal as well as daily activities and routines. Finally, patients can be asked to keep a more prolonged daily dietary and exercise log [20] that can be reviewed at the next visit. With any of these approaches, attention should be paid to eating patterns (regular meals including breakfast), methods of food preparation (home-cooked vs. take-out), and emotional or social triggers to overeat.

For example the health care professional might ask:

“How many times a week do you skip breakfast?”

“Please tell me everything that you ate and drank yesterday. This will help me to get a sense of your habits.”

“Do you regularly drink sodas, bottled teas, sports drinks, or juice?”

“What vegetables and fruits do you eat on a regular basis?”

“What type of exercise or activities do you enjoy?”

**ADVISE**

**Method and Amount of Weight Loss**

The primary care physician advises specific behavior changes and timing based on the patient’s individual obesity risk factors, as described in the “advise” section of Table 1. A healthy weight loss goal is defined as an average no more than 1 to 2 pounds of weight loss per week or 5% to 10% weight loss in the first 6 months [2].

The primary care physician should then probe the patient for his or her goals and break down long-term weight loss goals into behaviorally specific short-term goals. This is the time to correct any misconceptions about what successful and clinically significant weight loss means for the individual patient: “For you, losing just 15 pounds over the next 6 months will reduce your risk of getting diabetes by 60% over the next few years!”

**Dietary Counseling**

Generally, dietary advice should be focused on making lower-calorie choices in the form of small changes that are sustainable. Low-fat, low-carbohydrate, and Mediterranean-type diets have been heavily promoted, but their effectiveness has yielded mixed results [22–24]. Therefore, a specific diet should be guided by patient individual preferences and comorbidities with an emphasis on lifestyle changes. Rather than focusing on diets, which many patients cannot sustain, the approach should be to promote goal setting around changes that patients can maintain for the rest of their lives. It may be helpful to start by asking patients how they think they could improve their diet and allow the response to guide the discussion.

We recommend 2 strategies for providing dietary advice: the SERVE method and the plate method. The first is based on the mnemonic “SERVE” that provides rapid assessment of habits that may be high-yield for change. “SERVE” reminds the health care professional to ask about:

- Sugar-sweetened beverages and other liquid calories [25–27]
- Exercise habits [28–31]
- Regularity of meals (especially breakfast) [32,33] and Restaurant use
- Vegetable- and fruit-rich-diet [34–37]
- Eating less or portion-size awareness [38–40]

SERVE is a useful mnemonic developed at our institution to train resident physicians, but its effectiveness for obesity counseling has not been studied. The plate method is an uncomplicated way to control portion sizes that was originally developed for nutritional counseling in diabetic patients. In this model (www.platemethod.com), vegetables take up at least half of the plate. The other half is subdivided, with starchy foods (bread, rolls, cereals, potatoes, beans) taking up ¼ of the plate and protein (meat, fish, soy, cheese) the other ¼ of the plate. The recommended plate size is 9 inches in diameter. Drawing the plate or providing a picture offers a meaningful visual reference for the patient on portion size. An initial goal may be to make 1 meal a day look like the plate.

The data regarding the efficacy of the plate method for weight loss counseling in a primary care setting is limited. A small pilot study that included 65 primary care patients randomized to a portion control plate versus standard patient education handouts showed improve weight loss at 3 months in those patients using the plate [41].

Meal replacement options have been found to be an effective management strategy as well, as noted in a 2003 meta-analysis [42]. There are several commercially avail-
able products (typically shakes or snack bars) that can be used as meal replacements though there are no high-quality comparative effective analyses to determine which types are best. Consideration such as price, taste, and clinician and patient preference may guide selection. Meal replacements can be used to substitute for one or more meals but we do not recommend that clinicians advise patients to use meal replacements exclusively (i.e., a liquid diet) without further training in how to monitor such patients safely.

**Physical Activity Counseling**

It should be noted that intensive physical activity alone does not reliably lead to (or promote) weight loss. However, exercise has been shown to be an effective weight maintenance measure and helps improve overall health. Questionnaires are available to facilitate the assessment process [43]. Physical activity should be increased slowly from the patient’s baseline level in order to avoid injuries. A long-term goal of at least 30 minutes of moderate intensity activity on most, preferably all, days of the week is appropriate for all adults.

**AGREE**

This portion of the model is where goal setting occurs. Goal setting is associated with effective lifestyle behavior change [44,45]. The health care professional and patient agree and set specific behavioral goals for weight loss. Current goal setting theory, much of which is derived from the occupational psychology literature, states that to maximize goal attainment, behavior change goals should be specific, proximal, and set collaboratively with the provider [45–47]. These goals are ideally formed during negotiation using patient-centered interviewing skills in which the physician and patient mutually agree upon 1 to 3 behaviorally specific weight loss goals, based upon the patient’s personal goals and the content of the health care professional’s advice offered while “advising”:

“Given all that we’ve just discussed—my advice and your reflections—what specific changes in your diet would you like to make?”

“What changes are you willing to commit to starting today?”

“May I offer you some suggestions based on what you already told me?”

As stated above, it is important that goals are as specific and realistic as possible. For example, “I would like to walk more” is far less likely to be achieved than “I would like to walk 20 minutes, 5 days per week with my dog after work and I will record my progress in an exercise diary until our next visit.” It is most realistic to choose only 1 to 2 specific goals, and these may be small behavior changes rather than sweeping lifestyle changes. Patients who achieve small goals may have more confidence to set higher goals [24,48].

It is also important to establish that goals should be set as a commitment to long-term lifestyle changes that they will maintain. We suggest that it is important that providers document goals both in the electronic medical record and on a prescription for the patient to take home, with the expectation that they will be asked about these goals at the following visit.

There are many tools available to help guide this process including the plate method as mentioned above, portion control and monitoring, and dietary and exercise monitoring tools [43]. Many of these tools can be used iteratively for assessing, advising, assisting and agreeing.

**ASSIST**

While this may be one of the most useful of the 5As, it is one of the least practiced parts of the 5As model [49,50]. As noted in Table 1, the primary care physician assists in addressing barriers with the patient and securing support. Assist may also involve prescribing weight loss medications, using meal replacements, or referring for bariatric surgery evaluation. While nonbehavioral obesity treatments are beyond the scope of this review, they should be offered in conjunction with high-quality counseling.

**Behavioral Therapy**

For some patients, important barriers must be addressed prior to committing to intensive weight loss efforts. For example, depression and other psychiatric disorders should be adequately treated. A focus on stress management techniques and stimulus control may improve compliance with dietary and physical activity changes. Patients should develop a habit of self-monitoring, which has been shown to be one of the most commonly reported strategies for long-term weight maintenance [43]. This includes keeping food diaries, logging exercise time, and frequently monitoring weight. Food diaries should include information about portion/volume of intake, time consumed, and type
Obesity Counseling

of food and drink. Activity logs should include information about activity performed, time spent doing activity, and intensity.

Motivational Interviewing

While many patients would like to lose weight, they may be ambivalent about change or lack confidence. Motivational interviewing can address these barriers and has been shown to enhance the effectiveness of weight loss interventions [51,52]. It is a patient-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence [53]. Evocation, one of the core principles of motivational interviewing, involves eliciting the patient’s rationale for change rather than stating the physician’s rationale. The underlying philosophy is that human beings are generally ambivalent about behavior change. Empathy, avoiding argument, and supporting self-efficacy are emphasized. In brief, there are several key skills that may help in exploring and managing the patient’s ambivalence to change. Some examples of skills include open-ended questions, reflective listening, affirmations and summarizing to further support self-efficacy, as illustrated below:

“How has your life been affected by your weight?”

or

“How do you anticipate things would change if you met your weight loss goal?” (Open-ended questions)

“Sounds like you were really frustrated when your last diet failed.” (Reflective listening)

“So, you want to prepare more vegetables, but you anticipate that your family may protest” (Reflective listening)

“I appreciate your willingness to discuss those painful experiences.” (Affirmations)

The primary care physician can probe the patient’s underlying ambivalence about weight loss or maintenance by then weighing the interest and confidence against one another, as was noted in the Assess section above. For example, “I hear you that your interest in losing weight is a 10 and your confidence is a 6. Why did you give your confidence rating a 6 instead of a 1? On the other hand, why didn’t you give it a 10? What would help you be more confident?”

When a primary care physician assesses motivation and confidence, they can go one step further and actually develop discrepancy. In other words, change can be motivated when there is a discrepancy between a patient’s current behavior and his or her goals and values (eg, “I noticed that you say you want to lose 20 pounds but at the same time have been eating fast food because it is easier with your busy schedule”). The physician emphasizes small steps as successes such as taking the stairs or coming to appointments even if the patient has failed to lose weight. For many patients struggling with weight loss, their ambivalence may relate to the burden of constant vigilance rather than whether weight loss is necessary. This is especially true when patients hit a weight plateau despite ongoing efforts. The plateau is an expected part of medical weight loss that patients should be anticipating. Once patients reach their weight loss goals, the focus shifts to weight maintenance using the 5As.

ARRANGE

The health care professional and patient must arrange for close follow-up to promote effective weight loss as well as referrals. Patients lose significantly more weight when they are part of an intensive lifestyle intervention as compared with standard of care; per recent CMS recommendations, primary care physicians who cannot perform intensive counseling should refer to more intensive programs. Reimbursement will occur for 1 face-to-face visit every week for the first month; 1 face-to-face visit every other week for months 2 to 6; 1 face-to-face visit every month for months 7 to 12, if the patient meets a 3-kg weight loss requirement [10]. For patients who do not achieve a weight loss of at least 3 kg during the first 6 months of intensive therapy, it is appropriate to reassess BMI and readiness to change after an additional 6-month period. Successful models include a combination of weekly group visits, monthly individual sessions, and frequent use of self-monitoring tools like food diaries [54,55]. Individual follow-up appointments consist of a reiteration of 5As, specifically focusing on barriers to meeting goals and setting new goals. Telephone follow-up may be an effective option as well [56].

A TIME-EFFICIENT APPROACH TO THE 5As

Within the construct of CMS-reimbursed weekly and biweekly visit schedule, the first visit should focus on assessment, agreeing on a weight loss goal, and having the patient keep a food and activity diary. Much of the assessment can be done during a first visit as part of general history and physical exam. The second visit could incorporate reviewing the food diary, agreeing on goals using the SERVE or plate method, and assisting in addressing barriers. Subsequent
visits should involve monitoring goals and assisting and arranging for more intensive services, if necessary.

One may advise and assist or even arrange depending on where the patient is on the stage-of-change continuum. If a patient is in the action stage and is knowledgeable, the primary care physician may spend more relative time arranging than with a patient with poor knowledge about nutrition and/or exercise that is pre-contemplative or contemplative. All in all, obesity counseling using the 5As is an iterative process in which the physician uses the 5As repeatedly over time with the patient (Table 2 and Table 3).

**CONCLUSION**

In general, behavioral counseling for obese patients can produce modest, though still clinically significant, long-term weight loss. Despite the paucity of studies examining the efficacy of the 5As in promoting weight loss, we believe that the 5As is a practical model for approaching obesity counseling. In this paper we reviewed the evidence for and concrete day-to-day use of the basic components of the model. Most importantly, obesity counseling is not synonymous with advice giving. This model guides the physician to use a collaborative, patient-centered approach to behavior change while respecting patient autonomy.

**REFERENCES**


