10 Years of the STOP Obesity Alliance: Addressing Gaps in Obesity Care And Prevention

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Disclosures

Weight Watchers Scientific Advisory Board
JPB Foundation Poverty Advisory Board
Consultant, RTI for Feeding Infants and Toddlers Study
Grant support for STOP from Novo Nordisk
Consultant – National Academy of Medicine Roundtable on Obesity Solutions
Robert Wood Johnson grant support to BPC for the development of obesity competencies
STOP Obesity Alliance: Purpose and Goal

- **Purpose**: Convene a diverse group to find ways to overcome and prevent obesity and weight-related health issues

- **Goal**: To identify and reduce systemic and cultural barriers that fail to support individual successes
  - Research that identifies cultural and systemic biases
  - Research treatment and prevention initiatives
  - Promote needed systems changes
Stakeholders Working Together to Advance Weight-Related Issues

George Washington University serves as Academic Home

• **60** Associate Member organizations (chronic disease, consumer, minority health, women’s & provider groups)
• **8** State-Level Members
• **5** Corporate Members
• **15** Alliance Steering Committee Members
The reduction of obesity will require a combination of effective clinical services for the treatment of obesity, and policy, systems, and environmental changes that prevent obesity and sustain weight loss to prevent relapse in patients who have lost weight.
Outline

Gaps in knowledge and practice
Provider competencies
Pharmacotherapy
Reimbursement
Stigma and bias
Metrics
Identified Gaps in Patient-Provider Interactions

TARGETS FOR IMPROVEMENT

➢ Time is the most important barrier, but providers need tools and programs

➢ Only 39% of adults with a BMI $\geq 30.0$ recalled being told that they have obesity by a HCP

➢ One-third of patients advised to lose weight were not given a plan to do so

➢ Most PCPs say no one in their practice has been trained to deal with weight issues
What Do Adult Primary Care Providers Know about Recommendations for Obesity Care?

Among family practitioners, internists, OB-GYNs, and nurse practitioners ($N = 1506$):

- **49%** knew that ≥ 150 mins/week of physical activity was necessary to achieve sustainable health benefits.
- **33%** knew that any suitable eating pattern can be recommended for weight loss (NHLBI guideline).
- **16%** knew that 12-26 sessions during the first year is the recommended for patients with obesity.

*DocStyles 2016; Unpublished data*
### DocStyles Research: Provider Practices

What could improve your ability to counsel a person with obesity?

<table>
<thead>
<tr>
<th>Option</th>
<th>PCPs (N=1000)</th>
<th>OB-GYNs (N=250)</th>
<th>NPs (N=251)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More time with the patient</td>
<td>70%</td>
<td></td>
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<tr>
<td>Training in obesity management</td>
<td></td>
<td>64%</td>
<td></td>
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<tr>
<td>Improved coverage/reimbursement process</td>
<td></td>
<td>56%</td>
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<tr>
<td>Tool to help patients recognize obesity risks</td>
<td></td>
<td></td>
<td>61%</td>
</tr>
<tr>
<td>Advice on how to avoid offending patients</td>
<td></td>
<td></td>
<td>31%</td>
</tr>
</tbody>
</table>
Efforts to Address Knowledge and Practice Gaps

• Why Weight? Provider Guide and Website
  • www.whyweightguide.org
• Weigh In Guide: Helping Families Address Weight and Health
  • www.weighinguide.com
**Why Weight? Provider Guide & Website**

A tool to help providers:

- **Initiate** open, productive conversations about weight and health
- **Assess** patient readiness to change
- **Engage** in active listening
- **Build** trust
- **Establish** realistic goals
- **Address** culture and social barriers and supports

**WHY WEIGHT?**
A Guide to Discussing Obesity & Health With Your Patients
Free e-guide for parents of children 7-11 yo
- Helps parents discuss weight and health with their children
- Real-world situations and plain language
- Avoids blame
- Provides ways to have conversations about the following
  - BMI confusion
  - Cultural differences
  - Bias and stigmatization
  - Bullying
  - Parental obesity
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Obesity Care Competencies
[Soon to be released at: www.obesitycompetencies.gwu.edu]

Core Obesity Knowledge
• Obesity as a medical condition
• Epidemiology & key drivers of the obesity epidemic
• Disparities / inequities in obesity prevention & care

Interprofessional Care
• Interprofessional obesity care
• Integration of clinical & community care systems

Patient Interactions
• Evidence-based strategies for patient care
• Discussions & language related to obesity
• Recognition & mitigation of weight bias & stigma
• Respectful accommodations for people with obesity
• Special considerations for comorbid conditions
Changing the Dialogue: Obesity Drug Outcome Measures

Spearheaded series of roundtables to transform the process used to evaluate interventions to treat obesity.
- Participants included 3 representatives from the FDA Center for Drug Evaluation and Research

- Focus on obesity rather than weight loss (cosmetic) drugs
- Results published in March 2013 issue of *Current Obesity Reports*. 
FDA Approves New Obesity Drugs

- Qysmia, FDA Approved July 2012
- Belviq, FDA Approved July 2012
- Contrave, FDA Approved September 2014
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State Medicaid Coverage

Unpublished data; collected Jan-Mar 2017
State Employee Coverage

Unpublished data; collected April-July 2017

Percent of States with Unrestricted Coverage

- **Bariatric Surgery**: +8 states
- **Nutrition Counseling**: +14 states
- **Pharmacotherapy**: +5 states

Unpublished data; collected April-July 2017
Breakdown of Non-Surgical Obesity Services
(% of Medicaid programs offering unrestricted adult benefit, 2016)

Preventive
- 45% Routine physicals
- 49% Healthy diet & physical activity counseling

Treatment
- 31% Medical nutritional therapy (MNT)
- 24% Dietician counseling
- 12% Intensive behavioral therapy for obesity
Solution

2008
Obesity GPS
Guide for Policy and Program Solutions

2011
CMS National Coverage Determination
Medicare approves behavioral counseling for patients w/ obesity

2015
Roundtables on Obesity Management & Coverage
Public and Private Sector Decision Making Tool (2008)

Obesity GPS - A Guide for Policy and Program Solutions

» First navigation tool to guide development of policies and programs geared to reducing the overweight and obesity epidemic

» Launched on Capitol Hill with key SC members and Dr. Carmona

» Presented at Partnership to Fight Chronic Disease Advisory Board Meeting (110 health care organizations)
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The Need for People-First Language in Our Obesity Journal

William H. Dietz

TO THE EDITOR: The May 2014 issue of Obesity included an eloquent Commentary from Ted Kyle and Rebecca Puhl (1) calling for the use of people-first language when referring to people affected by obesity. As they correctly pointed out, referring to a person as an obese person is an identity, whereas the use of the term obesity indicates that a person is affected by a disease. As Kyle and Puhl stated, “People-first language is the standard for respectfully addressing people with chronic disease, rather than labeling them by their illness.” Just as we use people-first language to state that a person has asthma, or a person has cancer, we should refer to a person affected by obesity as a person with obesity. If we are to be successful in labeling obesity as a disease, the use of appropriate terms and descriptors that indicate obesity is a disease will be essential to change the perception of providers and the public. These efforts should start with our journal.
Algorithm for Health Plan Success of obesity treatment at the population level

**Assessment & Patient Goal Setting**

- All patients with BMI ≥ 18.5

**Metrics:**
- weight, BMI

**Population strategies in place**
- No change in population prevalence

**Intervention achieves at least 3-5% loss**

- Metrics: weight, BMI, PA (goals, satisfaction)

**Intensify treatment**
- Intensification of behavioral therapy
- Pharmacotherapy
- Bariatric surgery

**Monitor**

**Reduce Comorbidities**
- Consider:
  - Intensification of behavioral therapy
  - Pharmacotherapy
  - Bariatric surgery

**Was the intervention delivered effectively?**
- YES
- NO

**Consider:**
- Intensification of behavioral therapy
- Pharmacotherapy
- Bariatric surgery

**Inadequate system in place**

**Appropriate system in place**
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