OVERCOMING OBESITY

A PCP'S GUIDE TO COMPREHENSIVE OBESITY CARE

This activity is supported by an educational grant from Eli Lilly and Company.

Activity Overview

TARGET AUDIENCE

US primary care physicians, NPs, and PAs including those who are community-based, practice in large ACOs; in rural communities; and who serve patients in underserved areas

EDUCATIONAL OBJECTIVES

After completing this activity, the participant should be better able to:

- Integrate evidence-based approaches to diagnose, manage, and treat obesity, such as BMI, waist circumference, body fat percentage, and routine visits, especially in patients with concurrent comorbidities.
- Determine appropriate treatment with consideration of the latest clinical evidence, mechanism of action, side effects, drug administration frequency, and patient-specific factors when developing individualized treatment plans for patients with obesity.
- Employ shared decision-making and multidisciplinary approaches when discussing weight management strategies, including treatment and lifestyle modifications, to support optimal adherence and outcomes for patients with overweight/obesity.

Part 2: No One-Size-Fits-All Approach: Individualizing Obesity Treatment

Faculty

Robert Kushner, MD, MS

Professor, Departments of
Medicine and Medical Education
Northwestern University Feinberg School of Medicine
Chicago, IL, USA

Jay H. Shubrook, DO, FACOFP, FAAFP

Professor and Diabeteologist, Department of
Clinical Sciences and Community Health
Touro University California
College of Osteopathic Medicine
Vallejo, CA, USA

Barriers to treatment initiation and adherence

Treatment Considerations for Patients with Overweight/Obesity

Successful Treatment Requires:

An Experienced Team

- Endocrinologists
- Primary Care/Family Practice
- Obesity Medicine Specialist
- Registered Dietitians
- Gastroenterologist
- Bariatric Surgeon
- Psychologists
- Support Staff

Treatments That Work

- Lifestyle
- Medication
- Devices
- Surgery

Often lacking or behind barriers

Insurance Coverage for Treatment

Often lacking or behind barriers

Importance of documentation and coding

T2D, Type 2 Diabetes.

Slide provided by Dr Caroline Apovian, MD, FACP, FTOS, DABOM

Weight Discrimination

- The prevalence of weight discrimination in the US is increasing and **is comparable to that of race and gender discrimination**
- There are few other medical diseases in our society that are as stigmatized and shunned as obesity
- The societal stigma often associated with excess **weight is perpetuated with focus on personal responsibility for obesity**

Andreyeva T, et al. *Obesity (Silver Spring)*. 2008;16(5):1129-1134; Puhl RM, Heuer CA. *Obesity (Silver Spring)*. 2009;17(5):941-964.

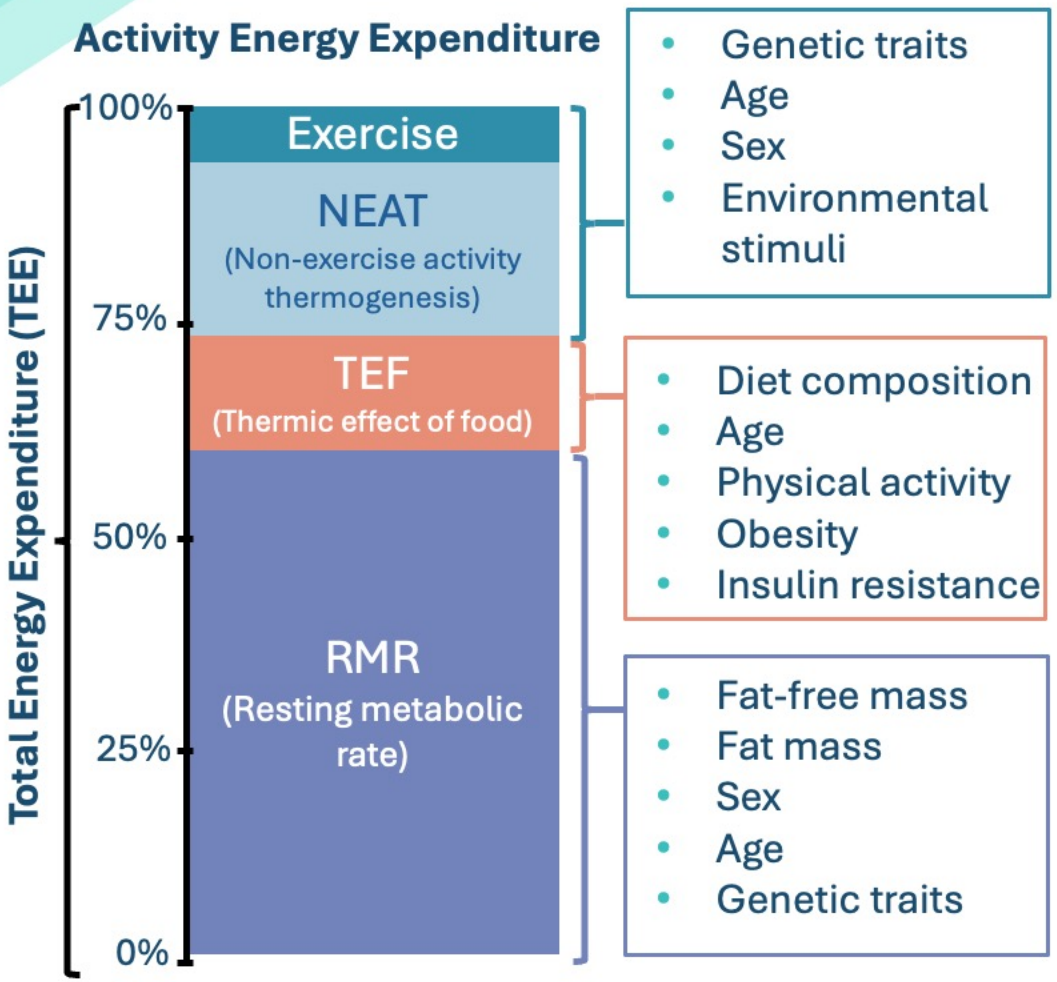
Case Study

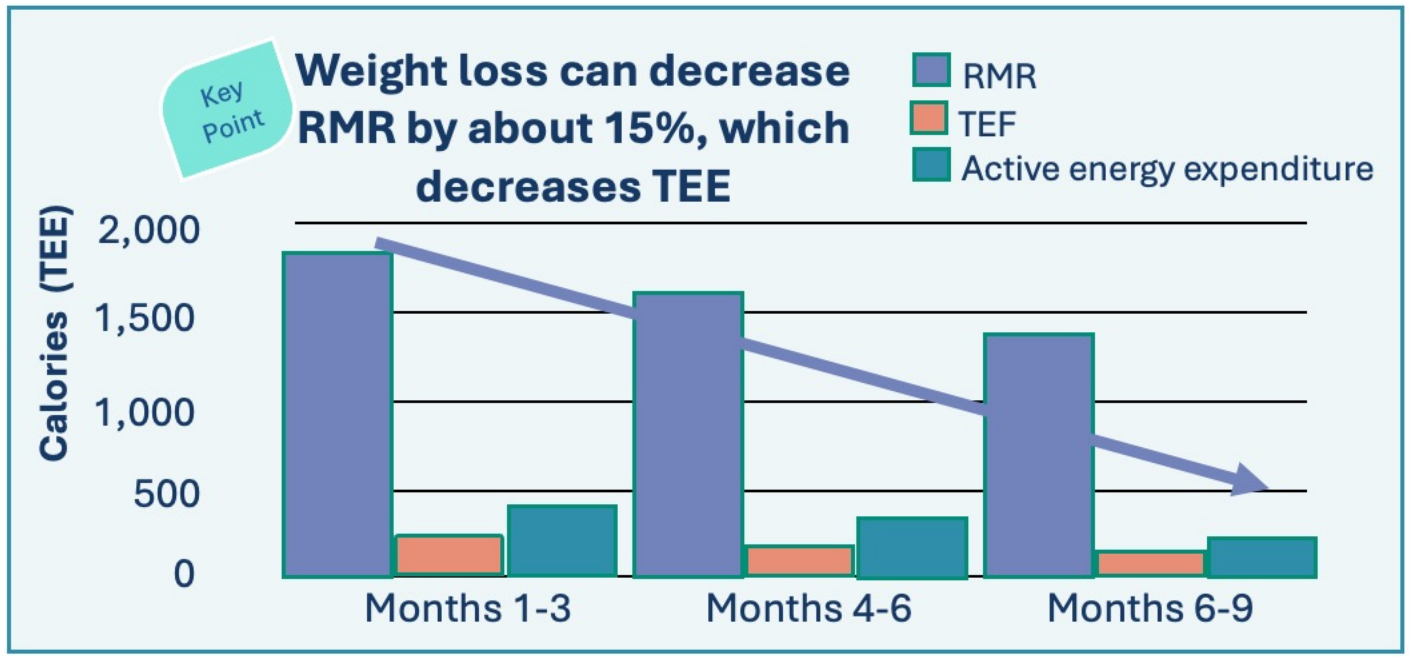
Andrea is a 42-year-old female patient who presents to your clinic for a routine checkup. She has experienced weight loss and gain in the past. Andrea has been researching weight loss therapies online and mentions various options, including prescription medications, meal replacement programs, and bariatric surgery. She asks for your professional opinion on whether these are suitable options to support her long-term weight loss goals. Her current body mass index (BMI) is 34.

Case Study

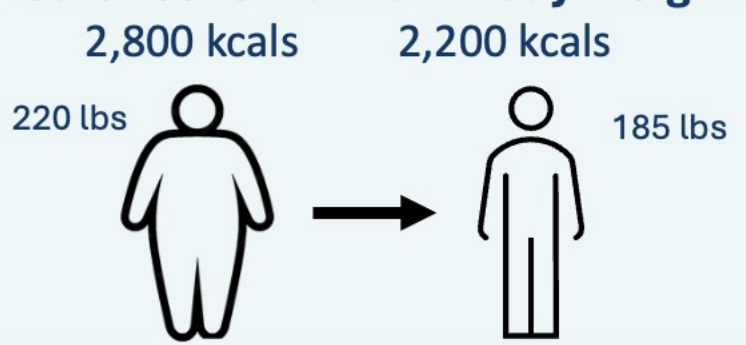
Slide courtesy of Dr. Lofton.

Calories in vs Calories Out is a Moving Target





A smaller body requires fewer calories to maintain body weight and function.

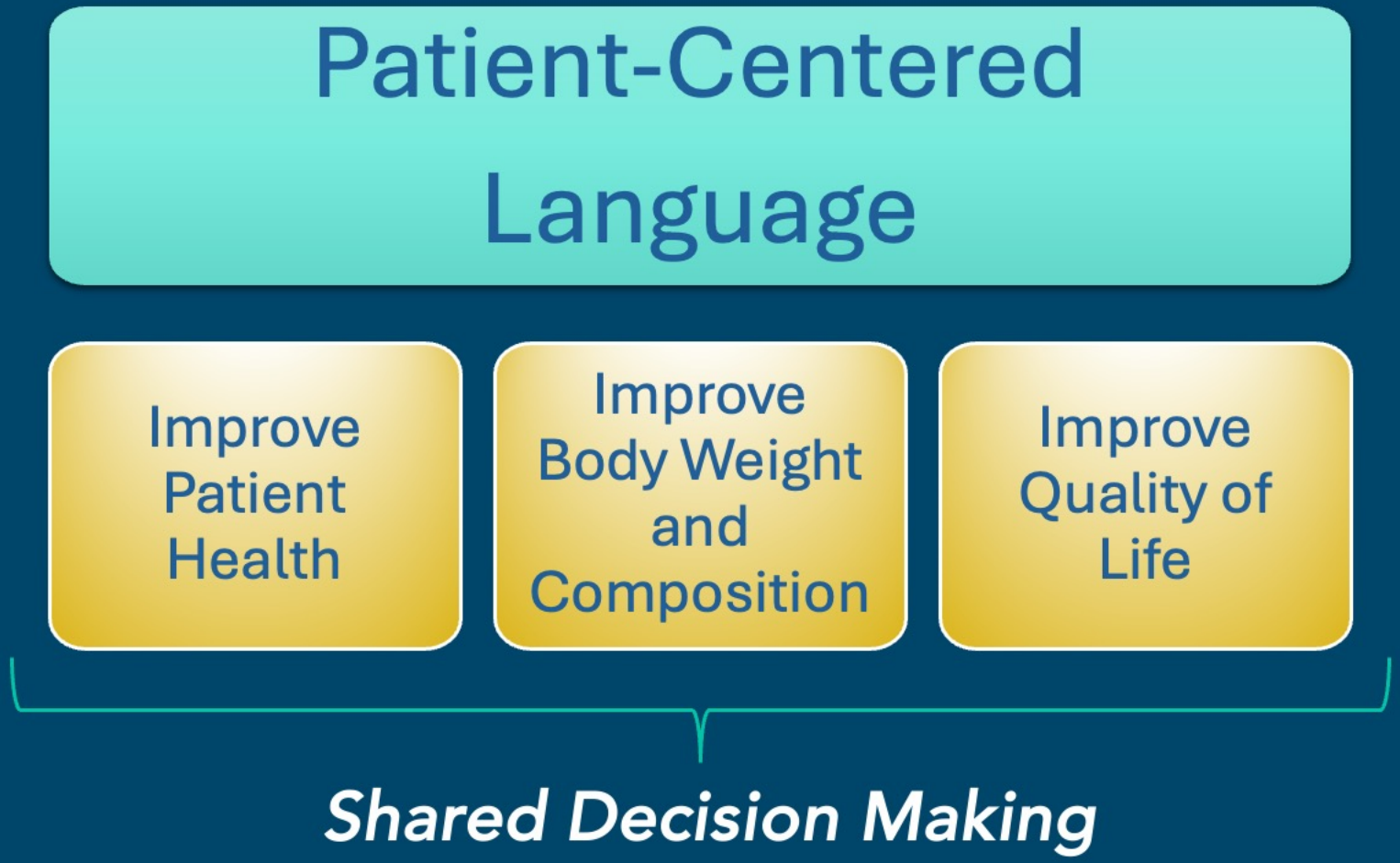


RMR, resting metabolic rate; TEE, total energy expenditure.

How Metabolic Adaptation Is Stalling Your Weight Loss Efforts. Box Nutrition. https://www.boxnutrition.co.uk/single-post/how-metabolic-adaptation-is-stalling-your-weight-loss-efforts.

Clinical evidence of the evolving treatment landscape of obesity

Obesity Management Goals



Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Obesity Treatment Guidelines

Multimodal

Multidisciplinary

BMI Category (kg/m2)	Staging	Suggested therapy	Care Setting
18.5-24.9 <23 in patients of certain ethnicities	Normal weight (no obesity)	Healthy lifestyle	• Primary care
25-29.9 23-24.9 in patients of certain ethnicities	Overweight	Lifestyle therapy	• Primary care • Consider referral to obesity medicine specialist if treatment is not effective
≥ 30 ≥ 25 in patients of certain ethnicities	Obesity stage 1 (no complications)	Lifestyle therapy Anti-obesity medications *Consider if lifestyle therapy fails to prevent progressive weight gain (BMI ≥27)*	• Primary care • Consider referral to obesity medicine specialist
	Obesity stage 2 (≥ 1 mild to moderate complications)	Lifestyle therapy Anti-obesity medications *Consider if lifestyle therapy fails to achieve therapeutic target or initiate with lifestyle therapy (BMI ≥27)*	• Primary care • Consider referral to obesity medicine specialist
	Obesity stage 3 (≥ 1 severe complication)	Lifestyle therapy Anti-obesity medications *Initiate with lifestyle therapy (BMI ≥27)* *Consider bariatric surgery (BMI ≥35)*	• Primary care • Consider referral to obesity medicine specialist

Cornier MA. *Am J Manag Care*. 2022;28(15 Suppl):S288-S296; Mechanick JI, et al. *Endocr Pract*. 2019;25(12):1346-1359; Nadolsky K, et al. *Endocr Pract*. 2023;29(6):417-427; Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Obesity Treatment Options: Nutrition

Limit

- Unhealthful **ultra-processed foods** of minimum nutritional value
- **Energy-dense foods** high in calories
- **Energy-dense beverages**: sugar-sweetened beverages, juice, cream
- Avoid **trans fats** and **excessive sodium**

Encourage

- Consumption of healthful proteins and fats, vegetables, leafy greens, fruits, berries, nuts, legumes, whole grains
- **Complex carbohydrates** over simple sugars: Low glycemic index over high glycemic index foods
- **High-fiber foods** over low-fiber foods
- Many dairy products (while being mindful of caloric content)
- Reading labels rather than marketing claims

Encourage foods that result in a negative caloric balance to achieve and maintain a healthy weight

Consider:

- Eating behaviors, and meal patterns
- Cultural background, traditions, and food availability
- Time constraints and financial issues
- Nutritional knowledge and cooking skills
- Medical conditions potentially affected by the nutrition plan
- Mediterranean diet
- Therapeutic lifestyle diet
- DASH (Dietary Approaches to Stop Hypertension)
- Ketogenic (modified Atkins) diet
- Ornish diet
- Paleo diet
- Vegetarian or vegan diet
- Intermittent fasting / time restricted eating
- Commercial diet programs

Ryan DH, et al. *Med Clin North Am*. 2018;102:49-63; Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Obesity Treatment Options: Physical Activity

Routine Physical Activity May Improve:	Goal: Increase Energy Expenditure	Goal: Decrease Physical Inactivity
• Body composition • Adiposopathic endocrine and immune body processes • Metabolic, musculoskeletal, cardiovascular, pulmonary, mental, sexual, and cognitive health	• Dynamic (aerobic) training • Resistive (anaerobic) strength training	• Leisure time physical activity • Transportational/occupational non-exercise activity thermogenesis (NEAT)

Medical evaluation to ensure safety before beginning new exercise program

Tracking Progress

Ryan DH, et al. *Med Clin North Am*. 2018;102:49-63; Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Synthesis of Exercise: Recommendations and Evidence

Evidence Statement	Strength of Evidence
Aerobic training reduces body weight ~2-3 kg without dietary intervention and by 1 kg compared to resistance training alone	High
Aerobic training alone or combined with resistance training performed during a weight loss diet leads to an additional 1.5 kg weight loss	High
Resistance training but not aerobic training performed during a weight loss diet decreases the loss of lean body mass (LBM)	Moderate
Aerobic training and high intensity interval training (HIIT) but not resistance training reduce abdominal visceral fat	High
Resistance training alone or in combination with aerobic training improve muscle strength	High

Oppert JM, et al. *Obes Rev*. 2021;22 Suppl 4(Suppl 4):e13273.

Obesity Treatment Options: Behavioral Therapy

Challenges around eating behaviors
• Physiologic • Mental stress • Timing and emotions • Environment • Information gap • Reward • Eating disorders

Elements for success in behavioral therapy
• Doable • Efficacious • Measurable/Accountable • Self-ownership

Why do people plateau with weight reduction or regain body weight?
• Physiologic priority imbalance • Neurobiology • Dynamic energy balance • Behavior

Barriers to routine physical activity
• Physiologic • Lack of time • Disinterest • Environment

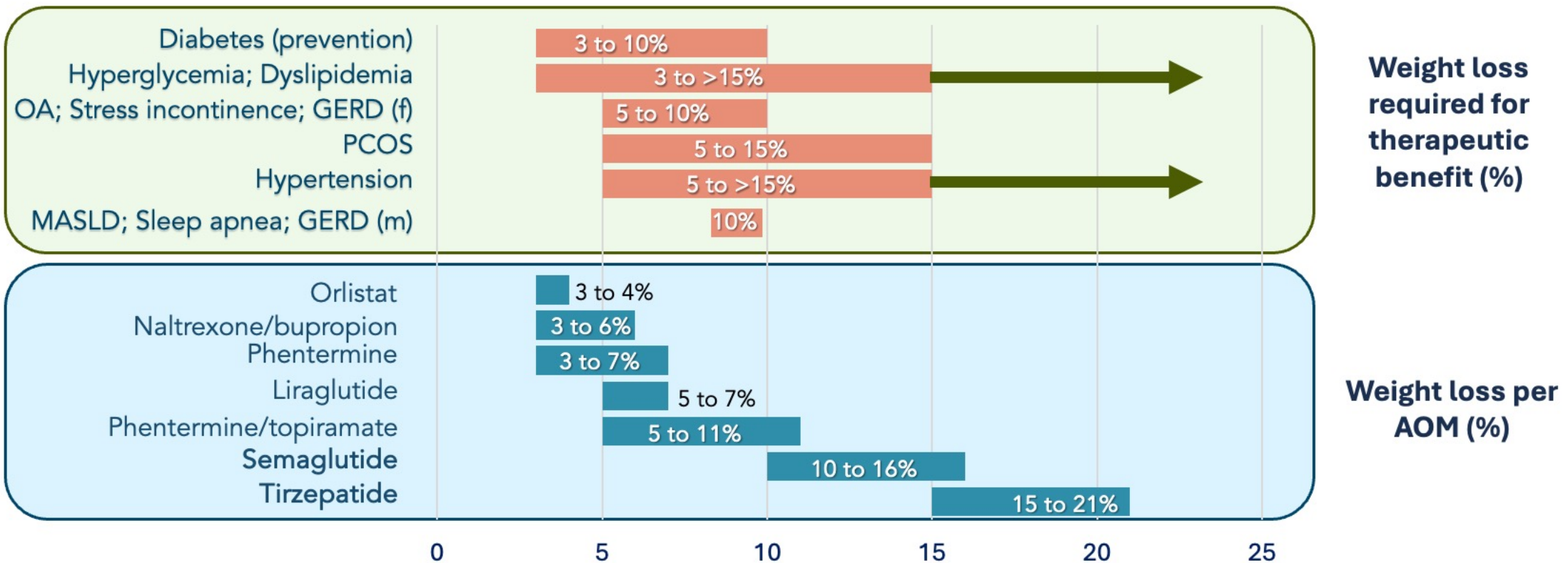
SMART goals
• **S**pecific • **M**easurable • **A**ssignable • **R**ealistic • **T**ime-related

Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Obesity Treatment Options: Pharmacotherapy

Adjunct to Nutritional, Physical Activity, and Behavioral Therapies

5 to 10% weight reduction may improve metabolic and fat mass disease



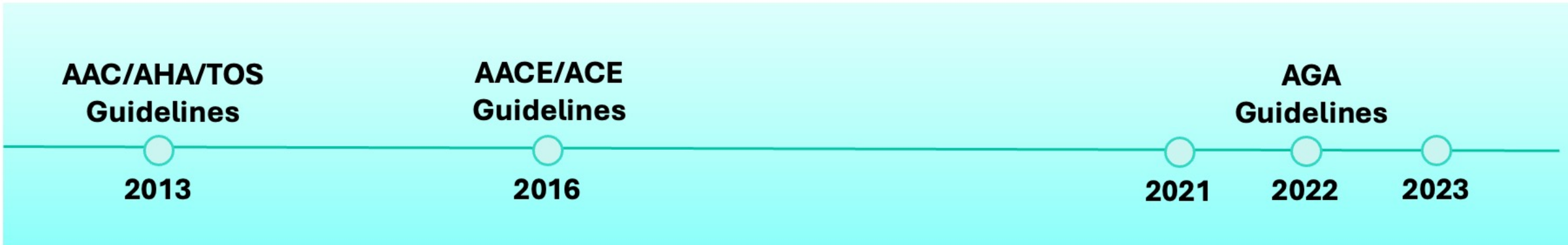
A1C, glycated hemoglobin; BP, blood pressure; GERD, gastroesophageal reflux disease; MASLD, metabolic dysfunction-associated steatotic liver disease; OA, osteoarthritis; PCOS, polycystic ovary syndrome; TG, triglycerides; AOM, anti-obesity medication.

Cefalu WT, et al. *Diabetes Care*. 2015;38(8):1567-1582; Garvey WT, et al. *Endocr Pract*. 2016:22 Suppl 3:1-203; Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Case Study

In addition to presenting with a BMI of 34, your evaluation leads you to suspect Andrea may suffer from OSA and PCOS.

Obesity Pharmacotherapy Treatment: A Timeline



AACE, American Association of Clinical Endocrinologists; ACE, ACE, American College of Endocrinology; AGA, American Gastroenterological Association; American Heart Association; TOS, The Obesity Society.

Cornier MA. *Am J Manag Care*. 2022;28(15 Suppl):S288-S296; Garvey WT, et al. *Endocr Pract*. 2016:22 Suppl 3:1-203; Jensen MD, et al. *J Am Coll Cardiol*. 2014;63(25 Pt B):2985-3023; Mechanick JI, et al. *Endocr Pract*. 2019;25(12):1346-1359

Pharmacologic Management of Obesity

1st and 2nd Generation AOMs

	Generic (Brand)	Indication	MOA	Effect	How taken	Weight loss
1st generation	Phentermine (Adipex)	Chronic Obesity Management	Sympathomimetic amine	↓ appetite	PO, up to TID	~3-7%
1st generation	Orlistat (Alli, Xenical)	Chronic Obesity Management	Gastrointestinal lipase inhibitor	↓ fat absorption	PO, up to TID	~3-4%
1st generation	Phentermine/ Topiramate-ER (Qsymia)	Chronic Obesity Management	Sympathomimetic amine + anticonvulsant, carbonic anhydrase inhibitor, gabaminergic	↓ appetite	PO, once daily	~5-11%
1st generation	Naltrexone-ER/ Bupropion-ER (Contrave)	Chronic Obesity Management	Opioid receptor antagonist + dopamine-norepinephrine reuptake inhibitor	↓ appetite	PO, twice daily	~3-6%
1st generation	Liraglutide (Saxenda)	Chronic Obesity Management	GLP-1 RA	↓ appetite	SQ, once daily	~5-7%
2nd generation	Semaglutide (Wegovy)	Chronic Obesity Management; Mitigate CV risk	GLP-1 RA	↓ appetite	SQ, once weekly	~10-16%
2nd generation	Tirzepatide (Zepbound)	Chronic Obesity Management	Dual GIP/GLP-1 RA	↓ appetite	SQ, once weekly	~15-21%

Key Point

GLP-1, glucagon-like peptide-1; PO, oral; SQ, subcutaneous injection; TID, three times a day.

Blonde L, et al. *Endocr Pract*. 2022;28(10):923-1049; Grunvald E, et al. *Gastroenterology*. 2022;163(5):1198-1225; FDA Prescribing Information; Jastreboff AM, et al. *N Engl J Med*. 2022;387(3):205-216; Enright C, et al. *J Endocr Soc*. 2023;7(3):bvac195; Wadden TA, et al. *Nat Med*. 2023;29(11):2909-2918.

GLP-1 receptor agonism

CNS

↑ Satiety ↑ Nausea ↓ Food intake ↓ Body weight

Pancreas

↑ Insulin ↓ Glucagon

Stomach

↓ Gastric emptying

GIP receptor agonism

CNS

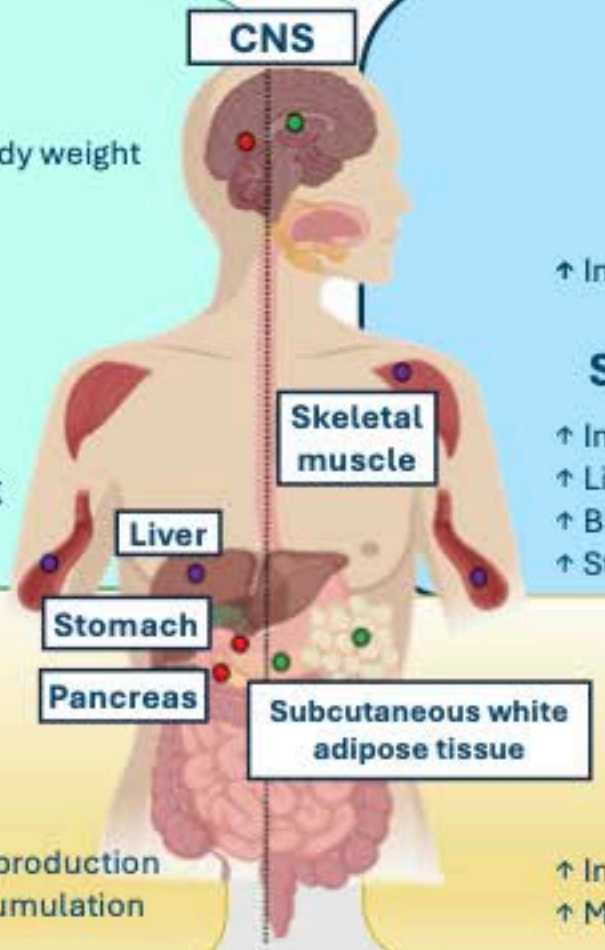
↓ Food intake
↓ Nausea
↓ Body weight

Pancreas

↑ Insulin ↓ Glucagon

Subcutaneous white adipose tissue

↑ Insulin sensitivity
↑ Lipid buffering capacity
↑ Blood flow
↑ Storage capacity
↓ Proinflammatory immune-cell infiltration



Systemic

↓ Hyperglycemia

Liver

↑ Insulin sensitivity ↓ Hepatic glucose production
↓ Ectopic lipid accumulation

Systemic

↓ Hyperglycemia
↓ Dietary TG

Skeletal muscle

↑ Insulin sensitivity ↓ Ectopic lipid accumulation
↑ Metabolic flexibility

GLP-1 receptor agonism | GIP receptor agonism | Indirect action

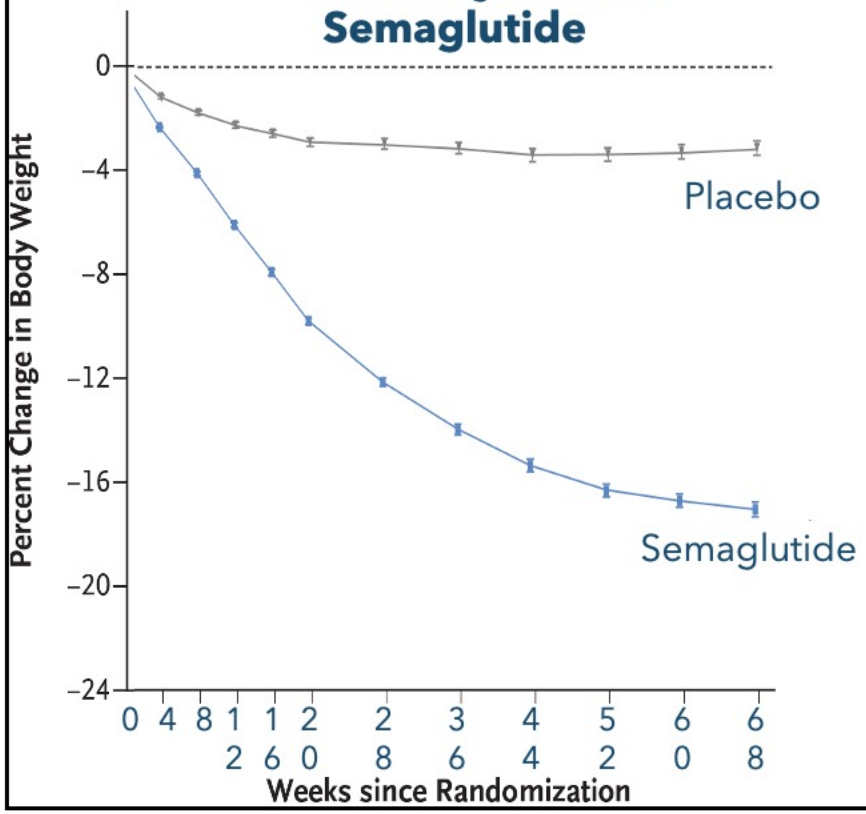
Slide provided by Dr Charles Vega, MD FAAFP
GLP-1, Glucagon-like peptide-1; GIP, Gastric inhibitory polypeptide.
Samms RJ, et al. *Trends Endocrinol Metab*. 2020;31(6):410-421.

Treatment of Obesity: Weight Loss with Semaglutide and Tirzepatide vs Placebo

Patients without T2D

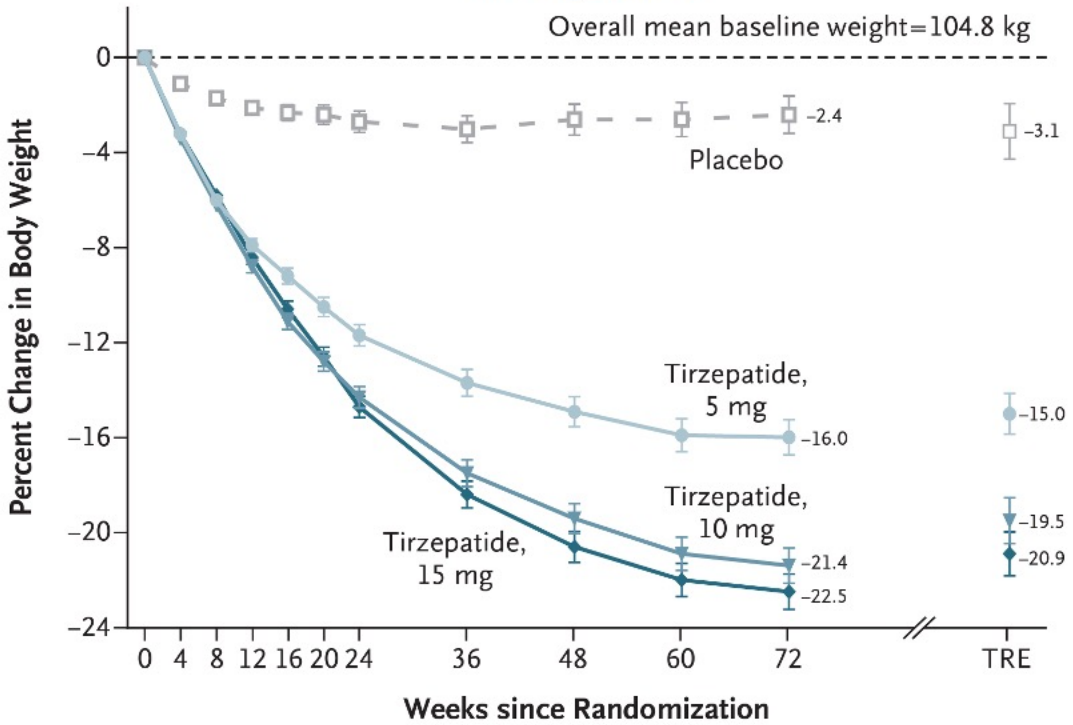
STEP-1, Phase 3 Trial in BMI ≥30 (excluding diabetes)

Semaglutide



SURMOUNT-1, Phase 3 Trial in BMI ≥30 or ≥27 with comorbidity (excluding diabetes)

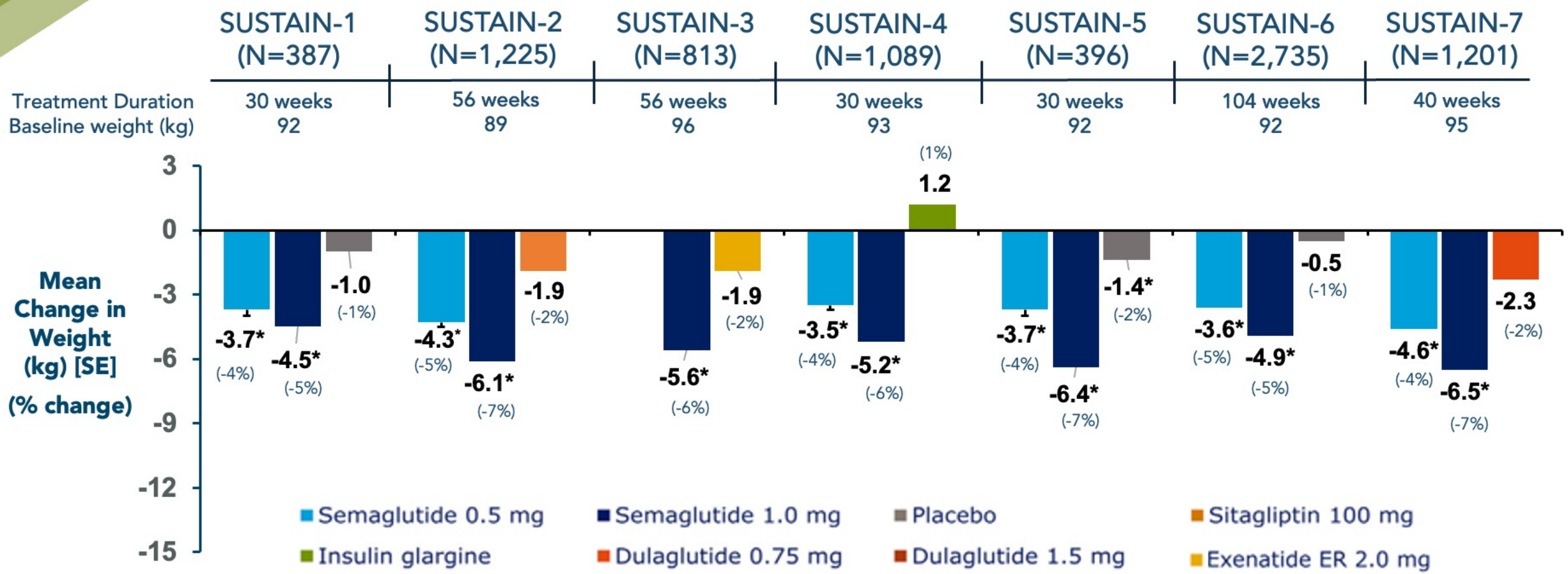
Tirzepatide



*Please note: these are not head-to-head trials.

Adapted from Wilding JPH, et al. *N Engl J Med*. 2021;384(11):989-1002. Jastreboff AM, et al. *N Engl J Med*. 2022;387(3):205-216

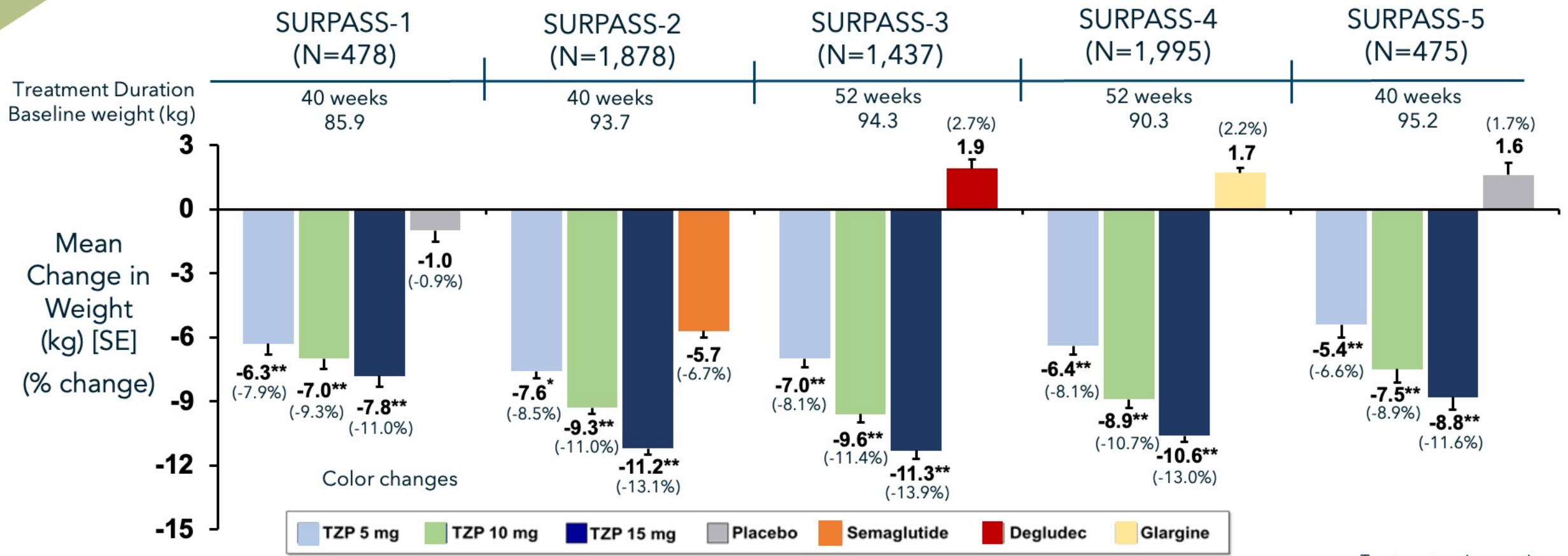
Weight Loss with Semaglutide vs Comparators in SUSTAIN Trials
Patients with T2D



Treatment-regimen estimate
Superiority vs placebo or active comparator: *P<0.01.

Sorli C, et al. *Lancet Diabetes Endocrinol*. 2017;5(4):251-260; Ahren B, et al. *Lancet Diabetes Endocrinol*. 2017;5(5):341-354; Ahmann AJ, et al. *Diabetes Care*. 2018;41(2):258-266; Aroda VR, et al. *Lancet Diabetes Endocrinol*. 2017;5(5):355-366; Rodbard HW, et al. *J Clin Endocrinol Metab*. 2018;103(6):2291-2301; Aroda VR, et al. *Diabetes Metab*. 2019;45(5):409-418.

Weight Loss with Tirzepatide vs Comparators in SURPASS Trials
Patients with T2D



Treatment-regimen estimand
Superiority vs placebo or active comparator: *P<0.05; **P<0.001

Rosenstock J, et al. *Lancet*. 2021;398(10295):143-155; Frías JP, et al. *N Engl J Med*. 2021;385(6):503-515; Ludvik B, et al. *Lancet*. 2021;398(10300):583-598; Del Prato S, et al. *Lancet*. 2021;398(10313):1811-1824; Dahl D, et al. *JAMA*. 2022;327(6):534-545; Rodriguez PJ, et al. *JAMA Intern Med*. 2024:e242525. Published online July 8, 2024.

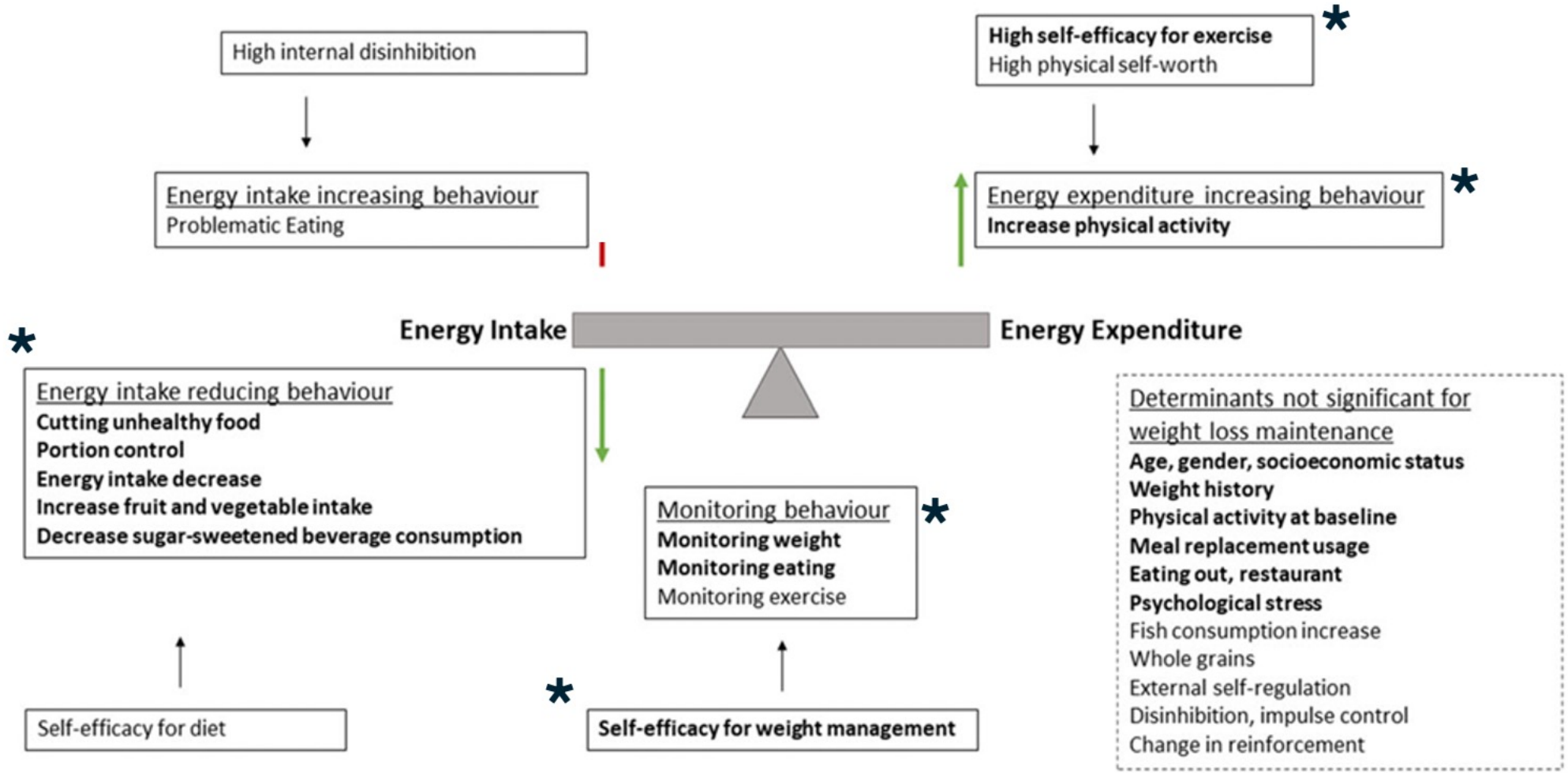
Obesity Treatment Options: Bariatric Surgery

2022 American Society for Metabolic and Bariatric Surgery	Two Most Common Bariatric Procedures	Poor Candidates
• BMI ≥30 with T2D or • BMI ≥30 without substantial or durable weight loss or co-morbidity improvement using nonsurgical methods • BMI ≥25 in people of Asian ethnicity • BMI ≥40 • BMI ≥27.5 in people of Asian ethnicity	The two most common bariatric surgical procedures are Roux-en-Y gastric bypass and vertical sleeve gastrectomy (often performed laparoscopically), which provide clinically meaningful improvement in metabolic diseases such as T2D	• Not seeking to lose weight • Medical condition contraindicating surgery • IBS, untreated gastric ulcer, GI motility disorders • Pregnancy or planned pregnancy • Dependence on drugs or alcohol • Uncontrolled depression, psychosis, or EDs • Inability to commit to life-long lifestyle changes

Tondt J, et al. *Obesity Algorithm eBook*. Obesity Medicine Association; 2023. https://obesitymedicine.org/obesity-algorithm-powerpoint/. Accessed July 9, 2024.

Determinants of Weight Loss Maintenance

A Systematic Review



Varkevisser RDM, et al. *Obes Rev*. 2019;20(2):171-211.

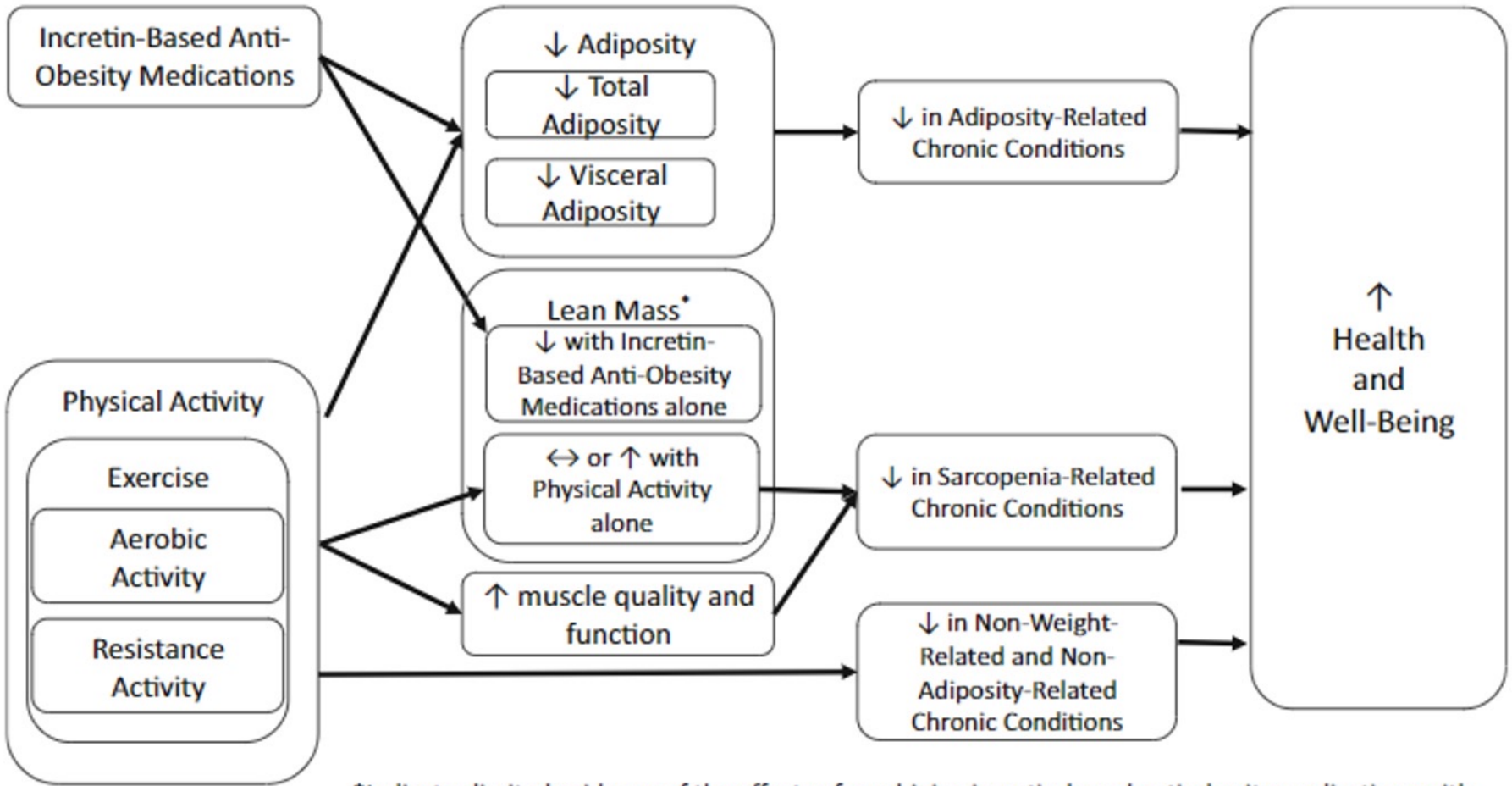
Case Study

Andrea wants to know what medications can help her lose weight and says she wants an "easy fix." When asked, you learn that Andrea unsuccessfully tried to lose weight in the past with popular diet programs, such as the keto diet and paleo diet. She also says she dislikes aerobic exercise.

Integration of new and emerging anti-obesity medicines into clinical practice

Professional Society Recommendations of Anti-Obesity Medications for Appropriate Patients

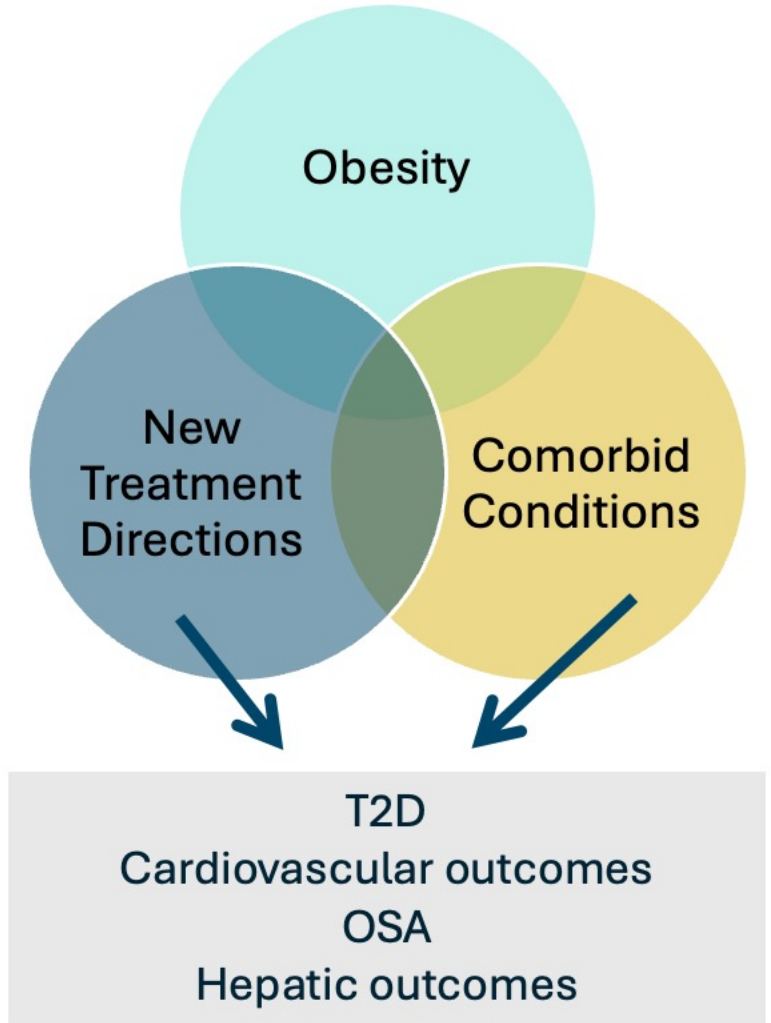
Benefits of Combined Use of AOM with Exercise



*Indicates limited evidence of the effects of combining incretin-based anti-obesity medications with physical activity on the change in lean mass.

Jakicic JM, et al. *Obesity (Silver Spring)*. 2024;32(2):234-236.

New Treatment Directions: Comorbidities of Obesity



Approaches to Glucose-Lowering Therapies in T2D Treatment

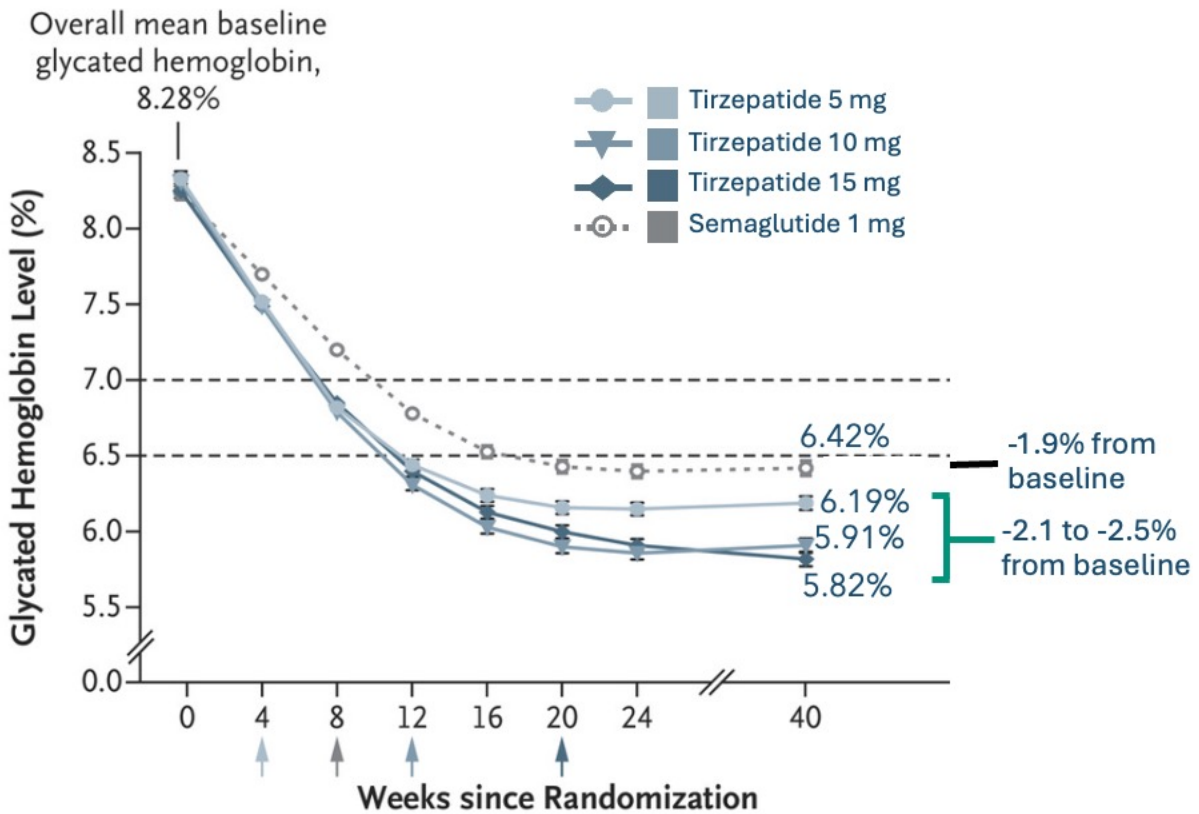
Weight Loss	Weight Neutral	Weight Gain
GLP-1 RA	DPP-4 inhibitors	Insulin secretagogues
Dual GIP and GLP-1 RA	Centrally acting dopamine agonist	Thiazolidinediones
SGLT2 inhibitors	A-glucosidase inhibitors	Insulin
Metformin	Bile acid sequestrants	
Amylin mimetics		

DPP, dipeptidyl peptidase-4; SGLT2, Sodium-glucose cotransporter-2

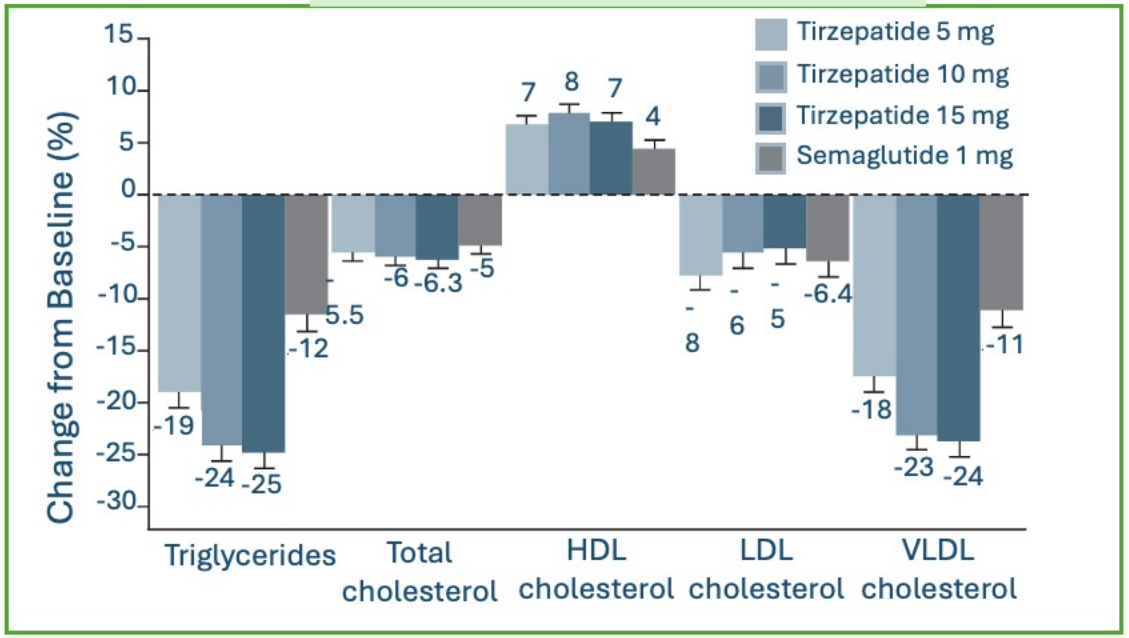
American Diabetes Association. *Diabetes Care*. 2024; Nauck MA, et al. *J Clin Endocrinol Metab*. 1993;76(4):912-917.

Benefits Beyond Weight Loss with Tirzepatide and Semaglutide

Glycemic Control in T2D



Lipid Levels in T2D



Lipid Levels in Obesity *% baseline change*	Semaglutide	Tirzepatide
TC	-3.3 to 7.1	-4.9 to -7.4
LDL-C	-6.5 to 1	-5.3 to -8.6
TG	-6 to -22.5	-24 to -31
HDL-C	-0.3 to 18	7 to 8.6

Frías JP, et al. *N Engl J Med*. 2021;385(6):503-515; Bergmann NC, et al. *Diabetes Obes Metab*. 2023;25(1):18-35; Jastreboff AM, et al. *N Engl J Med*. 2022;387(3):205-216.

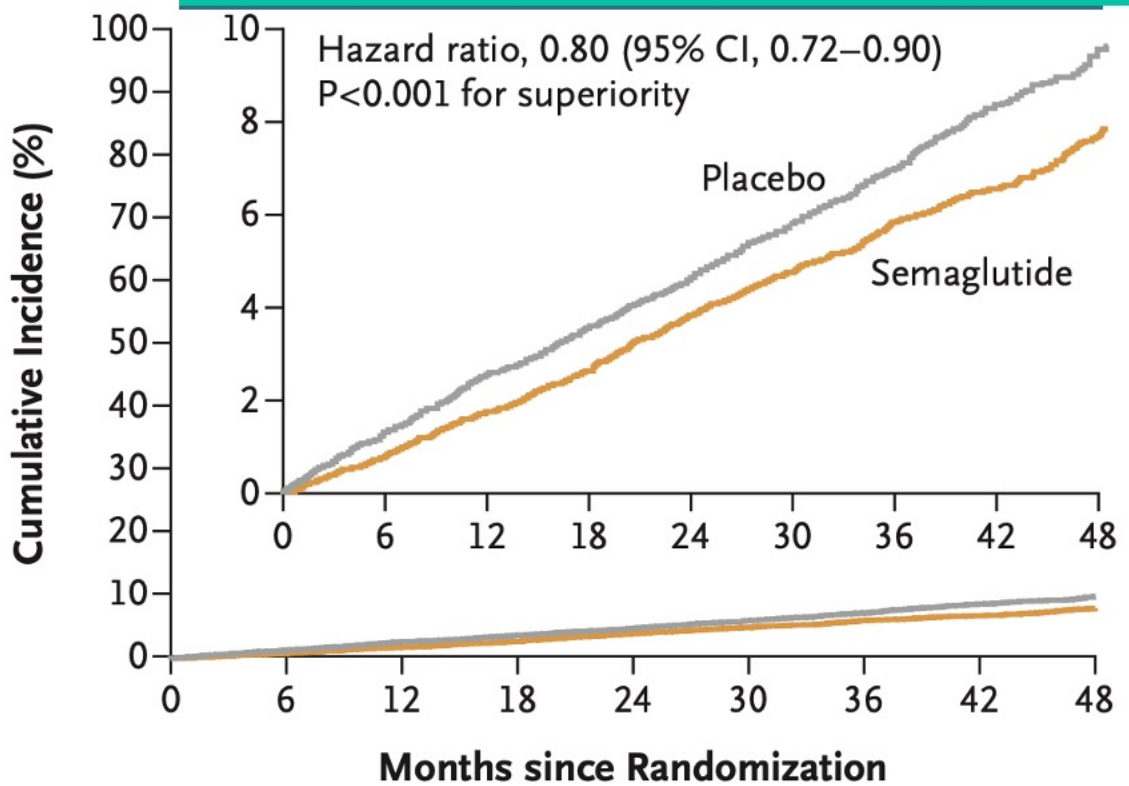
Cardiovascular Outcomes in Obesity without Diabetes with Semaglutide

March 2024
New FDA Indication for Semaglutide 2.4 mg:

To reduce the risk of major adverse **cardiovascular events** (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight

Pivotal trial results of SELECT found weekly subcutaneous semaglutide at a dose of 2.4 mg was superior to placebo in reducing the incidence of death from cardiovascular causes, nonfatal myocardial infarction, or nonfatal stroke at a mean follow-up of 39.8 months in a cohort with CVD and overweight or obesity (no diabetes)

SELECT – BMI >27 with **CVD disease (no diabetes)**
Patients with Primary Outcome Event
(composite of CV death, nonfatal MI, or stroke)

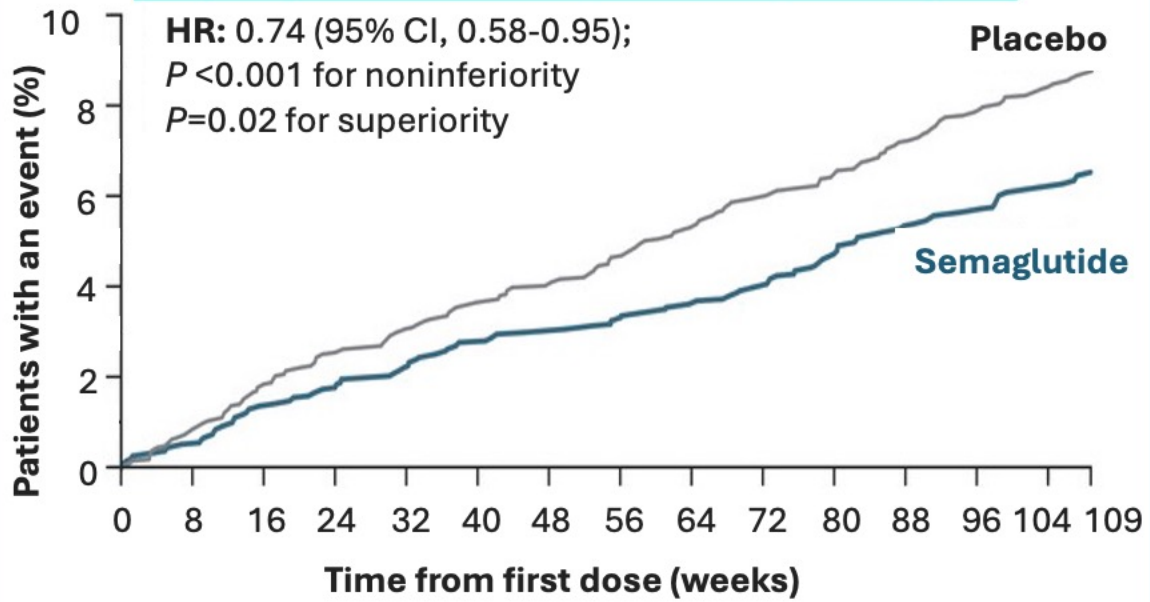


The insets show the same data on an enlarged y axis. The x axis is truncated at 48 months because of the limited number of patients in the trial after 48 months

FDA. Prescribing Information; Lincoff, AM, et al. *N Engl J Med*. 2023;389:2221-2232.

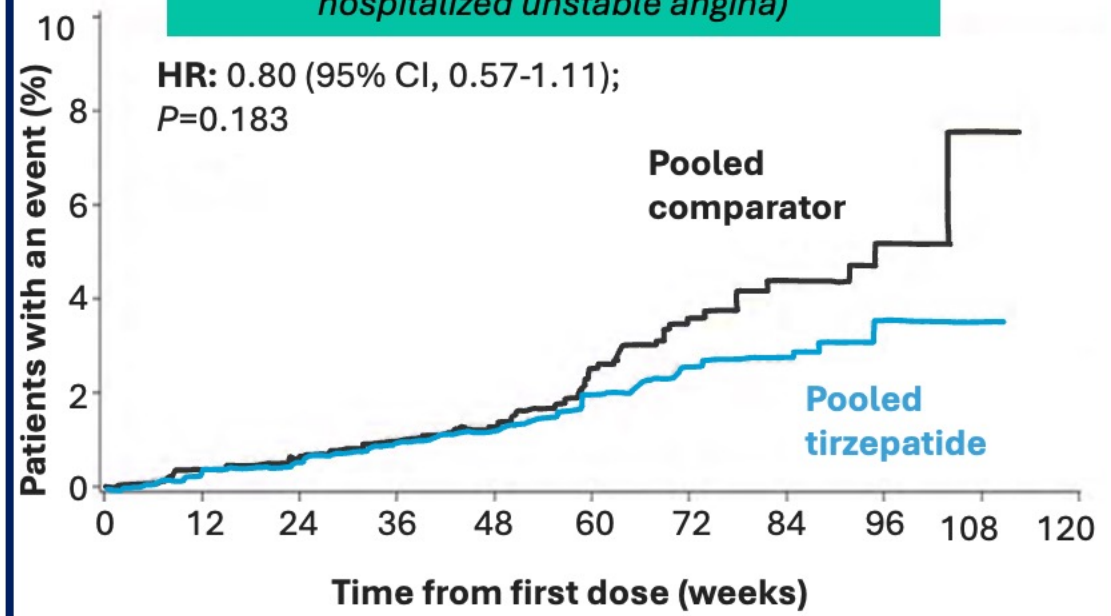
Cardiovascular Risk with Tirzepatide & Semaglutide Among Patients with T2D

SUSTAIN 6 – T2D with **CVD Risk**
Patients with Primary Outcome Event
(composite of CV death, nonfatal MI, or stroke)



Important to note the differences in outcomes being measured between studies, as well as comparator vs placebo

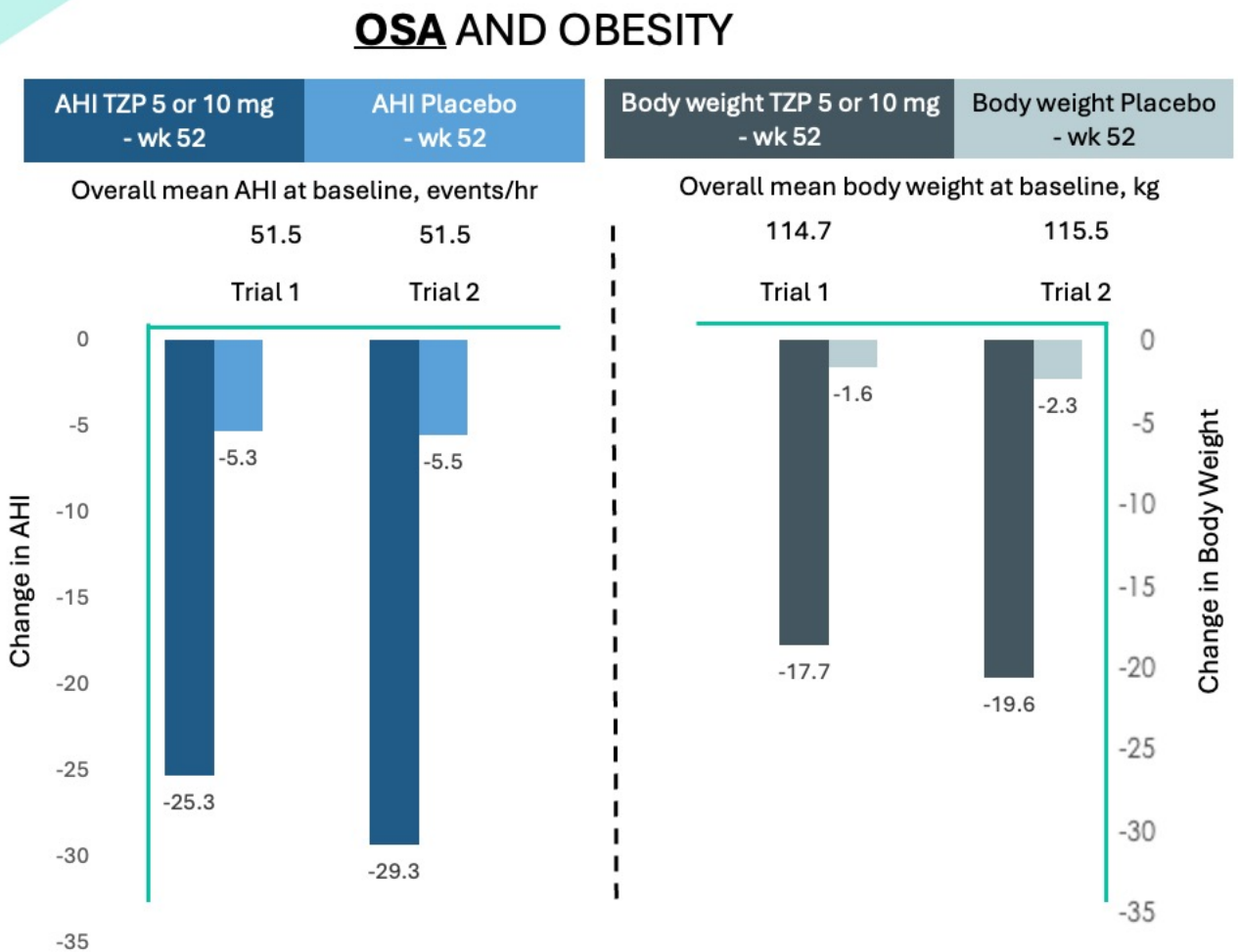
SURPASS T2D Trials Meta-Analysis
Patients with Primary Outcome Event
(MACE-4; CV death, MI, stroke, and hospitalized unstable angina)



Meta-analysis included over 7,000 patients, comparing tirzepatide to comparator. Tirzepatide had a statistically significant lower risk of MACE-4 (CV death, MI, stroke, hospitalized unstable angina) compared to comparators. CVOT data with tirzepatide will be available later in 2024.

Marso SP, et al. *N Engl J Med*. 2016;375(19):1834-1844; Sattar N, et l. *Nat Med*. 2022;28(3):591-598.

AHI and Weight Change With Tirzepatide vs Placebo in SURMOUNT-OSA



Two phase 3, double-blind, randomized, controlled trials involving adults with moderate-to-severe OSA and obesity

Trial 1: Participants who were not receiving treatment with PAP at baseline

Trial 2: Participants who were receiving PAP therapy at baseline

Primary Endpoint

- Change in AHI

Secondary Endpoints

- Percent change in AHI and body weight and changes in hypoxic burden, patient-reported sleep impairment and disturbance, hsCRP concentration, and systolic blood pressure

Results

- Significant improvements in the measurements for all prespecified key secondary end points were observed with tirzepatide as compared with placebo
- Most frequently reported AEs with tirzepatide were GI in nature and mostly mild to moderate in severity

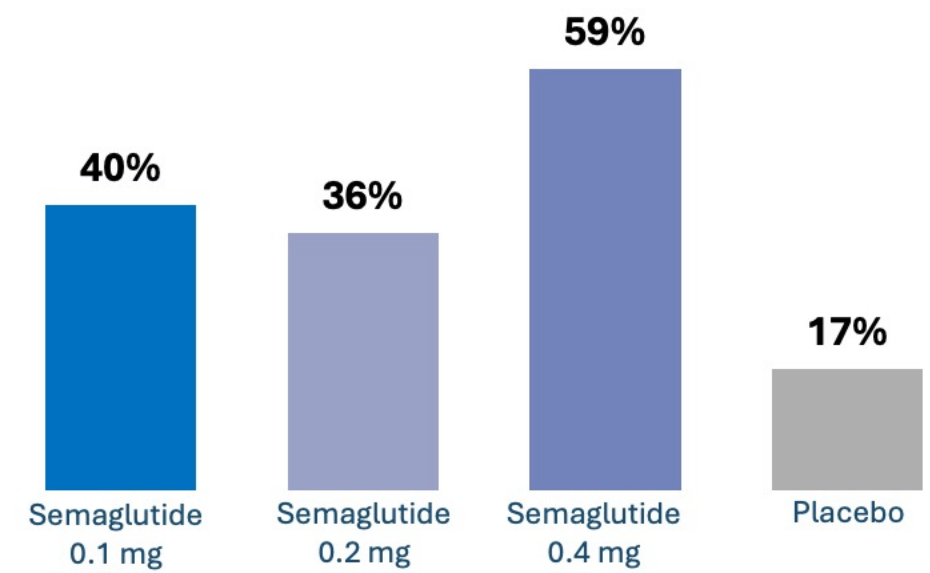
AE, adverse event; AHI, apnea–hypopnea index; GI, gastrointestinal; hsCRP, high- sensitivity C-reactive protein; PAP, positive airway pressure; TZP, tirzepatide; wk, week.

Malhotra A, et al. *N Engl J Med*. Published online June 21, 2024. doi:10.1056/NEJMoa2404881.

Hepatic Outcomes with Tirzepatide and Semaglutide

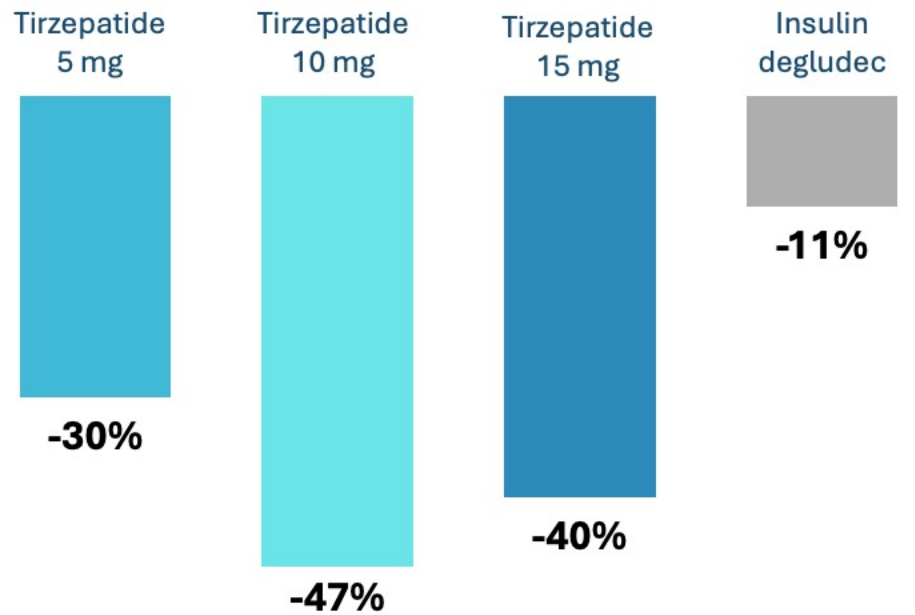
Semaglutide Phase 2 Trial for Biopsy-Confirmed **MASH** (no diabetes)

Resolution of MASH with no worsening of liver fibrosis



SURPASS-3 MRI: Sub study with Tirzepatide (with diabetes)

Relative Change (%) of Liver Fat Content (LFC)



MASH, Metabolic dysfunction-associated steatohepatitis

Newsome PN, et al. *N Engl J Med*. 2021;384(12):1113-1124; Gastaldelli A, et al. *Lancet Diabetes Endocrinol*. 2022;10(6):393-406.

Most Common Side Effects of Semaglutide and Tirzepatide

- **17-22%** — Nausea
- **12-16%** — Diarrhea
- **6-10%** — Vomiting
- **6-9%** — Dyspepsia
- **5-7%** — Constipation
- **3-5%** — Abdominal pain

It is important to communicate with your patient about strategies to manage side effects to encourage adherence to therapy

Contraindications and Limitations of Use

Semaglutide and Tirzepatide

Contraindications

- Personal or family history of medullary thyroid cancer or patients with multiple endocrine neoplasia syndrome type 2
- Known serious hypersensitivity to tirzepatide/semaglutide or any of the excipients

Limitations of Use

- Has not been studied in patients with a history of pancreatitis
- Is not indicated for use in patients with type 1 diabetes

Patient Consulting and Counseling

GI side effects are typically mild to moderate and temporary in nature
HCPs should titrate doses up to help mitigate adverse events.

- ✓ Eat slowly
- ✓ Smaller portions
- ✓ Do not skip meals
- ✓ Eat when hungry
- ✓ Increase meal frequency
- ✓ Limit overactivity after meal
- ✓ Incorporate a low-fat diet
- ✓ Refrain from lying down after a meal

Other Considerations

- Muscle mass change
- Role of combination therapies
- Duration of pharmacotherapy treatment

FDA Prescribing Information; Wharton S, et al. *Postgrad Med.* 2022;134(1):14-19; Gorgojo-Martinez JJ, et al. *J Clin Med.* 2023;12(1):145.

THANK YOU

Up Next Part 3

Best Practices in Shared Decision-Making to Enhance Patient Outcomes