Care Transition Considerations for Obesity Management

Foundational Principles for Every Care Transition

Many people with obesity have associated chronic conditions and/or diseases.[1-3] Care transitions—between health care settings and HCPs—are part of the long-term care that these patients need, but suboptimal transitions can negatively affect patient health and healthcare costs.[4] Evidence-based principles for optimizing care transitions can improve health outcomes and reduce costs.[4]

ACP-Recommended Principles of Effective Care Transition[4]	Considerations for Applying Principles in Obesity Management
Discuss patient goals with patients, families, and care providers	Communicate the need to plan for long-term care, based on obesity biology and management to improve associated complications.[3] Perceived bias can delay or disrupt care. Use respectful, clear language and communication practices that avoid bias and stigma to improve transitions.[5] See the resources on avoiding bias and stigma in weight conversations for more information. Share decision-making. Before starting, intensifying, or stopping treatment, discuss options, expected benefits, possible side effects, access, and the need for long-term follow-up.[3]
Address SDOH	Use SDOH screening tools (eg, CMS AHC-HRSN Screening Tool, Hunger Vital Sign) to identify and address negative SDOH.[6,7] See the resource on SDOH considerations in obesity care for more information.
Scope transitional care in the context of the care trajectory over the course of the illness	A patient's total care team should collaborate to ensure completion of care transition processes (eg, identifying and scheduling follow-up appointments, obtaining prior authorizations for testing or therapies), regardless of where in the care trajectory the actions are started.[4] When planning care transitions, remember that obesity is a chronic disease with a long-term care trajectory.[4]
Provide clear communication among all members of the clinical care team	Document information at each transition (eg, weight and BMI trends, treatment history, response, adverse effects, relevant laboratory results, and patient goals).[3,4] Designate an individual to manage care coordination.[4] Provide a means to provide patients with information (eg, what to expect from an upcoming visit with a new HCP, goals of the care transition).[4] Avoid information overload and provide written documentation of communications.[4]

Common Transition Points in Obesity Care

Obesity care often moves across settings, including emergency care, primary care, specialty clinics, hospital care, and follow-up after discharge. Each handoff can maintain or disrupt continuity. The table below highlights some key points to communicate at common transitions.

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Transition	Key Considerations	Examples of Information to Communicate to the Receiving HCP
Acute care (eg, hospital discharge, emergency department visit) → Primary care	Patients are rarely hospitalized for obesity itself, but hospitalization for obesity-related conditions (for example, cardiac events, heart failure, or diabetes crises) may provide an opportunity to address obesity at discharge. Standardized handoffs can support follow-up.[8]	• Admission/visit reason • Weight and BMI • Changes in antiobesity medications • Obesity care recommendations • Discharge instructions
Primary care → Obesity medicine specialist	Consider referral when weight and health goals are not being met in primary care, when individualized pharmacotherapy decisions become complex, or when managing obesity-related complications would benefit from specialist input.[3]	• BMI trend • Prior weight management interventions and outcomes • Current and prior antiobesity medications • Obesity-related complications • Behavioral and psychosocial factors • Patient goals
Pediatric → Adult obesity care	Use a structured, gradual handoff. Without a clear transition process, adolescents—especially those who have had bariatric surgery—may be lost to follow-up and may develop nutritional deficiencies.[9]	• Growth and BMI history • Pubertal stage • Comorbidities • Prior pharmacotherapy or surgery • Family and social context • Readiness for self-management
Primary care → Bariatric/metabolic surgery	Metabolic and bariatric surgery is appropriate for adults with BMI of 35 kg/m^2 or greater, regardless of comorbidities, and for those with metabolic disease and BMI of 30–34.9 kg/m^2.[10]	• Comorbidities • Medications • Nutritional status • Mental health screening • Prior weight management history • Social support
Bariatric surgery center → Primary care (long-term follow-up)	After discharge from the bariatric center, primary care should review nutritional intake, activity, supplement adherence, weight, and comorbidities, and arrange annual laboratory monitoring for nutritional deficiencies.[11]	• Procedure type and date • Surgical complications • Postoperative weight trajectory • Current supplements • Most recent labs • Red flags (for example, persistent vomiting, anemia, neurologic symptoms)

Abbreviations: AHC-HRSN, Accountable Health Communities Health-Related Social Needs; BMI, body mass index; CMS, Centers for Medicare and Medicaid Services; HCP, healthcare professional; SDOH, social determinants of health.

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