



## General

### Guideline Title

Adult weight management evidence-based nutrition practice guideline.

### Bibliographic Source(s)

Academy of Nutrition and Dietetics. Adult weight management evidence-based nutrition practice guideline. Chicago (IL): Academy of Nutrition and Dietetics; 2014. Various p.

### Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Dietetic Association (ADA). Adult weight management evidence based nutrition practice guideline. Chicago (IL): American Dietetic Association (ADA); 2006 May. Various p. [151 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Recommendations

### Major Recommendations

Ratings for the strength of the recommendations (Strong, Fair, Weak, Consensus, Insufficient Evidence), conclusion grades (I-V), and statement labels (Conditional versus Imperative) are defined at the end of the "Major Recommendations" field.

#### Adult Weight Management (AWM): Screening and Referral for Medical Nutrition Therapy (MNT)

AWM: Annual Screening for Overweight/Obesity

The registered dietitian nutritionist (RDN), in collaboration with other health care professionals, administrators and public policy decision-makers, should ensure that all adult patients have the following measurements at least annually:

- Height and weight to calculate body mass index (BMI), classified as overweight (BMI more than 25.0 kg/m<sup>2</sup> to 29.9 kg/m<sup>2</sup>) or obese
  - Class I obesity: BMI 30kg/m<sup>2</sup> to 34.9kg/m<sup>2</sup>
  - Class II obesity: BMI 35kg/m<sup>2</sup> to 39.9kg/m<sup>2</sup>
  - Class III (extreme) obesity: 40kg/m<sup>2</sup> or higher
- Waist circumference to determine the risk of cardiovascular disease (CVD), type 2 diabetes and all-cause mortality
  - National Institutes of Health/National Heart, Lung, and Blood Institute (NIH/NHLBI)
    - Men: More than 102 cm (more than 40 inches)

- Women: More than 88 cm ( more than 35 inches)

Annual BMI screening will identify adults who are overweight or obese and therefore, may be at elevated risk of CVD and all-cause mortality. In addition, the greater the waist circumference, the greater the risk of CVD, type 2 diabetes and all-cause mortality.

Fair, Imperative

AWM: Referral to RDN for MNT

The RDN, in collaboration with other health care professionals, administrators and public policy decision-makers, should ensure that overweight or obese adults are referred to an RDN for MNT. Intensive counseling and behavioral interventions promote sustained weight loss and reduce known risk factors for diet-related chronic disease.

Fair, Imperative

AWM: MNT

AWM: MNT

MNT provided by a RDN is recommended for overweight and obese adults. MNT provided by an RDN results in both statistically significant and clinically meaningful weight loss in overweight and obese adults, as well as reduced risk for diabetes, disorders of lipid metabolism and hypertension.

Strong, Imperative

Recommendation Strength Rationale

- Conclusion statements are Grades I, II, and IV.

AWN: Duration and Frequency of MNT

AWM: Duration and Frequency of MNT for Weight Loss

For weight loss, the RDN should schedule at least 14 MNT encounters (either individual or group) over a period of at least six months. High-frequency comprehensive weight loss interventions result in weight loss.

Strong, Imperative

AWM: Duration and Frequency of MNT for Weight Maintenance

For weight maintenance, the RDN should schedule at least monthly MNT encounters over a period of at least one year. High-frequency comprehensive weight maintenance interventions result in maintenance of weight loss.

Strong, Imperative

AWN: Incorporating Telenutrition Interventions

AWM: Incorporating Telenutrition Interventions for Weight Loss

If the RDN incorporates telenutrition interventions for weight loss, MNT should consist of both in-person and non-in-person encounters. Research on telenutrition interventions involving an RDN reported that hybrid interventions (containing both in-person and non-in-person components) were more effective for weight loss than using telenutrition interventions (only non-in-person components).

Strong, Conditional

AWM: Incorporating Telenutrition Interventions for Weight Maintenance

If the RDN incorporates telenutrition interventions for weight maintenance, MNT may consist of either in-person or non-in-person encounters. Research on telenutrition interventions involving an RDN reported that either hybrid interventions (containing both in-person and non-in-person components) or telenutrition interventions (only non-in-person components) were effective for weight maintenance.

Strong, Conditional

Recommendation Strength Rationale

- Conclusion statements are Grade I.

#### AWM: Weight Management for Older Adults

##### AWM: Weight Management for Older Adults

For older adults (aged 65 years and older) who are overweight or obese, the RDN should provide MNT for weight loss and weight maintenance. Research has reported reduced risk of mortality, reduced development of type 2 diabetes and improved cardiovascular risk factors with intentional weight loss in older persons and weight gain produces increased risk for several health outcomes.

Fair, Conditional

#### AWM: Assess Data to Individualize the Comprehensive Weight Management Program

##### AWM: Assess Data to Individualize the Comprehensive Weight Management Program

The RDN should assess the following data in order to individualize the comprehensive weight management program for overweight and obese adults:

Food- and nutrition-related history, including but not limited to:

- Beliefs and attitudes, including food preferences and motivation
- Food environment, including access to fruits and vegetables
- Dietary behaviors, including eating out and screen time
- Diet experience, including food allergies and past dieting history
- Medications and supplements
- Physical activity

Anthropometric measurements, including but not limited to:

- Height, weight, BMI
- Waist circumference
- Weight history
- Body composition (if available)

Biochemical data, medical tests and procedures, including but not limited to:

- Glucose and endocrine profile
- Lipid profile

Nutrition-focused physical findings, including but not limited to:

- Ability to communicate
- Affect
- Amputations
- Appetite
- Blood pressure
- Body language
- Heart rate

Client history, including but not limited to:

- Appropriateness of weight management in certain populations (such as eating disorders, pregnancy, receiving chemotherapy)
- Client and family medical and health history
- Social history, including living or housing situation and socio-economic status

Moderately strong evidence indicates that the food environment is associated with dietary intake, especially less consumption of vegetables and fruits and higher body weight. Strong and consistent evidence indicates that adults who eat fast food often are at increased risk of weight gain, overweight and obesity and that screen time, especially television screen time, is directly associated with increased overweight and obesity.

Strong, Imperative

### AWM: Assess Motivation for Weight Management

#### AWM: Assess Motivation for Weight Management

The RDN should assess motivation, readiness and self-efficacy for weight management, based on behavior change theories and models (such as cognitive-behavioral therapy, transtheoretical model and social cognitive theory/social learning theory). While research supports cognitive-behavioral therapy as an effective method of overweight and obesity treatment, there is limited research in the areas of the transtheoretical model and social cognitive theory and social learning theory.

Fair, Imperative

#### Recommendation Strength Rationale

- Conclusion statements are Grades II and III.

### AWM: Assess Energy Needs

#### AWM: Measure Resting Metabolic Rate (RMR)

If indirect calorimetry is available, the RDN should use a measured RMR to determine energy needs in overweight or obese adults. Measurement of RMR using indirect calorimetry is more accurate than estimating RMR using predictive equations.

Consensus, Conditional

#### AWM: Use Mifflin-St. Jeor Equation to Estimate RMR

If indirect calorimetry is not available, the RDN should use the Mifflin-St. Jeor equation using actual weight to estimate RMR in overweight or obese adults. The majority of research reviewed supports the use of the Mifflin-St. Jeor equation (using actual body weight) to predict RMR in overweight or obese adults because it demonstrated good accuracy and correlation with indirect calorimetry.

Strong, Conditional

#### AWM: Estimate Total Energy Needs

The RDN should multiply the RMR (measured or estimated) by one of the following physical activity factors to estimate total energy needs:

- *Sedentary*: 1.0 or more to less than 1.4
- *Low active*: 1.4 or more to less than 1.6
- *Active*: 1.6 or more to less than 1.9
- *Very active*: 1.9 or more to less than 2.5.

The Dietary Reference Intakes (DRI) Physical Activity Levels (PAL) represent the ratio of total energy expenditure to basal energy expenditure and are defined as sedentary, low active, active or very active.

Consensus, Imperative

#### Recommendation Strength Rationale

- Conclusion statement is Grade I.

### AWM: Assess Energy Intake and Nutrient Content of the Diet

#### AWM: Assess Energy Intake and Nutrient Content of the Diet

The RDN should assess the energy intake and nutrient content of the diet. Any nutrient inadequacy and the nutrients affected are dependent on the composition of the diet followed, as well as on the nutritional needs of the individual.

Strong, Imperative

#### Recommendation Strength Rationale

- Conclusion statement is Grade II.

### AWM: Realistic Weight Goal Setting

## AWM: Realistic Weight Goal Setting

The RDN should collaborate with the individual regarding a realistic weight loss goal, such as one of the following:

- Up to two pounds per week
- Up to 10% of baseline body weight
- A total of 3% to 5% of baseline body weight if cardiovascular risk factors (hypertension, hyperlipidemia and hyperglycemia) are present

Studies regarding the effectiveness of MNT for under six months reported significant weight losses of approximately one to two pounds per week, and six to 12 months of MNT resulted in significant mean weight losses of up to 10% of body weight. While a sustained weight loss of 3% to 5% is likely to result in clinically meaningful reductions in triglycerides, blood glucose, glycosylated hemoglobin (HbA1c), and the risk of developing type 2 diabetes, greater amounts of weight loss will also reduce blood pressure, improve low-density lipoprotein cholesterol (LDL-C) and high-density lipoprotein cholesterol (HDL-C), and reduce the need for medications.

Strong, Imperative

Recommendation Strength Rationale

- Conclusion statement is Grade I.

## AWM: Components of a Comprehensive Weight Management Program

AWM: Components of a Comprehensive Weight Management Program

For weight loss and weight maintenance, the RDN should include the following components as part of a comprehensive weight management program:

- Reduced calorie diet
- Increasing physical activity
- Use of behavioral strategies

Adequate evidence indicates that intensive, multi-component behavioral interventions for overweight and obese adults can lead to weight loss as well as improved glucose tolerance and other physiologic risk factors for cardiovascular disease.

Strong, Imperative

## AWM: Caloric Reduction and Nutrient Adequacy

AWM: Achieve Nutrient Adequacy during Weight Loss

During weight loss, the RDN should prescribe an individualized diet, including patient preferences and health status, to achieve and maintain nutrient adequacy and reduce caloric intake, based on one of the following caloric reduction strategies:

- 1,200 kcal to 1,500 kcal per day for women and 1,500 kcal to 1,800 kcal per day for men (kcal levels are usually adjusted for the individual's body weight)
- Energy deficit of approximately 500 kcal per day or 750 kcal per day
- One of the evidence-based diets that restricts certain food types (such as high-carbohydrate foods, low-fiber foods, or high-fat foods) in order to create an energy deficit by reduced food intake

Several studies report changes in nutrient adequacy with caloric restriction, however the extent of nutrient inadequacy and the nutrients affected are dependent on the composition of the diet followed, as well as on the nutritional needs of the individual. Limited research reports reductions in nutrient adequacy with weight loss through an energy restriction of at least 500 kcal per day or daily consumption below 1,200 kcal per day.

Strong, Imperative

AWM: Maintain Nutrient Adequacy during Weight Maintenance

During weight maintenance, the RDN should prescribe an individualized diet (including patient preferences and health status) to maintain nutrient adequacy and reduce caloric intake for maintaining a lower body weight. Several studies report changes in nutrient adequacy with caloric restriction, however the extent of nutrient inadequacy and the nutrients affected are dependent on the composition of the diet followed, as well as on the nutritional needs of the individual. Limited research reports reductions in nutrient adequacy with weight loss through an energy restriction of

at least 500 kcal per day or daily consumption below 1,200 kcal per day.

Strong, Imperative

Recommendation Strength Rationale

- Conclusion statement is Grade II.

AWM: Dietary Approaches for Caloric Reduction

AWM: Dietary Approaches for Caloric Reduction in Weight Loss

For weight loss, the RDN should advise overweight or obese adults that as long as the target reduction in calorie level is achieved, many different dietary approaches are effective. There is strong and consistent evidence that when calorie intake is controlled, macronutrient proportion, glycemic index and glycemic load of the diet are not related to losing weight.

Strong, Imperative

AWM: Dietary Approaches for Caloric Reduction in Weight Maintenance

For weight maintenance, the RDN should advise overweight and obese adults that as long as the target reduction in calorie level is achieved, many different dietary approaches are effective. A moderate body of evidence provides no data to suggest that any one macronutrient is more effective than any other for avoiding weight re-gain in weight-reduced persons. Strong and consistent evidence shows that glycemic index and glycemic load are not associated with body weight and do not lead to better weight maintenance.

Strong, Imperative

AWM: Eating Frequency and Meal Patterns

AWM: Eating Frequency and Meal Patterns for Weight Loss and Weight Maintenance

For weight loss and weight maintenance, the RDN should individualize the meal pattern to distribute calories at meals and snacks throughout the day, including breakfast. Research reports inconsistent results regarding the association between eating frequency and body weight, which may be due to the role of portion size, energy density or compensation of energy intake at subsequent eating occasions. The majority of observational research reported that breakfast consumption is associated with a lower BMI and decreased obesity risk, while omitting breakfast is associated with a higher BMI and increased obesity risk. Several studies suggest that cereal-based breakfasts are associated with lower BMI, while breakfasts that are very high in energy are associated with higher BMI.

Fair, Imperative

Recommendation Strength Rationale

- Conclusion statements are Grade II.

AWM: Portion Control and Meal Replacements/Structured Meal Plans

AWM: Portion Control and Meal Replacements/Structured Meal Plans

For weight loss and weight maintenance, the RDN should recommend portion control and meal replacements or structured meal plans as part of a comprehensive weight management program. Strong evidence documents a positive relationship between portion size and body weight and research reports that the use of various types of meal replacements or structured meal plans was helpful in achieving health and food behavior change.

Strong, Imperative

Recommendation Strength Rationale

- Conclusion statement is Grade I.

AWM: Encourage Physical Activity

AWM: Encourage Physical Activity for Weight Loss

For weight loss, the RDN should encourage physical activity as part of a comprehensive weight management program, individualized to gradually accumulate 150 to 420 minutes or more of physical activity per week, depending on intensity, unless medically contraindicated. Physical activity less than 150 minutes per week promotes minimal weight loss, physical activity more than 150 minutes per week results in modest weight loss of approximately 2 kg to 3 kg, and physical activity of more than 225 to 420 minutes per week results in 5 kg to 7.5 kg weight loss, and a dose–response exists.

Consensus, Imperative

AWM: Encourage Physical Activity for Weight Maintenance

For weight maintenance, the RDN should encourage physical activity as part of a comprehensive weight management program, individualized to accumulate 200 to 300 minutes or more of physical activity per week, depending on intensity, unless medically contraindicated. Some studies support the value of approximately 200 to 300 minutes per week of physical activity during weight maintenance to reduce weight regain after weight loss.

Consensus, Imperative

AWM: Multiple Behavior Therapy Strategies

AWM: Multiple Behavior Therapy Strategies

For weight loss and weight maintenance, the RDN should incorporate one or more of the following strategies for behavior therapy:

- *Self-monitoring*: Strong evidence shows that for adults who need or desire to lose weight or for adults who are maintaining body weight following weight loss, self-monitoring of food intake improves nutrition-related outcomes related to weight loss and weight maintenance.
- *Motivational interviewing*: Research demonstrated that motivational interviewing significantly enhanced adherence to program recommendations and improved targeted diet-related outcomes including glycemic control, percentage of energy intake from fat, fruit and vegetable intake and weight loss.
- *Structured meal plans and meal replacements and portion control*: Research reports that the use of various types of meal replacements or structured meal plans was helpful in achieving health and food behavior change and strong evidence documents a positive relationship between portion size and body weight.
- *Goal-setting*: Clients' active participation in selecting and setting goals led to the selection of a goal from the area that could use the most improvement and the goal that was most personally appropriate.
- *Problem-solving*: Studies based on the use of problem-solving strategies resulted in improvements in key outcome measures, including maintenance of weight loss and in subjects with diabetes, was linked to improvements in fat consumption, self-efficacy and physical activity.

Strong, Imperative

AWM: Consider Use of Additional Behavior Therapy Strategies

For weight loss and weight maintenance, the RDN may consider using the following behavior therapy strategies:

- Cognitive restructuring
- Contingency management
- Relapse prevention techniques
- Slowing the rate of eating
- Social support
- Stress management
- Stimulus control and cue reduction

These strategies are not well researched and there is limited evidence demonstrating their effectiveness.

Fair, Imperative

Recommendation Strength Rationale

- Conclusion statements are Grades I, II, and III.

AWM: Coordination of Care

AWM: Coordinate Care with Interdisciplinary Team

For weight loss and weight maintenance, the RDN should implement MNT and coordinate care with an interdisciplinary team of health professionals (may include specialized RDNs, nurses, nurse practitioners, pharmacists, physicians, physician assistants, physical therapists, psychologists, social workers, and so on), especially for patients with obesity-related co-morbid conditions. Coordination of care may include collaboration on:

- Use of U.S. Food and Drug Administration (FDA)-approved weight-loss medications
- Appropriateness of bariatric surgery for people who have not achieved weight loss goals with less invasive weight loss methods

Coordination of care with an interdisciplinary team of health professionals promotes the greatest effectiveness of MNT.

Consensus, Imperative

AWM: Recommend Use of Community Resources

The RDN should recommend use of community resources, such as local food sources, food assistance programs, support systems and recreational facilities. Moderately strong evidence indicates a relationship between the food environment and dietary intake.

Strong, Imperative

AWM: Monitor and Evaluate the Effectiveness of the Comprehensive Weight Management Program

AWM: Monitor and Evaluate the Effectiveness of the Comprehensive Weight Management Program

The RDN should monitor and evaluate the effectiveness of the comprehensive weight management program for overweight or obese adults, through the following data:

Food and nutrition-related history, including but not limited to:

- Beliefs and attitudes, including motivation
- Food environment, including access to fruits and vegetables
- Dietary behaviors, including eating out and screen time
- Medications and supplements
- Physical activity

Anthropometric measurements, including but not limited to:

- Weight and BMI
- Waist circumference
- Body composition (if available)

Biochemical data, medical tests and procedures, including but not limited to:

- Glucose/endocrine profile
- Lipid profile

Nutrition-focused physical findings, including but not limited to:

- Affect
- Appetite
- Blood pressure
- Body language
- Heart rate

Moderately strong evidence indicates that the food environment is associated with dietary intake, especially less consumption of vegetables and fruits and higher body weight. Strong and consistent evidence indicates that adults who eat fast food often are at increased risk of weight gain, overweight and obesity and that screen time, especially television screen time, is directly associated with increased overweight and obesity.

Strong, Imperative

AWM: Monitor and Evaluate Energy Intake and Energy Needs

AWM: Monitor and Evaluate Energy Intake and Nutrient Content

For weight loss and weight maintenance, the RDN should monitor and evaluate energy intake and nutrient content and consider adjusting the selected caloric reduction strategy (if necessary):

- Prescribe 1,200 kcal to 1,500 kcal per day for women and 1,500 kcal to 1,800 kcal per day for men (kcal levels are usually adjusted for the individual's body weight).
- Prescribe 500 kcal per day or 750 kcal per day energy deficit.
- Prescribe one of the evidence-based diets that restricts certain food types (such as high-carbohydrate foods, low-fiber foods or high-fat foods) in order to create an energy deficit by reduced food intake.

Several studies report changes in nutrient adequacy with caloric restriction. However, the extent of nutrient inadequacy and the nutrients affected are dependent on the composition of the diet followed, as well as on the nutritional needs of the individual. Limited research reports reductions in nutrient adequacy with weight loss through an energy restriction of at least 500 kcal per day or daily consumption below 1,200 kcal per day.

Strong, Imperative

AWM: Monitor and Evaluate Total Energy Needs

For weight loss and weight maintenance, the RDN should monitor and evaluate total energy needs and consider one of the following (if necessary):

- Re-measure RMR using indirect calorimetry, since measurement of RMR using indirect calorimetry is more accurate than estimating RMR using predictive equations.
- Re-calculate Mifflin-St. Jeor, since the majority of research reviewed supports the use of the Mifflin-St. Jeor equation (using actual body weight) to predict RMR in overweight or obese adults because it demonstrated good accuracy and correlation with indirect calorimetry
- Re-apply a new physical activity factor to RMR (measured or estimated) to estimate total energy needs:
  - Sedentary: 1.0 to 1.4
  - Low active: 1.4 to 1.6
  - Active: 1.6 to 1.9
  - Very active: 1.9 to 2.5

The DRI PAL represent the ratio of total energy expenditure to basal energy expenditure and are defined as sedentary, low active, active or very active.

Consensus, Imperative

Recommendation Strength Rationale

- Conclusion statements are Grades I and II.

Definitions:

Conditional vs Imperative Recommendations

Recommendations are categorized in terms of either *conditional* or *imperative* statements. While conditional statements clearly define a specific situation, imperative statements are broadly applicable to the target population and do not impose restraints on their application.

Conditional recommendations are presented in an if/then format, such that:

If CONDITION then ACTION(S) because REASON(S).

Fulfillment of the condition triggers one or more guideline-specified actions. In contrast, imperative recommendations include terms such as "require," "must," and "should," and do not contain conditional text that would limit their applicability to specified circumstances.

Conclusion Grading Table

Strength of Evidence Elements	Grades				
	I Good/Strong	II Fair	III Limited	IV Expert Opinion Only	V Grade Not Assignable
Quality	Studies of strong design for	Studies of	Studies of weak design	No studies available	No

Strength of Evidence Elements	question	strong design for question	for answering the question	Conclusion based on usual practice, expert consensus, clinical experience, opinion, or extrapolation from basic research	evidence that pertains to question being addressed
	Free from design flaws, bias and execution problems	with minor methodological concerns	OR III Limited		
		OR  Only studies of weaker study design for question	Inconclusive findings due to design flaws, bias or execution problems		
Consistency  Of findings across studies	Findings generally consistent in direction and size of effect or degree of association, and statistical significance with minor exceptions at most	Inconsistency among results of studies with strong design  OR  Consistency with minor exceptions across studies of weaker designs	Unexplained inconsistency among results from different studies  OR  Single study unconfirmed by other studies	Conclusion supported solely by statements of informed nutrition or medical commentators	NA
Quantity  • Number of studies • Number of subjects in studies	One to several good quality studies  Large number of subjects studied  Studies with negative results having sufficiently large sample size for adequate statistical power	Several studies by independent investigators  Doubts about adequacy of sample size to avoid Type I and Type II error	Limited number of studies  Low number of subjects studied and/or inadequate sample size within studies	Unsubstantiated by published studies	Relevant studies have not been done
Clinical Impact  • Importance of studied outcomes • Magnitude of effect	Studied outcome relates directly to the question  Size of effect is clinically meaningful  Significant (statistical) difference is large	Some doubt about the statistical or clinical significance of effect	Studied outcome is an intermediate outcome or surrogate for the true outcome of interest  OR  Size of effect is small or lacks statistical and/or clinical significance	Objective data unavailable	Indicates area for future research
Generalizability  To population of interest	Studied population, intervention and outcomes are free from serious doubts about generalizability	Minor doubts about generalizability	Serious doubts about generalizability due to narrow or different study population, intervention or outcomes studied	Generalizability limited to scope of experience	NA

This grading system was based on the grading system from Greer, Mosser, Logan, & Wagstrom Halaas. A practical approach to evidence grading. *Jt Comm J Qual Improv.* 2000;26:700-712. In September 2004, The ADA Research Committee modified the grading system to this current version.

#### Criteria for Recommendation Rating

Statement Rating	Definition	Implication for Practice
Strong	A Strong recommendation means that the workgroup believes that the	Practitioners should follow a Strong

Statement Rating	Definition	Implication for Practice
	benefits of the recommended approach clearly exceed the harms (or that the harms clearly exceed the benefits in the case of a strong negative recommendation), and that the quality of the supporting evidence is excellent/good (grade I or II).* In some clearly identified circumstances, strong recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits strongly outweigh the harms.	recommendation unless a clear and compelling rationale for an alternative approach is present.
<b>Fair</b>	A Fair recommendation means that the workgroup believes that the benefits exceed the harms (or that the harms clearly exceed the benefits in the case of a negative recommendation), but the quality of evidence is not as strong (grade II or III).* In some clearly identified circumstances, recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits outweigh the harms.	Practitioners should generally follow a Fair recommendation but remain alert to new information and be sensitive to patient preferences.
<b>Weak</b>	A Weak recommendation means that the quality of evidence that exists is suspect or that well-done studies (grade I, II, or III)* show little clear advantage to one approach versus another.	Practitioners should be cautious in deciding whether to follow a recommendation classified as Weak, and should exercise judgment and be alert to emerging publications that report evidence. Patient preference should have a substantial influencing role.
<b>Consensus</b>	A Consensus recommendation means that Expert opinion (grade IV)* supports the guideline recommendation even though the available scientific evidence did not present consistent results, or controlled trials were lacking.	Practitioners should be flexible in deciding whether to follow a recommendation classified as Consensus, although they may set boundaries on alternatives. Patient preference should have a substantial influencing role.
<b>Insufficient Evidence</b>	An Insufficient Evidence recommendation means that there is both a lack of pertinent evidence (grade V)* and/or an unclear balance between benefits and harms.	Practitioners should feel little constraint in deciding whether to follow a recommendation labeled as Insufficient Evidence and should exercise judgment and be alert to emerging publications that report evidence that clarifies the balance of benefit versus harm. Patient preference should have a substantial influencing role.

\*Conclusion statements are assigned a grade based on the strength of the evidence. Grade I is good; grade II, fair; grade III, limited; grade IV signifies expert opinion only and grade V indicates that a grade is not assignable because there is no evidence to support or refute the conclusion. The evidence and these grades are considered when assigning a rating (Strong, Fair, Weak, Consensus, Insufficient Evidence - see chart above) to a recommendation.

Adapted by the Academy of Nutrition and Dietetics (AND) from the American Academy of Pediatrics, Classifying Recommendations for Clinical Practice Guideline, Pediatrics. 2004;114:874-877. Revised by the AND Evidence-Based Practice Committee, Feb 2006.

## Clinical Algorithm(s)

None provided

## Scope

## Disease/Condition(s)

- Overweight
- Obesity

## Guideline Category

Counseling

Evaluation

Management

Prevention

Treatment

## Clinical Specialty

Cardiology

Endocrinology

Family Practice

Internal Medicine

Nursing

Nutrition

Preventive Medicine

Psychiatry

Psychology

Surgery

## Intended Users

Advanced Practice Nurses

Allied Health Personnel

Dietitians

Health Care Providers

Managed Care Organizations

Nurses

Patients

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

## Guideline Objective(s)

Overall Objective

To provide evidence-based recommendations on medical nutrition therapy (MNT) for adult weight management

### Specific Objectives

- To define evidence-based nutrition recommendations for registered dietitian nutritionists (RDNs) that are carried out in collaboration with other healthcare providers
- To guide practice decisions that integrate medical, nutritional and behavioral strategies
- To reduce variations in practice among RDNs
- To provide the RDN with evidence-based practice recommendations to adjust MNT or recommend other therapies to achieve positive outcomes
- To develop guidelines for interventions that have measurable clinical outcomes
- To promote optimal nutrition support within the cost constraints of the healthcare environment

### Target Population

Overweight and obese adults (19 years and older)

### Interventions and Practices Considered

1. Nutrition screening and referral
  - Annual screening for overweight/obesity (height and weight, body mass index [BMI], waist circumference)
  - Referral to registered dietitian nutritionist (RDN) for medical nutrition therapy (MNT)
2. Nutrition assessment
  - Duration and frequency of MNT for weight loss and weight maintenance
  - Incorporating telenutrition interventions for weight loss and weight maintenance
  - Weight management for older adults
  - Assessing data to individualize the comprehensive weight management program
  - Assessing motivation for weight management
  - Assessing energy needs (measuring resting metabolic rate [RMR], use of Mifflin-St. Jeor equation, estimating total energy needs)
  - Assessing energy intake and nutrient content of the diet
3. Nutrition interventions
  - Realistic weight goal setting
  - Using a comprehensive weight management program that includes reduced calorie diet, increased physical activity, and behavioral strategies
  - Ensuring nutrient adequacy during weight loss and weight maintenance
  - Dietary approaches for caloric reduction in weight loss and weight maintenance
  - Individualized approaches to eating frequency and meal patterns for weight loss and weight maintenance
  - Use of portion control and meal replacements or structured meal plans
  - Encouraging physical activity for weight loss and weight maintenance
  - Use of multiple behavior therapy strategies
  - Coordination of care with interdisciplinary team
  - Use of community resources
4. Nutrition monitoring and evaluation
  - Monitoring and evaluating the effectiveness of the comprehensive weight management program
  - Monitoring and evaluating energy intake, nutrient content, and total energy needs

### Major Outcomes Considered

- Mean weight reduction
- Changes in blood pressure level
- Changes in total cholesterol and triglyceride level
- Intake of saturated fatty acids
- Energy intake

# Methodology

## Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

## Description of Methods Used to Collect/Select the Evidence

### General Methods for Collecting/Selecting the Evidence

The following list provides an overview of the steps which the Academy evidence analysis team goes through to identify research through database searches.

1. Plan the search strategy to identify the current best evidence relevant to the question. The plan for identification and inclusion of articles and reports should be systematic and reproducible, not haphazard. Write out the original search strategy and document adjustments to the strategy if they occur. Allow for several iterations of searches.
  - List inclusion and exclusion criteria. The workgroup will define the inclusion and exclusion criteria. These criteria will be used in defining the search strategy and for filtering the identified research reports. The Academy uses only peer-reviewed research; that is, articles accepted for evidence analysis must be peer-reviewed and published in a juried publication. Additionally, the Academy only uses human subjects in its research and does not include animal studies in its evidence analysis.
  - Identify search words. During the process of considering outcomes, interventions, nutrition diagnoses, and assessments, the work group may have identified a number of specific terms or factors that were important, but were not included in the actual question. These terms can be used as additional search terms to help identify relevant pieces of research. Both text word search and keyword search using Medical Subject Headings (MeSH) definitions may be used.
  - Identify databases to search. PubMed, Medline, CINAHL, EMBASE, Cochrane, Agricola, DARE, TRIP, AHRQ and ERIC are some common databases for clinical nutritional research. Note that search terms can vary depending on the database.
2. Conduct the search. Depending on the number and type of sources found in the initial search, adjustments might have to be made in the search strategy and to inclusion/exclusion criteria, and additional searches run. Changes to the search plan should be recorded for future reference. Document the number of sources identified in each search.
3. Review titles and abstracts. At this point, a filtering procedure is used to determine whether a research article matches the inclusion criteria and is relevant to the work group's questions. Typically, the lead analyst, along with a member of the expert workgroup, first reviews the citations and abstracts to filter out reports that are not applicable to the question. If a determination cannot be made based on the citation and abstract, then the full text of the article is obtained for review.
4. Gather all remaining articles and reports. Obtain paper or electronic copies of research articles that remain on the list following the citation and abstract review. If there are less than six citations, it could mean that the search was too specific to identify relevant research or that research has not been done on this topic. A broadened search should be tried. When there is a long list of citations, ascertain whether it includes articles that are tangential to the question or address the question in only a general way. In this case a more focused search strategy may be necessary.

### Specific Methods for This Guideline

The recommendations in the guideline were based on a systematic review of the literature. Searches of PubMed, Medline, CENTRAL, Database of Abstracts of Reviews of Effects (DARE), and Agency for Healthcare Research and Quality (AHRQ) database were performed on the following topics:

- Metabolic syndrome and disorders of lipid metabolism
- Weight management
- Effectiveness of medical nutrition therapy (MNT) for overweight/obesity in adults
- Telenutrition provided by registered dietitian
- Counseling theories
- Mifflin-St. Jeor equation

- Nutrition adequacy
- Meal and snack patterns
- Breakfast consumption

Each evidence analysis topic has a link to supporting evidence, where the Search Plan and Results can be found. Here, the reader can view when the search plan was performed, inclusion and exclusion criteria, search terms, databases that were searched and the excluded articles.

## Number of Source Documents

The total number of supporting documents for all of the reviewed topics is below:

- Recommendations: 20
- Conclusion Statements: 6 (27 total, including those from other Evidence Analysis Library [EAL] projects)
- Evidence Summaries: 6 (27 total, including those from other EAL projects)
- Article Worksheets: 87 (169 total, including those from other EAL projects)

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Conclusion Grading Table

Strength of Evidence Elements	Grades				
	I Good/Strong	II Fair	III Limited	IV Expert Opinion Only	V Grade Not Assignable
Quality <ul style="list-style-type: none"> <li>• Scientific rigor/validity</li> <li>• Considers design and execution</li> </ul>	Studies of strong design for question  Free from design flaws, bias and execution problems	Studies of strong design for question with minor methodological concerns  OR  Only studies of weaker study design for question	Studies of weak design for answering the question  OR  Inconclusive findings due to design flaws, bias or execution problems	No studies available  Conclusion based on usual practice, expert consensus, clinical experience, opinion, or extrapolation from basic research	No evidence that pertains to question being addressed
Consistency  Of findings across studies	Findings generally consistent in direction and size of effect or degree of association, and statistical significance with minor exceptions at most	Inconsistency among results of studies with strong design  OR  Consistency with minor exceptions across studies of weaker designs	Unexplained inconsistency among results from different studies  OR  Single study unconfirmed by other studies	Conclusion supported solely by statements of informed nutrition or medical commentators	NA
Quantity	One to several good quality studies	Several studies by	Limited number of studies	Unsubstantiated by published studies	Relevant studies have

Strength of Evidence Elements	Number of studies	Number of subjects in studies	independent investigators	Grades		not been done
	I	Good/Strong	II	III	IV	V
	Large number of subjects studied	Studies with negative results	Doubts about adequacy of sample size to avoid Type I and Type II error	Low number of subjects studied and/or inadequate sample size within studies	Expert Opinion Only	Grade Not Assignable
	having sufficiently large sample size for adequate statistical power					
Clinical Impact <ul style="list-style-type: none"> <li>Importance of studied outcomes</li> <li>Magnitude of effect</li> </ul>	Studied outcome relates directly to the question  Size of effect is clinically meaningful  Significant (statistical) difference is large	Some doubt about the statistical or clinical significance of effect	Studied outcome is an intermediate outcome or surrogate for the true outcome of interest  OR  Size of effect is small or lacks statistical and/or clinical significance	Objective data unavailable	Indicates area for future research	
Generalizability  To population of interest	Studied population, intervention and outcomes are free from serious doubts about generalizability	Minor doubts about generalizability	Serious doubts about generalizability due to narrow or different study population, intervention or outcomes studied	Generalizability limited to scope of experience	NA	

This grading system was based on the grading system from Greer, Mosser, Logan, & Wagstrom Halaas. A practical approach to evidence grading. *Jt Comm J Qual Improv.* 2000;26:700-712. In September 2004, The ADA Research Committee modified the grading system to this current version.

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Step 1: Formulate Evidence Analysis Question

Specify a question in a defined area of practice or state a tentative conclusion or recommendation that is being considered. Include the patient type and special needs of the target population involved, the alternatives under consideration, and the outcomes of interest (PICO format).

Step 2: Gather and Classify Evidence

Conduct a systematic search of the literature to find evidence related to the question, gather studies and reports, and classify them by type of evidence. Classes differentiate primary reports of new data according to study design, and distinguish them from secondary reports that include systematic and/or narrative review.

Step 3: Critically Appraise Each Article

Review each article for relevance to the question and use the checklist of questions to evaluate the research design and implementation. Abstract key information from the report.

Step 4: Summarize Evidence

Synthesize the reports into an overview table and summarize the research relevant to the question.

Step 5: Write and Grade the Conclusion Statement

Develop a concise conclusion statement (the answer to the question). Assign a grade to indicate the overall strength or weakness of evidence

informing the conclusion statement (see the "Rating Scheme for the Strength of the Evidence" field).

## Methods Used to Formulate the Recommendations

Expert Consensus

### Description of Methods Used to Formulate the Recommendations

#### Development of Evidence-Based Nutrition Practice Guidelines

The expert work group, which includes practitioners and researchers with a depth of experience in the specific field of interest, develops the disease-specific guideline. The guideline development involves the following steps:

1. Review the Conclusion Statements: The work group meets to review the materials resulting from the evidence analysis, which may include conclusion statements, evidence summaries, and evidence worksheets.
2. Formulate Recommendations for the Guideline Integrating Conclusions from Evidence Analysis: The work group uses an expert consensus method to formulate the guideline recommendations and complete the various sections on the recommendation page. These include:
  - Recommendation(s): This is a course of action for the practitioner. The recommendation is written using two brief and separate statements. The first statement is "what" the dietitian should do or not do. The second statement describes the "why" of the recommendation. More than one recommendation may be formulated depending on a particular topic and the supporting conclusion statements.
  - Rating: The rating for the recommendation is based on the strength of the supporting evidence. The grade of the supporting conclusion statement(s) will help determine this rating (see the "Rating Scheme for the Strength of the Recommendations" field).
  - Label of Conditional or Imperative: Each recommendation will have a label of "conditional" or "imperative." Conditional statements clearly define a specific situation, while imperative statements are broadly applicable to the target population without restraints on their pertinence.
  - Risks and Harms of Implementing the Recommendations: Includes any potential risks, anticipated harms or adverse consequences associated with applying the recommendation(s) to the target population.
  - Conditions of Application: Includes any organizational barriers or changes that would need to be made within an organization to apply the recommendation in daily practice. Also includes any conditions which may limit the application of the recommendation(s). For instance, application may be limited to only people in an inpatient setting, or not applicable for pregnant women. Facilitators for the application of the guideline may also be listed here. Conditional recommendations will always have conditions specified. Imperative recommendations may have some general conditions for application.
  - Potential Costs Associated with Application: Includes any costs that may be associated with the application of this recommendation such as specialized staff, new equipment or treatments.
  - Recommendation Narrative: Provides a brief description of the evidence that supports this recommendation.
  - Recommendation Strength Rationale: Provides a brief list of the evidence strength and methodological issues that determined the recommendation strength.
  - Minority Opinions: If the expert work group cannot reach consensus on the recommendation, the minority opinions may be listed here.
  - Supporting Evidence: Provides links to the conclusions statements, evidence summaries and worksheets related to the formulation of this recommendation(s).
3. References Not Graded in the Academy's Evidence Analysis Process: Recommendations are based on the summarized evidence from the analysis. Sources that are not analyzed during the evidence analysis process may be used to support and formulate the recommendation or to support information under other categories on the recommendation page, if the workgroup deems necessary. References must be credible resources (e.g., consensus reports, other guidelines, position papers, standards of practice, articles from peer-reviewed journals, nationally recognized documents or websites). If recommendations are based solely on these types of references, they will be rated as "consensus." Occasionally recommendations will include references that were not reviewed during the evidence analysis process but are relevant to the recommendation, risks and harms of implementing the recommendation, conditions of application, or potential costs associated with application. These references will be listed on the recommendation page under "References Not Graded in the Academy's Evidence Analysis Process."
4. Develop a Clinical Algorithm for The Guideline: The workgroup develops a clinical algorithm based on Academy's Nutrition Care Process, to display how each recommendation can be used within the treatment process and how they relate to the Nutrition Assessment, Diagnosis, Intervention and Monitoring and Evaluation.

5. Complete the Writing of the Guideline: Each disease-specific guideline has a similar format which incorporates the Introduction (includes: Scope of the Guideline, Statement of Intent, Guideline Methods, Implementation, Benefits and Risks/Harms of Implementation), Background Information and any necessary Appendices. The work group develops these features.
6. Criteria Used in Guideline Development: The criteria used in determining the format and process for development of Academy's guidelines are based on the following tools and criteria for evidence-based guidelines:
  - Guideline Elements Model (GEM) which has been incorporated by the American Society for Testing and Materials (ASTM) as a Standard Specification for clinical practice guidelines.
  - Appraisal for Guidelines Research and Evaluation (AGREE) Instrument
  - National Guideline Clearinghouse [www.guideline.gov](http://www.guideline.gov)

## Rating Scheme for the Strength of the Recommendations

### Criteria for Recommendation Rating

Statement Rating	Definition	Implication for Practice
<b>Strong</b>	A Strong recommendation means that the workgroup believes that the benefits of the recommended approach clearly exceed the harms (or that the harms clearly exceed the benefits in the case of a strong negative recommendation), and that the quality of the supporting evidence is excellent/good (grade I or II).* In some clearly identified circumstances, strong recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits strongly outweigh the harms.	Practitioners should follow a Strong recommendation unless a clear and compelling rationale for an alternative approach is present.
<b>Fair</b>	A Fair recommendation means that the workgroup believes that the benefits exceed the harms (or that the harms clearly exceed the benefits in the case of a negative recommendation), but the quality of evidence is not as strong (grade II or III).* In some clearly identified circumstances, recommendations may be made based on lesser evidence when high-quality evidence is impossible to obtain and the anticipated benefits outweigh the harms.	Practitioners should generally follow a Fair recommendation but remain alert to new information and be sensitive to patient preferences.
<b>Weak</b>	A Weak recommendation means that the quality of evidence that exists is suspect or that well-done studies (grade I, II, or III)* show little clear advantage to one approach versus another.	Practitioners should be cautious in deciding whether to follow a recommendation classified as Weak, and should exercise judgment and be alert to emerging publications that report evidence. Patient preference should have a substantial influencing role.
<b>Consensus</b>	A Consensus recommendation means that Expert opinion (grade IV) supports the guideline recommendation even though the available scientific evidence did not present consistent results, or controlled trials were lacking.	Practitioners should be flexible in deciding whether to follow a recommendation classified as Consensus, although they may set boundaries on alternatives. Patient preference should have a substantial influencing role.
<b>Insufficient Evidence</b>	An Insufficient Evidence recommendation means that there is both a lack of pertinent evidence (grade V)* and/or an unclear balance between benefits and harms.	Practitioners should feel little constraint in deciding whether to follow a recommendation labeled as Insufficient Evidence and should exercise judgment and be alert to emerging publications that report evidence that clarifies the balance of benefit versus harm. Patient preference should have a substantial influencing role.

\*Conclusion statements are assigned a grade based on the strength of the evidence. Grade I is good; grade II, fair; grade III, limited; grade IV signifies expert opinion only and grade V indicates that a grade is not assignable because there is no evidence to support or refute the conclusion. The evidence and these grades are considered when assigning a rating (Strong, Fair, Weak, Consensus, Insufficient Evidence - see chart above) to a recommendation.

Adapted by the Academy of Nutrition and Dietetics (AND) from the American Academy of Pediatrics, Classifying Recommendations for Clinical Practice Guideline, Pediatrics. 2004;114:874-877. Revised by the AND Evidence-Based Practice Committee, Feb 2006.

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

Each guideline is reviewed internally and externally using the Appraisal for Guidelines Research and Evaluation (AGREE) Instrument as the evaluation tool. The external reviewers consist of an interdisciplinary group of individuals (may include dietitians, doctors, psychologists, nurses, etc.). The guideline is adjusted by consensus of the expert panel and approved by Academy's Evidence-Based Practice Committee prior to publication on the Evidence Analysis Library (EAL).

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The guideline contains conclusion statements that are supported by evidence summaries and evidence worksheets. These resources summarize the important studies (randomized controlled trials [RCTs], clinical studies, observational studies, cohort and case-control studies) pertaining to the conclusion statement and provide the study details.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

- A primary goal of implementing these recommendations includes improving a person's ability to achieve optimal nutrition through healthful food choices and a physically-active lifestyle.
- Although costs of medical nutrition therapy (MNT) sessions and reimbursement vary, MNT is essential for improved outcomes.
- MNT education can be considered cost-effective when considering the benefits of nutrition interventions on the onset and progression of comorbidities versus the cost of the intervention.

### Potential Harms

#### Overall Risk/Harm Considerations

When using these recommendations, consider the following general risks and harms:

- Review the patient's age, socio-economic status, cultural issues, psychosocial and mental health status, health history and other health conditions.
- Use clinical judgment in applying the guidelines.

#### Recommendation-Specific Risks/Harms

#### Components of a Comprehensive Weight Management Program

Adequate evidence indicates that the harm of screening and behavioral interventions for obesity is small. Possible harm of behavioral weight-loss

interventions include:

- Decreased bone mineral density and increased fracture risk
- Serious injuries resulting from increased physical activity
- Increased risk for eating disorders

Encourage Physical Activity

Intense physical activity in some overweight and obese individuals may contribute to disability or death; thus, consultation with a physician prior to beginning an exercise program should be recommended.

Coordinate Care with Interdisciplinary Team

Bariatric surgery is associated with complications such as pulmonary embolism and post-operative death.

## Qualifying Statements

### Qualifying Statements

- This nutrition practice guideline is meant to serve as a general framework for handling clients with particular health problems. The independent skill and judgment of the health care provider must always dictate treatment decisions.
- This guideline is intended for use by registered dietitian nutritionists (RDNs) involved in providing medical nutrition therapy (MNT) for adult weight management. The application of the guideline must be individualized to assist the RDN to successfully integrate MNT into the overall medical management of overweight/obese adults.
- While the evidence-based nutrition practice guideline represents a statement of promising practice based on the latest available evidence at the time of publication, the guideline is not intended to overrule professional judgment. Rather, it may be viewed as a relative constraint on individual clinician discretion in a particular clinical circumstance. The independent skill and judgment of the health care provider must always dictate treatment decisions. These nutrition practice guidelines are provided with the express understanding that they do not establish or specify particular standards of care, whether legal, medical or other.
- This guideline recognizes the role of patient and family preferences for possible outcomes of care, when the appropriateness of a clinical intervention involves a substantial element of personal choice or values. With regard to types of evidence that are associated with particular outcomes, two major classes have been described. Patient-oriented evidence that matters (POEM) deals with outcomes of importance to patients, such as changes in morbidity, mortality or quality of life. Disease-oriented evidence (DOE) deals with surrogate end-points, such as changes in laboratory values or other measures of response. Although the results of DOE sometimes parallel the results of POEM, they do not always correspond. When possible, the Academy of Nutrition and Dietetics recommends using POEM-type evidence rather than DOE. When DOE is the only guidance available, the guideline indicates that key clinical recommendations lack the support of outcomes evidence.

## Implementation of the Guideline

### Description of Implementation Strategy

The publication of this guideline is an integral part of supporting registered dietitian nutritionists in engaging with, teaching about, and researching this topic. National implementation workshops at various sites around the country and during the Academy of Nutrition and Dietetics Food Nutrition Conference Expo (FNCE) are planned. Additionally, there are recommended dissemination and adoption strategies for local use of the *Academy of Nutrition and Dietetics Adult Weight Management Evidence-Based Nutrition Practice Guideline*.

The guideline development team recommended multi-faceted strategies to disseminate the guideline and encourage its implementation. Management support and learning through social influence are likely to be effective in implementing guidelines in dietetic practice. However, additional interventions may be needed to achieve real change in practice routines.

Implementation of the guideline will be achieved by announcement at professional events, presentations and training. Some strategies include:

- National and local events: State dietetic association meetings and media coverage will help launch the guideline.

- Local feedback adaptation: Presentation by members of the work group at peer review meetings and opportunities for continuing education units (CEUs) for courses completed.
- Education initiatives: The guideline and supplementary resources will be freely available for use in the education and training of dietetic interns and students in approved Commission on Accreditation of Dietetics Education (CADE) programs.
- Champions: Local champions have been identified and expert members of the recommendation team will prepare articles for publications. Resources will be provided that include PowerPoint presentations and pre-prepared case studies.
- Practical tools: Some of the tools that will be developed to help implement the guideline include specially designed resources such as clinical algorithms, slide presentations, training and toolkits.

Specific distribution strategies include:

Publication in full: The guideline is available electronically at the [Academy Evidence Analysis Library Web site](#)  and announced to all Academy Dietetic Practice Groups. The Academy's Evidence Analysis Library will also provide downloadable supporting information and links to relevant position papers.

## Implementation Tools

Patient Resources

Quick Reference Guides/Physician Guides

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Getting Better

Living with Illness

Staying Healthy

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

### Bibliographic Source(s)

Academy of Nutrition and Dietetics. Adult weight management evidence-based nutrition practice guideline. Chicago (IL): Academy of Nutrition and Dietetics; 2014. Various p.

### Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2006 May (revised 2014)

## Guideline Developer(s)

Academy of Nutrition and Dietetics - Professional Association

## Source(s) of Funding

Academy of Nutrition and Dietetics

## Guideline Committee

Adult Weight Management Evidence-Based Nutrition Practice Guideline Workgroup

## Composition of Group That Authored the Guideline

*Workgroup Members:* Rebecca Reeves, DrPH, RD, FADA (*Chair*); Chris Biesemeier, MS, RD, LD, FADA; Molly Gee, MEd, RD, LD; Patricia Harper, MS, RD, LDN; Sachiko St. Jeor, PhD, RD

## Financial Disclosures/Conflicts of Interest

In the interest of full disclosure, the Academy has adopted the policy of revealing relationships workgroup members have with companies that sell products or services that are relevant to this topic. Workgroup members are required to disclose potential conflicts of interest by completing the Academy Conflict of Interest Form. It should not be assumed that these financial interests will have an adverse impact on the content, but they are noted here to fully inform readers.

None of the workgroup members listed above disclosed potential conflicts.

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Dietetic Association (ADA). Adult weight management evidence based nutrition practice guideline. Chicago (IL): American Dietetic Association (ADA); 2006 May. Various p. [151 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Electronic copies: Available to members from the [Academy of Nutrition and Dietetics Web site](#) .

## Availability of Companion Documents

The following are available:

- Adult weight management evidence-based nutrition practice guideline. Executive summary of recommendations. Chicago (IL): Academy of

Nutrition and Dietetics; 2014. Electronic copies: Available from the [Academy of Nutrition and Dietetics \(AND\) Web site](#) .

- Adult weight management evidence-based nutrition practice guideline. PowerPoint presentation. Chicago (IL): Academy of Nutrition and Dietetics; 2014. 59 p. Electronic copies: Available for purchase from the [AND Web site](#) .

## Patient Resources

The following is available:

- Adult weight management. Managing and losing weight the healthy way. Chicago (IL): Academy of Nutrition and Dietetics; 2014. Electronic copies: Available for purchase from the [Academy of Nutrition and Dietetics \(AND\) Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI Institute on November 7, 2008. The information was verified by the guideline developer on December 9, 2008. This summary was updated by ECRI Institute on January 15, 2015.

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