

# Evidence-based Practices for Obesity, Health & Wellbeing

Ted Kyle, RPh, MBA

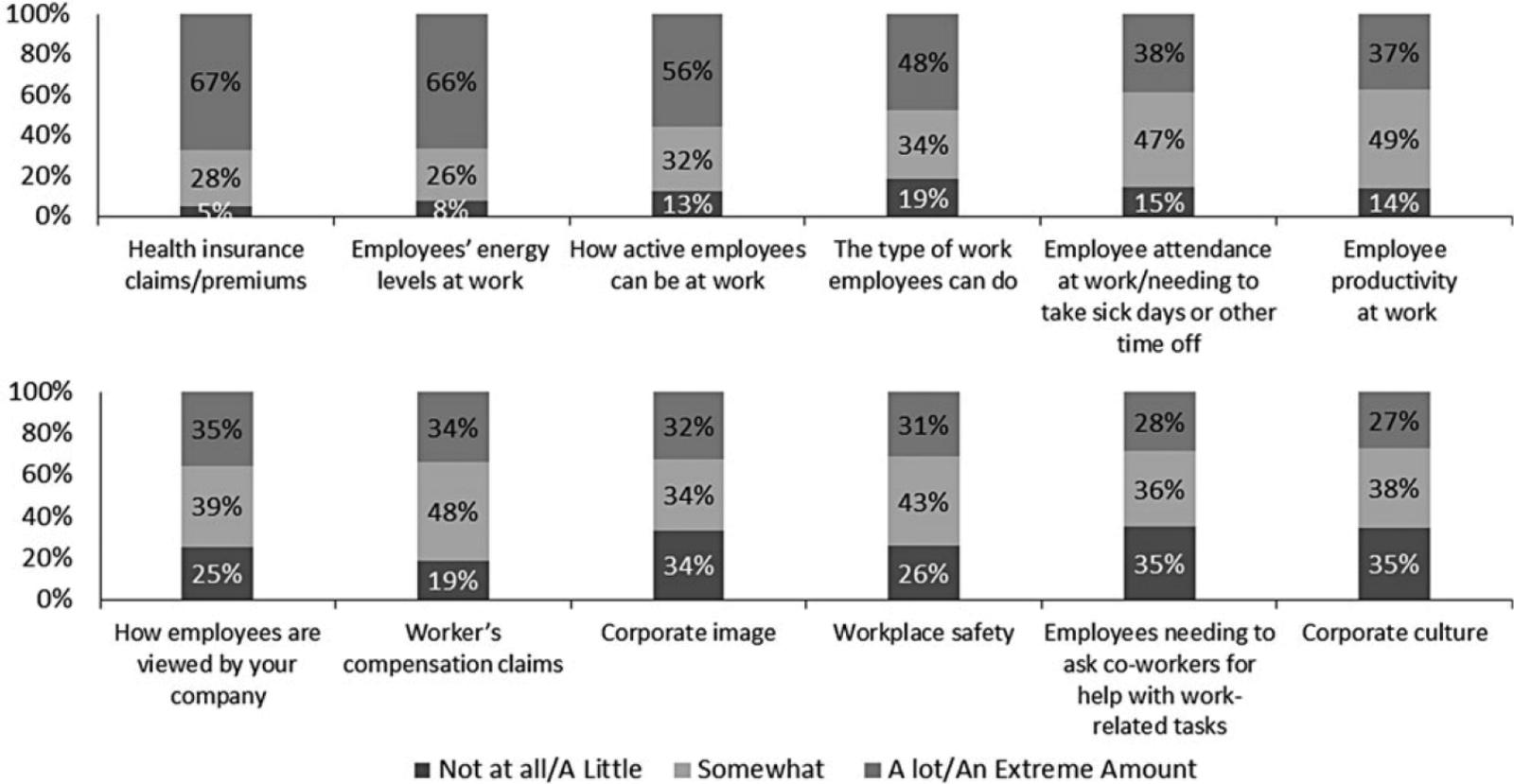
November 11, 2019

# Agenda

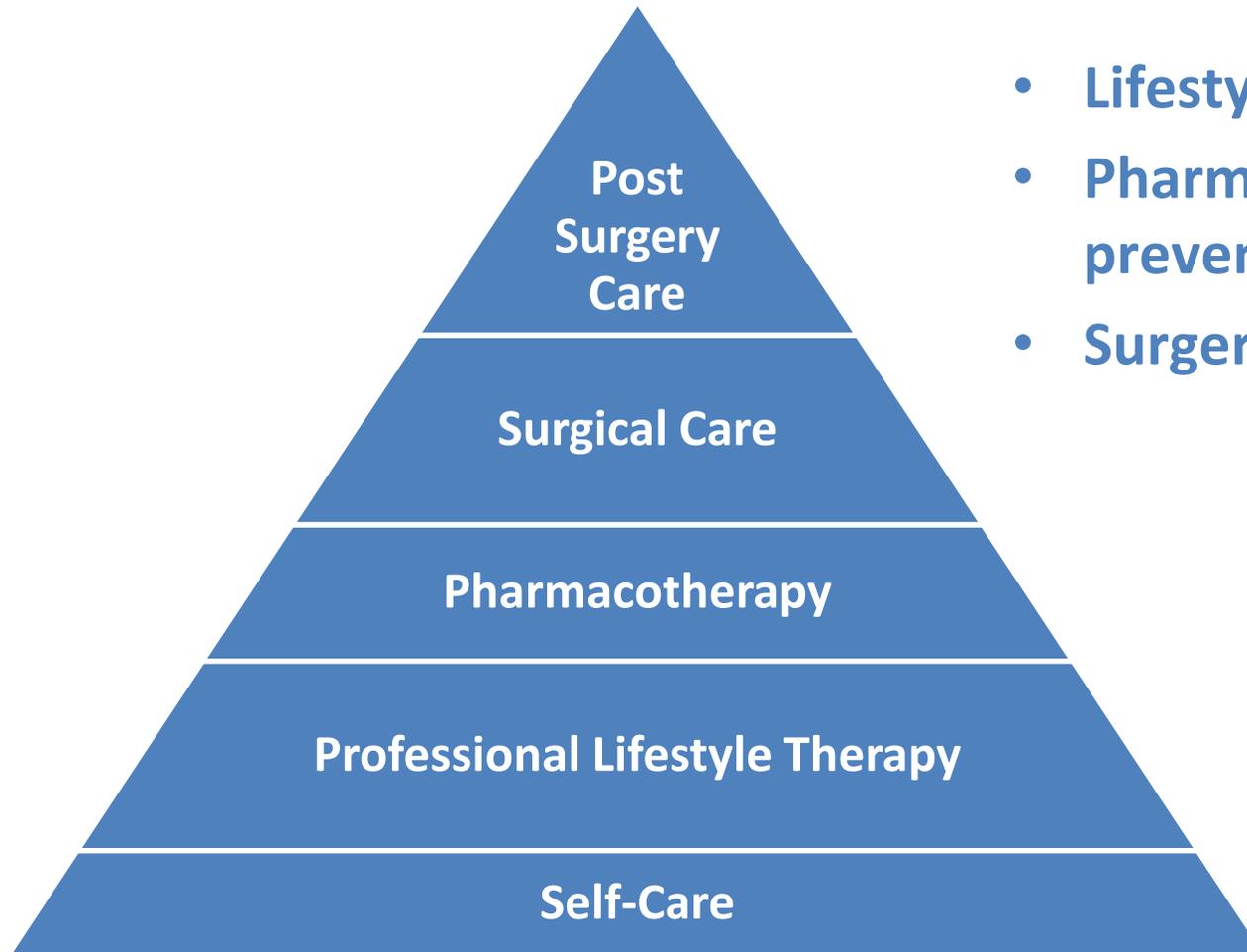
- **A quick overview**
  - Issues
  - Opportunities
- **Christine Gallagher**  
**Current care delivery and gaps**
- **William Dietz**  
**Standard of care and benefits**
- **Abby Ammerman**  
**The Case Study of H-E-B**

# Obesity Is Costly for Health Benefits, Productivity, and Competitiveness

## Employers Recognize the Impacts of Obesity



# Good Obesity Care Works to Prevent and Even Reverse Type 2 Diabetes



- Lifestyle therapy can prevent diabetes
- Pharmacotherapy can prevent progression to diabetes
- Surgery can put diabetes into remission

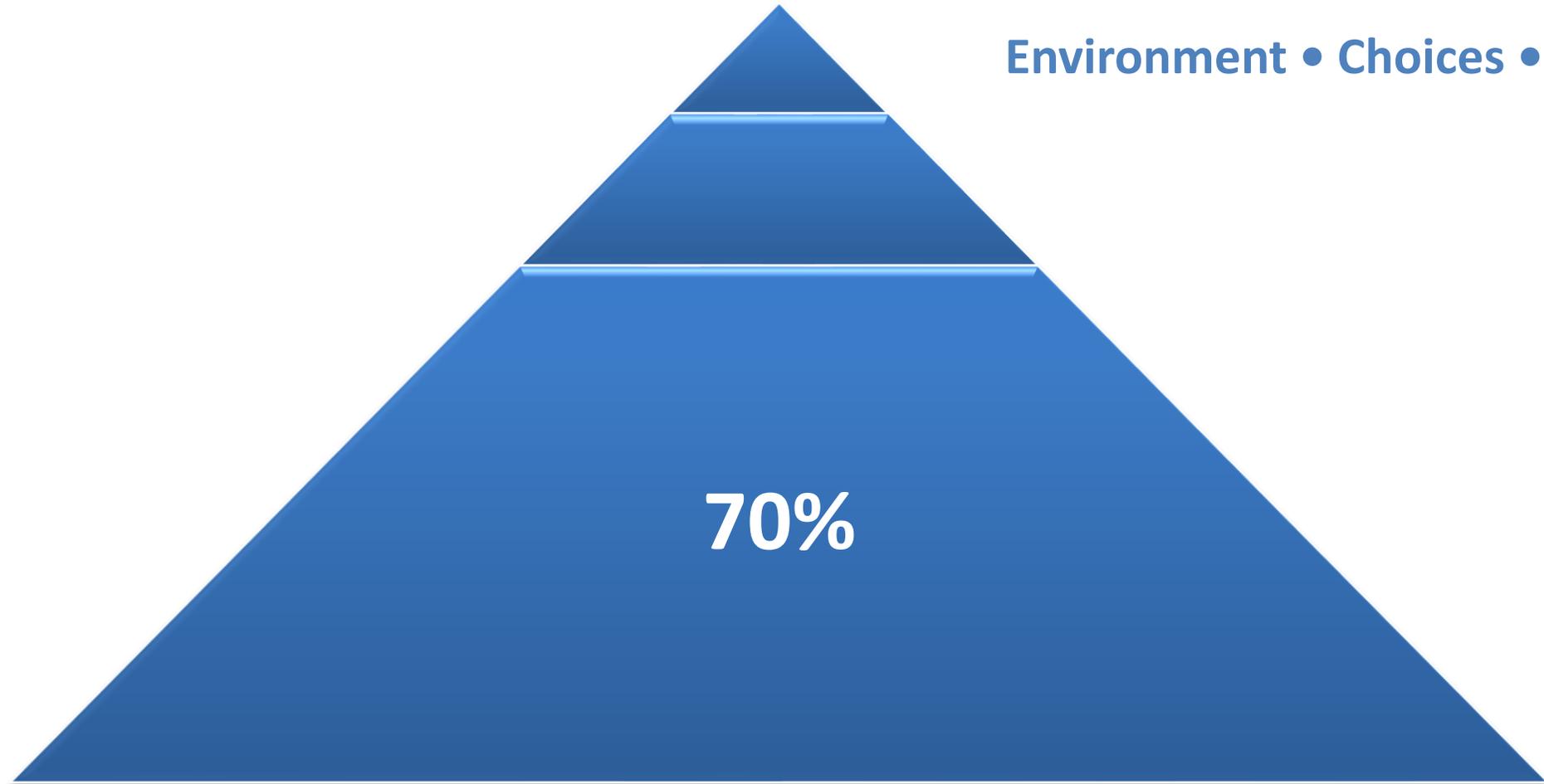
# But Bias Often Gets in the Way

- **Intellectual bias**  
favoring personal convictions
- **Weight bias**  
directed at people with obesity



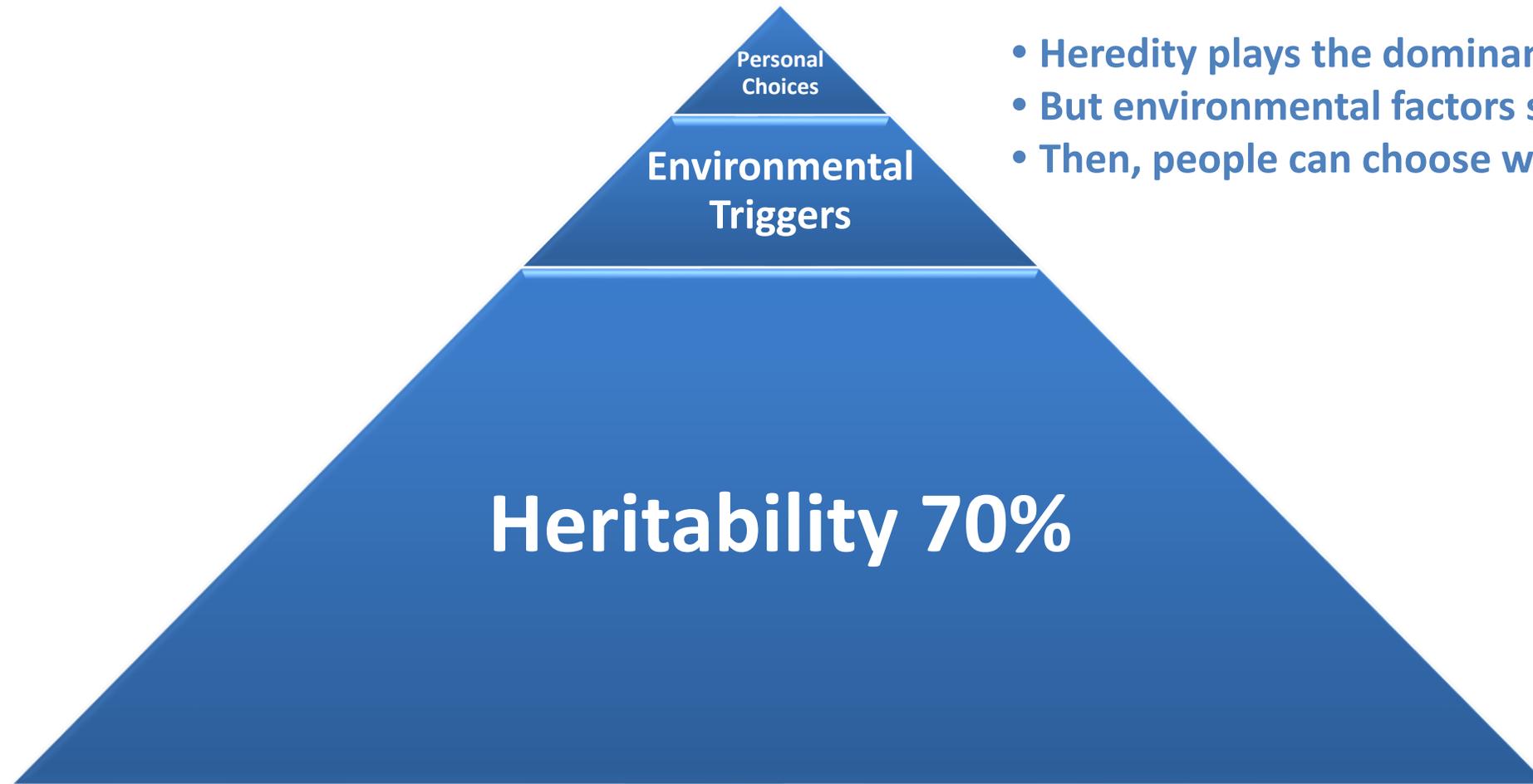
God Judging Adam, Etching by William Blake / WikiArt

# People Typically View Obesity as the Result of Poor Choices



Environment • Choices • Genes

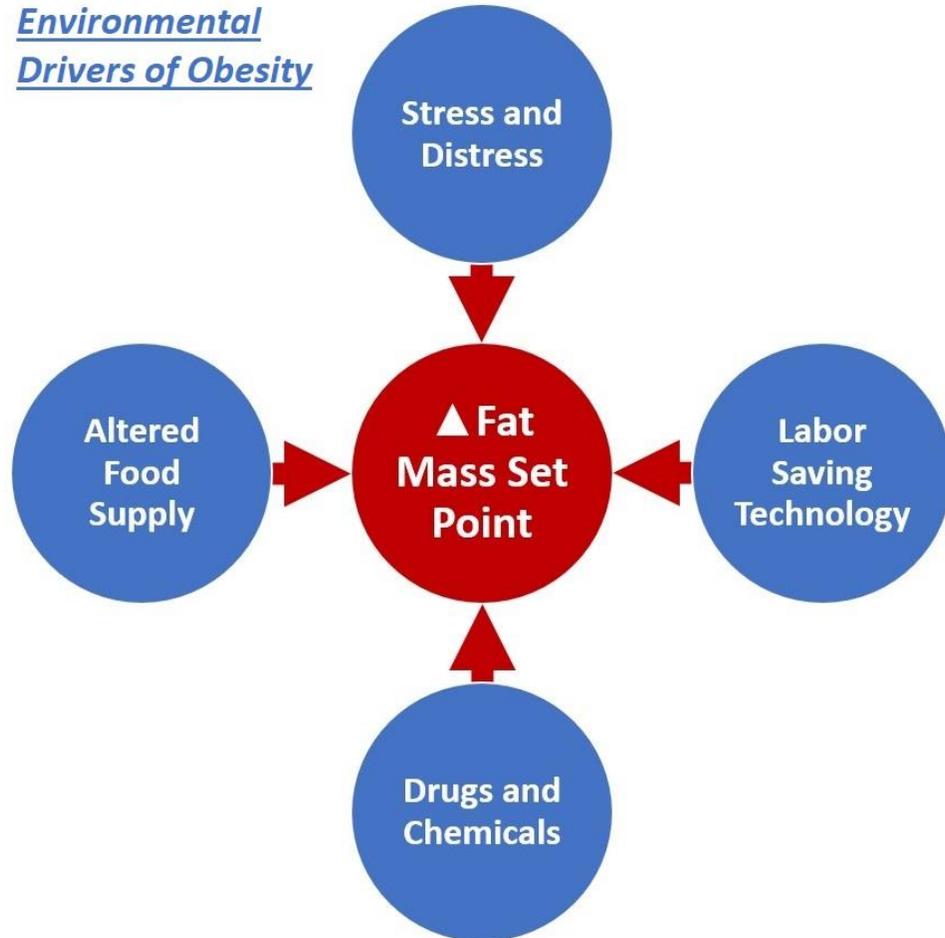
# The Truth Is Obesity Is a Highly Heritable Chronic Disease



- Heredity plays the dominant role in obesity risk
- But environmental factors serve to activate it
- Then, people can choose what to do about it

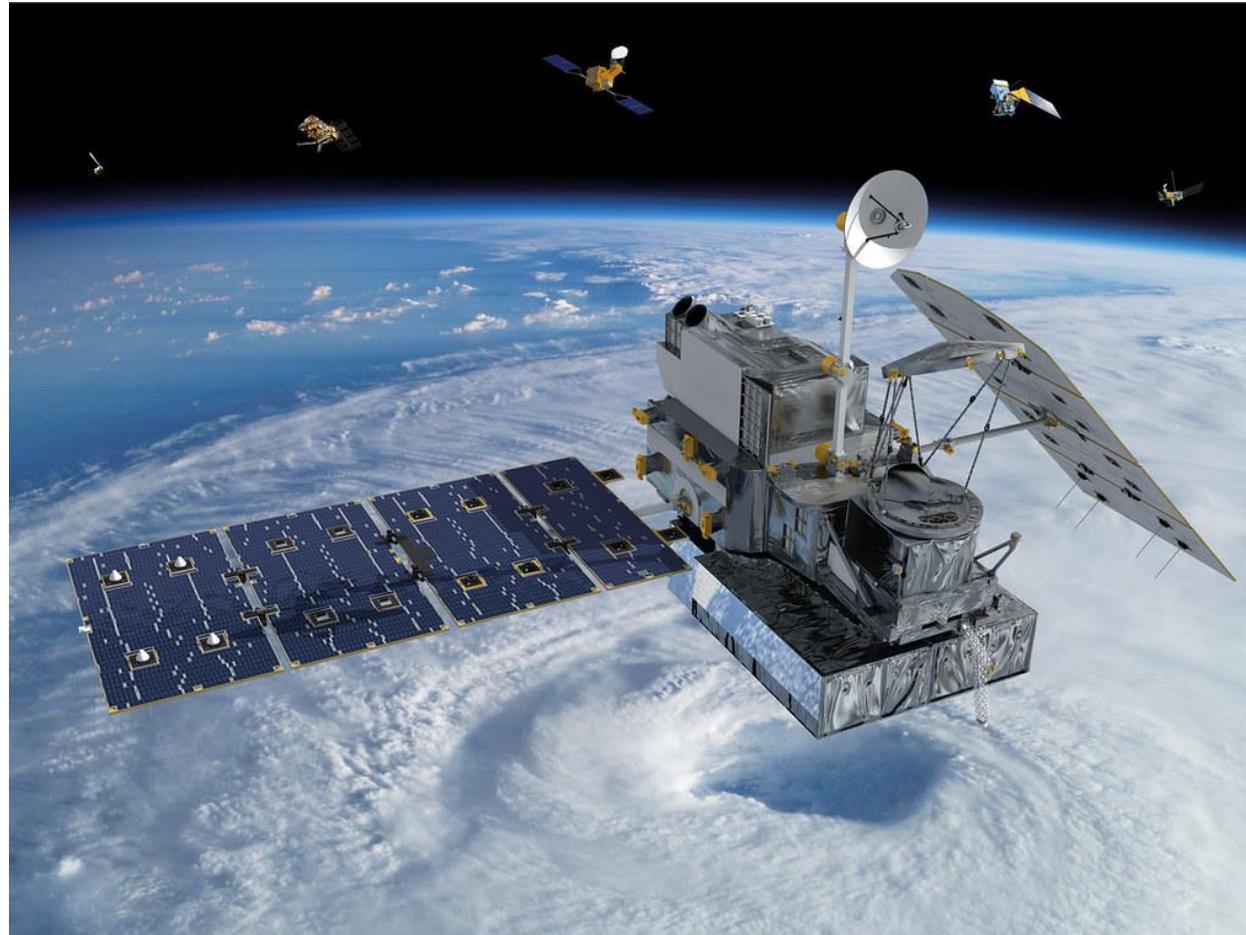
# Ever More Obesity from A Perfect Storm of Environmental Triggers

## Environmental Drivers of Obesity



- Simplistic explanations are invariably wrong
- The more accurate view is a perfect storm of multiple factors

# Rocket Science May Be Complicated . . .



GPM Core Observatory, illustration by NASA Goddard Space Flight Center / flickr



# Weight Bias Flows from Demeaning Stereotypes About People with Obesity

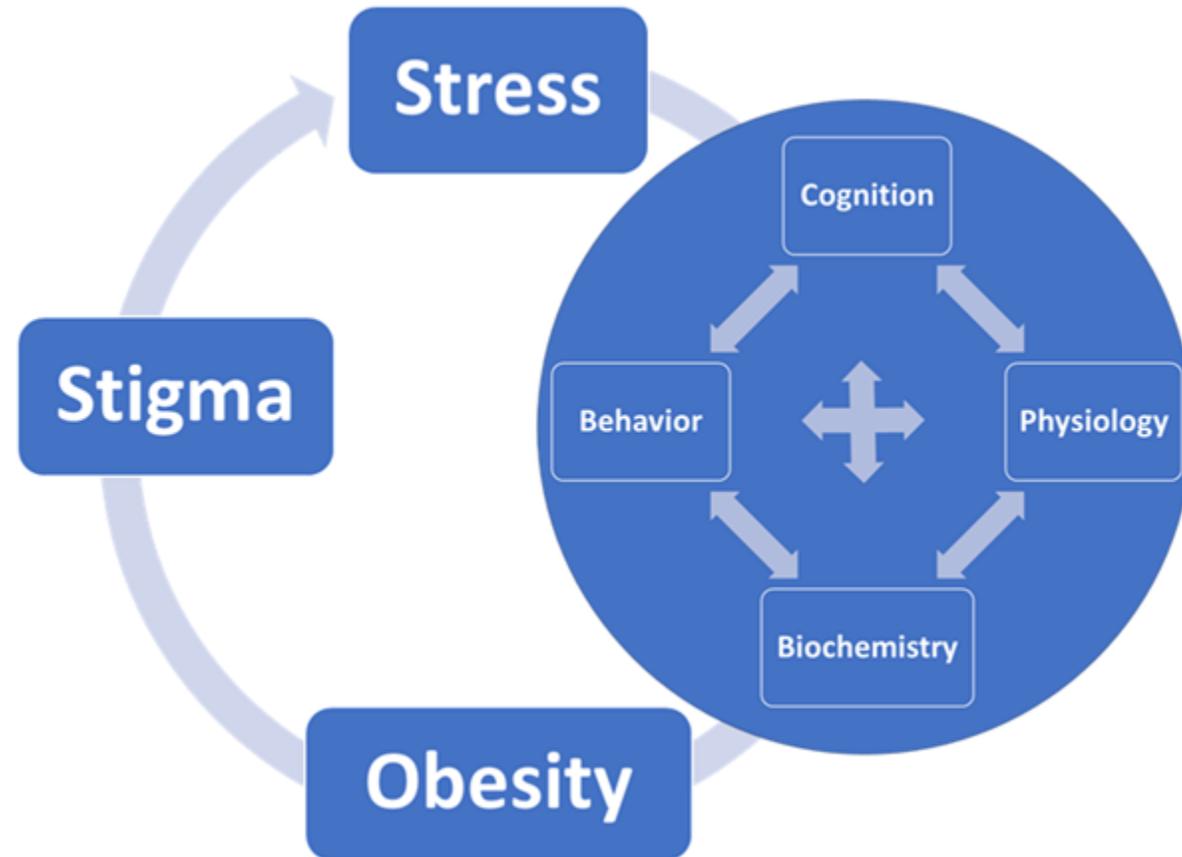
- Lazy
- Stupid
- Undisciplined
- Sloppy
- Awkward
- Losers
- Dishonest
- Won't follow directions
- Uniformly unhealthy
- Ignorant about nutrition
- Lives spent gorging on junk food



*In the Kitchen, photograph © Obesity Action Coalition / OAC Image Gallery*

# Living with Bias & Stigma Makes People Sicker

*Pathways from stress to obesity*



Source: Tomiyama, 2019, *Ann Rev Psych*

# Explicit Bias Is Down, But Implicit Bias Is Growing

Dimension	Explicit Bias Trend 2007-2016	Implicit Bias Trend 2001-2016
Sexuality	Down	Down
Race	Down	Down
Skin Tone	Down	Down
Age	Down	Flat
Disability	Down	Flat
Weight	Down	Up

Source: Charlesworth and Banaji, 2018, Patterns of Implicit and Explicit Attitudes, Long-Term Change and Stability From 2007 to 2016

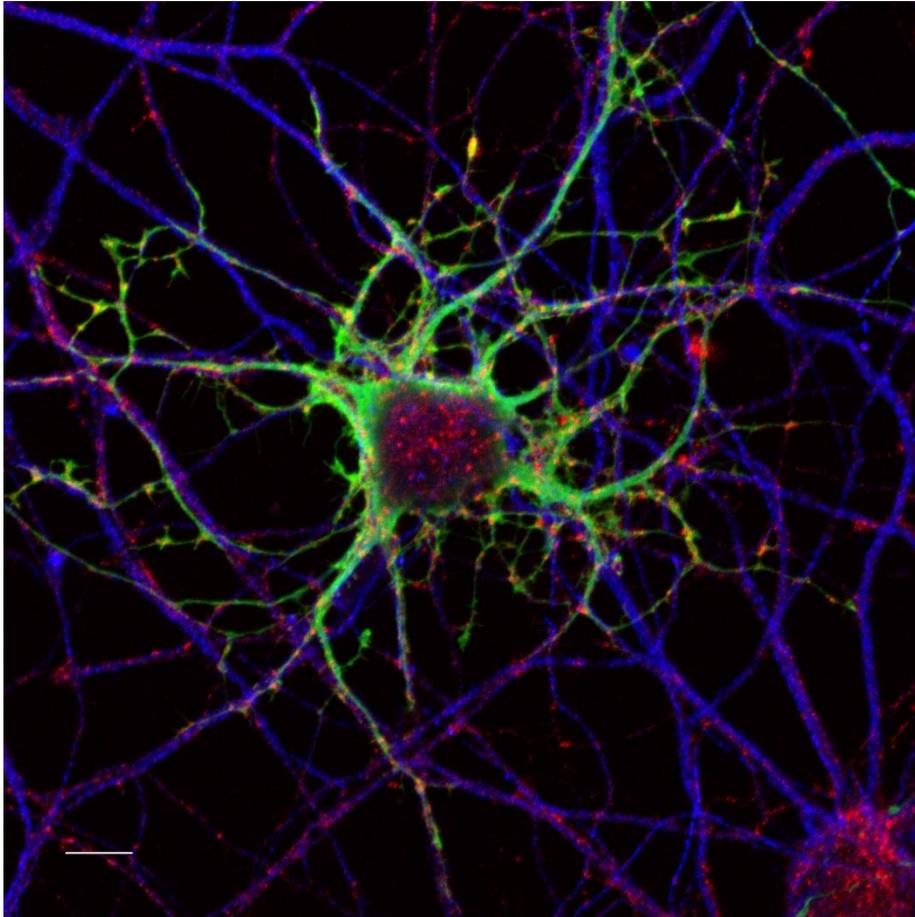
# Because of Bias, Self-Care Is Often the Only Option Available for Obesity



# Good Obesity Care Requires Access to the Full Range of Obesity Care Tools



# Obesity Science Is Bringing Better Insights and Solutions



Neurons, photograph © ZEISS Microscopy / flickr

- Hypothalamus controls fat mass and blood sugar
- More, better therapies on the horizon for obesity
- A growing evidence base for bariatric surgery

# Smart Benefit and Well-Being Strategies Can Bring Competitive Advantages

- Reduce diabetes and obesity impact
- Work culture that promotes health and well-being
- Diabetes prevention
- Access to obesity care



Targets of Opportunity, photograph by Randy Robertson / flickr

# More Information



[conscienhealth.org/news](https://conscienhealth.org/news)



[@ConscienHealth](https://twitter.com/ConscienHealth)



[Facebook.com/ConscienHealth](https://facebook.com/ConscienHealth)

**For these slides:**

<https://conscienhealth.org/wp-content/uploads/2019/11/Alliance.pdf>



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# Leveraging Evidence-based Practices for Obesity, Health & Wellbeing

Christine Gallagher, MPAff,  
Research Project Director

Milken Institute School  
of Public Health

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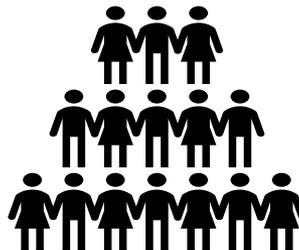
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**STOP**  
STRATEGIES TO  
OVERCOME & PREVENT **OBESITY**  
**ALLIANCE**

**A diverse membership dedicated to reversing the obesity epidemic**

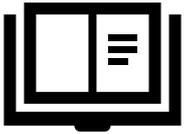
- 15 Steering Committee Members**
- 60 Associate Member organizations**
- 4 Corporate Members**



# What we do...



- **Conduct Research**



- **Develop Tools**



- **Drive Collaboration**

# Provider Knowledge of Obesity Care is Limited

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

**49%**

Knew that  $\geq 150$  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

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

Among family practitioners, internists, OB-GYNs, and nurse practitioners ( $N = 1501$ ):



**70%** More time with the patient



**64%** Additional training in obesity management



**56%** Improved coverage/ reimbursement process



**61%** Tool to help patients recognize obesity risks



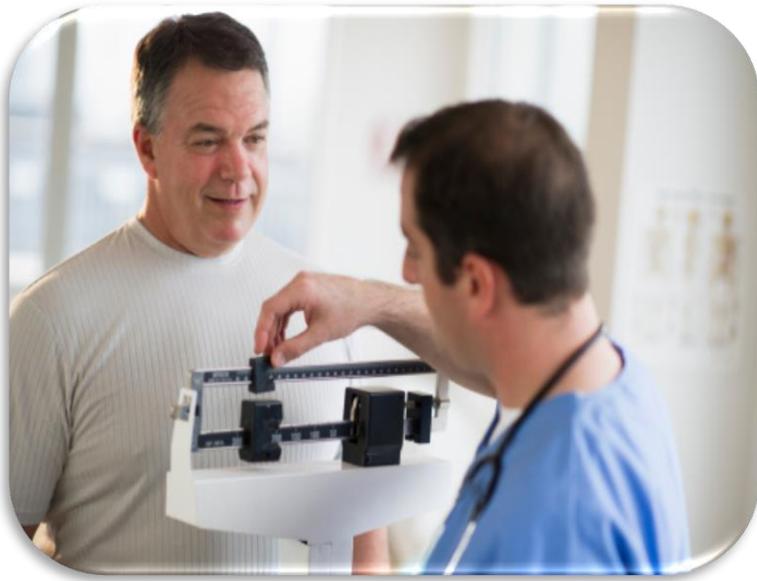
**31%** Advice on how to avoid offending patients

# Physicians lack the training and education to treat obesity

- There is no standard minimum level of obesity-related education and training that health professionals should receive
- Most medical residency programs devote very little time to the topics of obesity, nutrition and physical activity



# Identified Gaps in Patient-Provider Interactions



- Providers are **not having constructive conversations** with their patients about weight.
- Physicians are **inconsistently diagnosing** obesity.
- Even when physicians have conversations about weight, **patients do not necessarily get the information they need and follow up rarely occurs.**

# People First Language



- **Overweight is a description**
- **An “obese person” is an identity – he or she is obese, not a father, mother, or a person characterized by their achievements**
- **An “obese person” is more likely to be held responsible for their weight**
- **Obesity is a disease**
- **Describing a person with obesity focuses attention on cause**

# Provider stigma and bias inhibits the ability of patients to receive care

- Only **38%** of adults with obesity have discussed a weight loss plan with their health care provider
- Several studies have demonstrated a **lack of respect** that some physicians have for patients with obesity
- Some providers are **biased** against people with obesity, and believe they are lazy, lack self-control, and blame them for their obesity



# Efforts to Address Knowledge and Practice Gaps

**Initiate** open, productive conversations about weight and health

**Assess** patient readiness to change

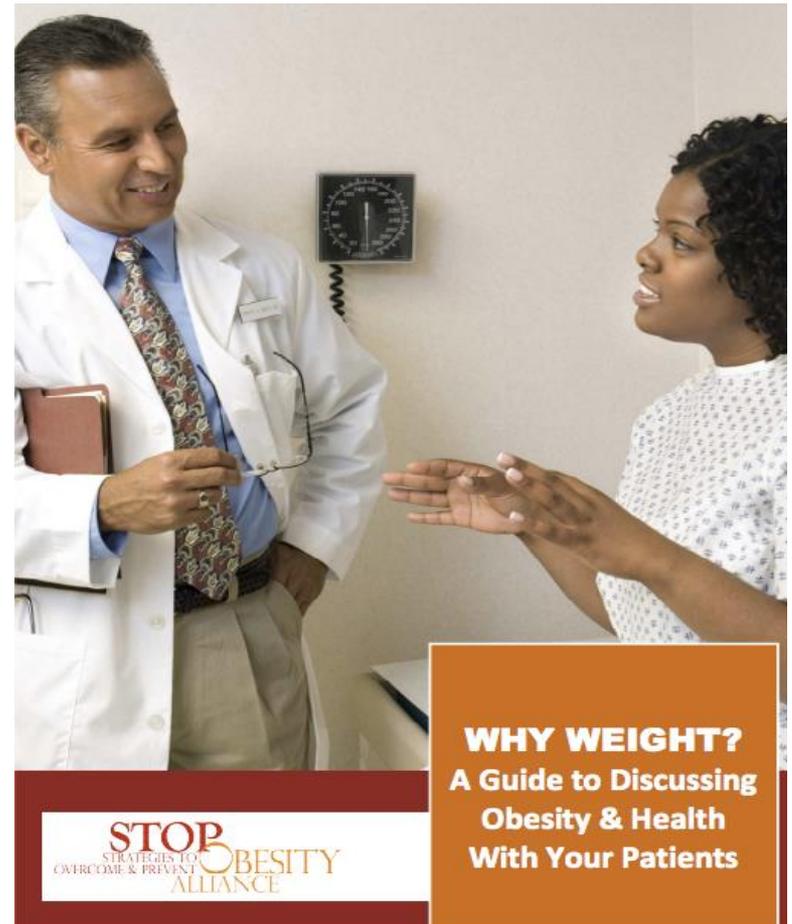
**Engage** in active listening

**Build** trust

**Shared-decision making** by patient and provider

**Address** culture and social barriers and supports

[www.whyweightguide.org](http://www.whyweightguide.org)





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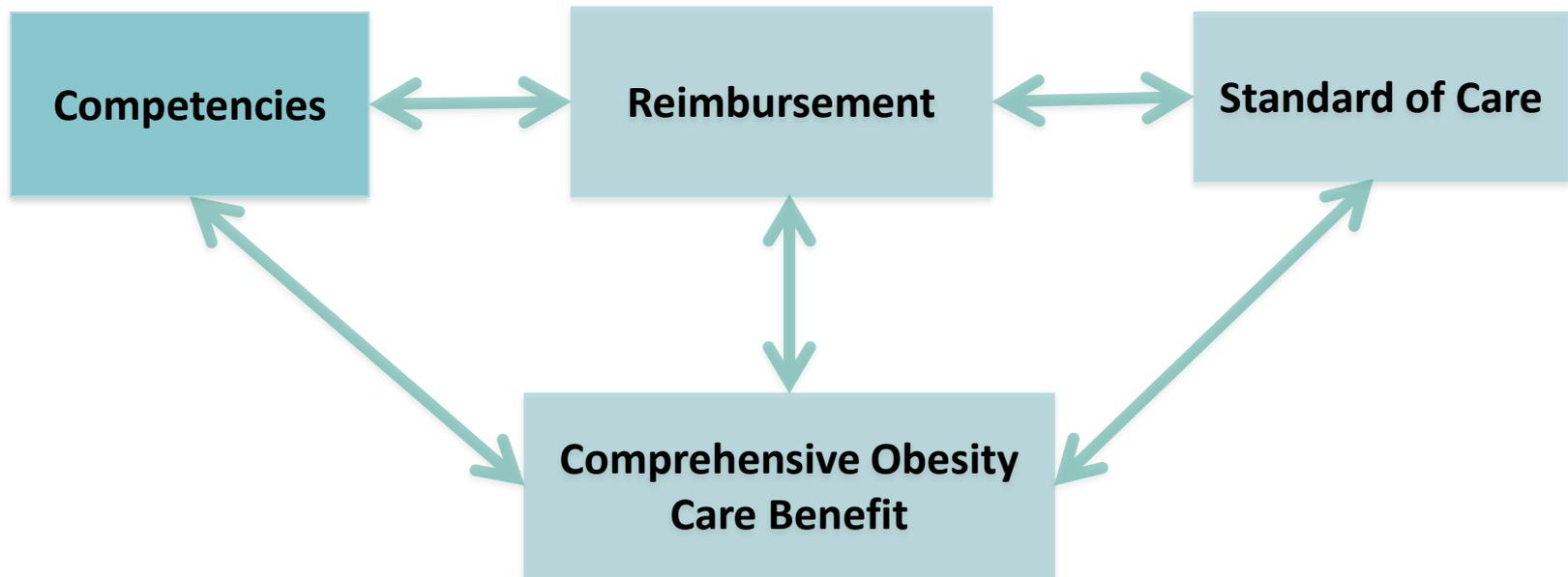
# Leveraging Evidence-based Practices for Obesity, Health & Wellbeing

William H. Dietz MD, PhD  
Chair  
Sumner M. Redstone Center

Milken Institute School  
of Public Health

Sumner M. Redstone  
Global Center for

# The Path to Developing a Comprehensive Obesity Care Benefit



# Competencies Development Working Group



BIPARTISAN POLICY CENTER



AMERICAN COLLEGE  
of SPORTS MEDICINE  
LEADING THE WAY



**Accreditation Council for Graduate  
Medical Education**  
**American Academy of Family  
Physicians**  
**American Academy of Pediatrics**  
**American Association of Colleges of  
Nursing**  
**American Association of Colleges of  
Osteopathic Medicine**  
**American Association of Colleges of  
Pharmacy**  
**American Board of Obesity Medicine**  
**American Council of Academic Physical  
Therapy**  
**American Dental Education Association**  
**Association for Prevention Teaching  
and Research**

**Association of American Medical  
Colleges**  
**Association of Schools and Programs of  
Public Health**  
**Centers for Medicare and Medicaid  
Services**  
**Interprofessional Education  
Collaborative**  
**National Organization of Nurse  
Practitioner Faculties**  
**Physician Assistant Education  
Association**  
**Society for Public Health Education**  
**Society of Teachers of Family Medicine**  
**The Obesity Society**  
**YMCA of the USA**

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# Obesity Care Competencies

[www.obesitycompetencies.gwu.edu](http://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

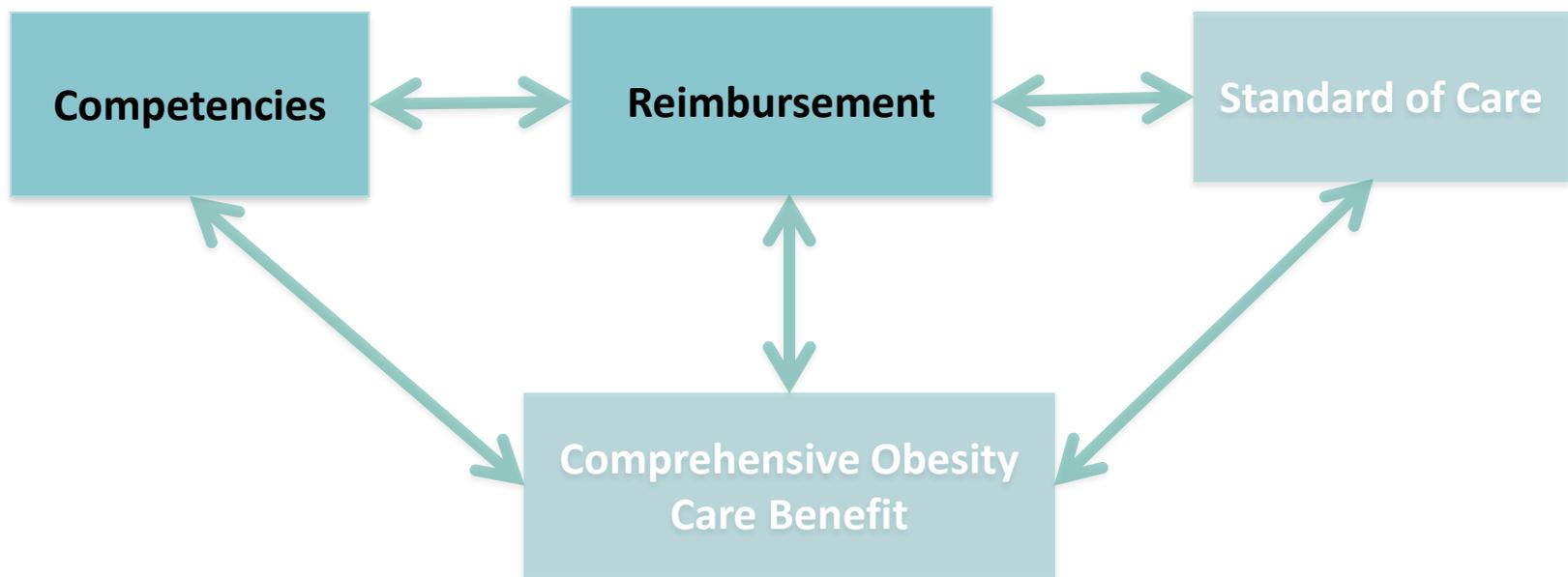
- Interprofessional obesity care
- Integration of clinical & community care systems



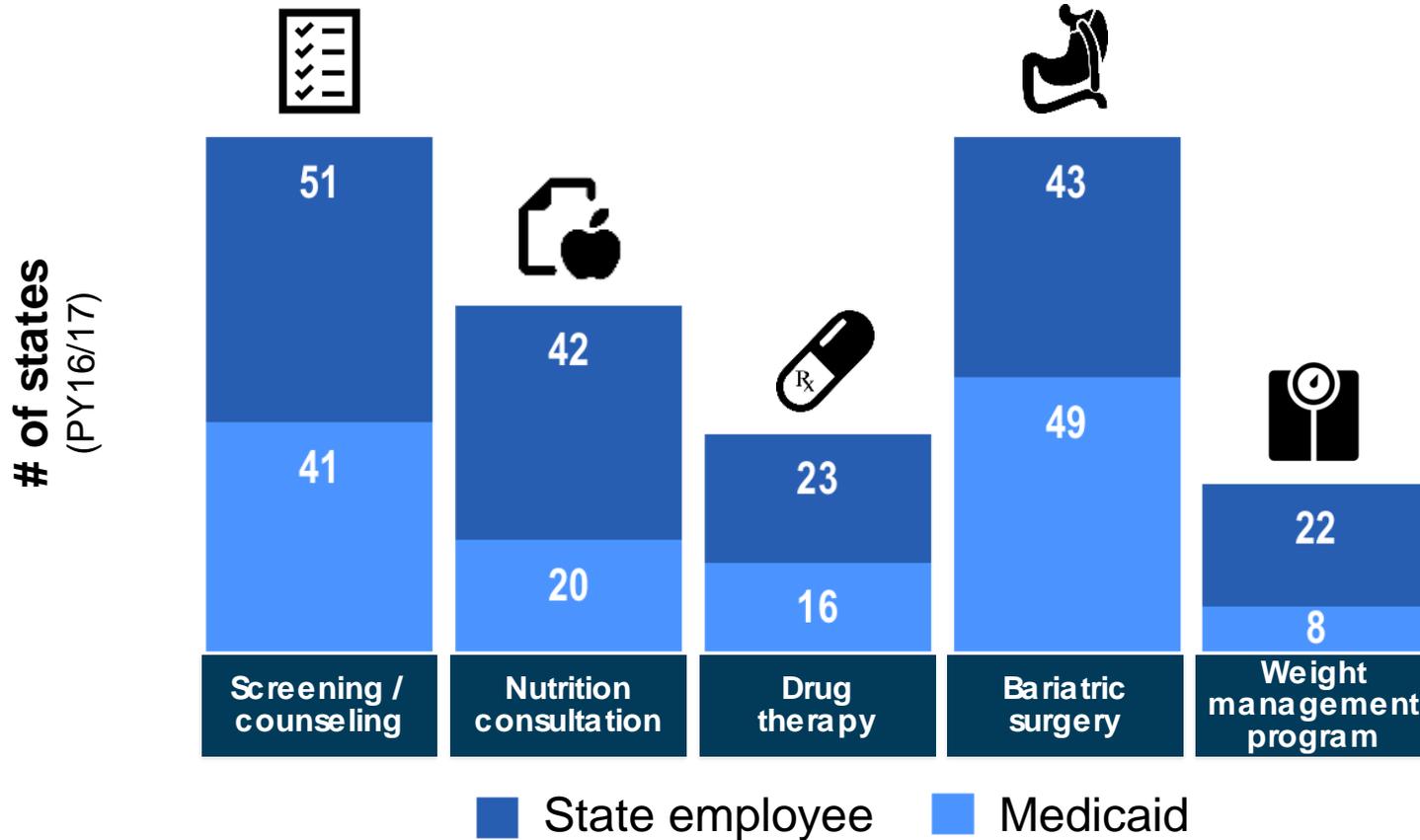
## Patient Interactions

- 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

# The Path to Developing a Comprehensive Obesity Care Benefit

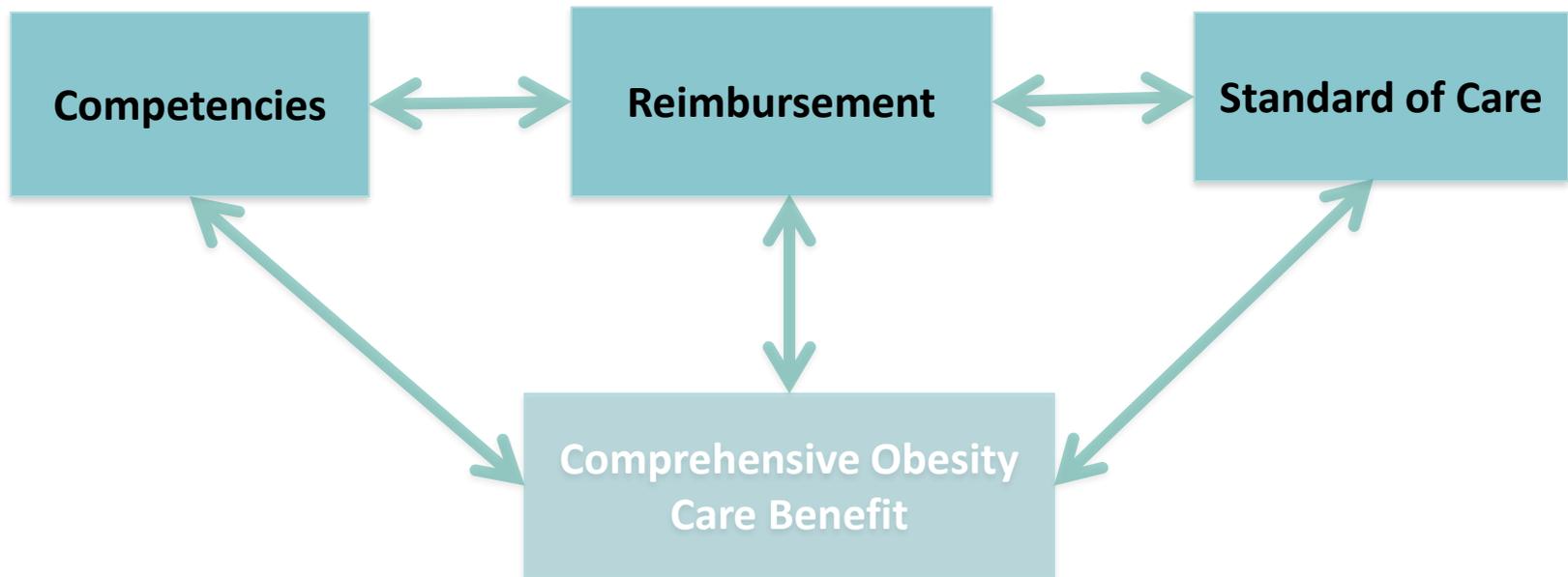


# Obesity Coverage in State Medicaid and State Employee Plans



Jannah NH, et al. *Obesity* 2018; 26:1834-1840.

# The Path to Developing a Comprehensive Obesity Care Benefit



# A Proposed Standard of Care

**Goal: *provide a model of care for all those who care for people with obesity***

- **Core principles of care**
- **Standards of Care for all providers**
- **Standards of Care for clinical providers (prescribers)**
- **Coverage and payment policy standards**



**Dietz, WH. and Gallagher C. *Obesity* 2019; 7: 1059-1062.**

# Core Principles of Care

- Treat obesity as a **chronic disease**
- Care should be **evidence-based pragmatic and deliverable**
- Provide **access to appropriate level of care**, regardless of point of entry
- Providers should be **sensitive to bias** and provide appropriate accommodation
- Providers should be **trained to initiate conversations** about weight
- **Shared decision making** and bidirectional communication
- **Evidence-based competencies** that are discipline-specific should be met by each type of provider

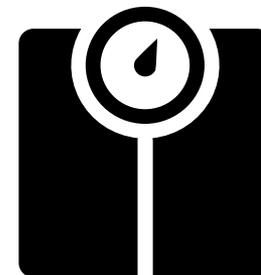
# What is the Appropriate Outcome from an Obesity Treatment/intervention?

## Community-based intervention

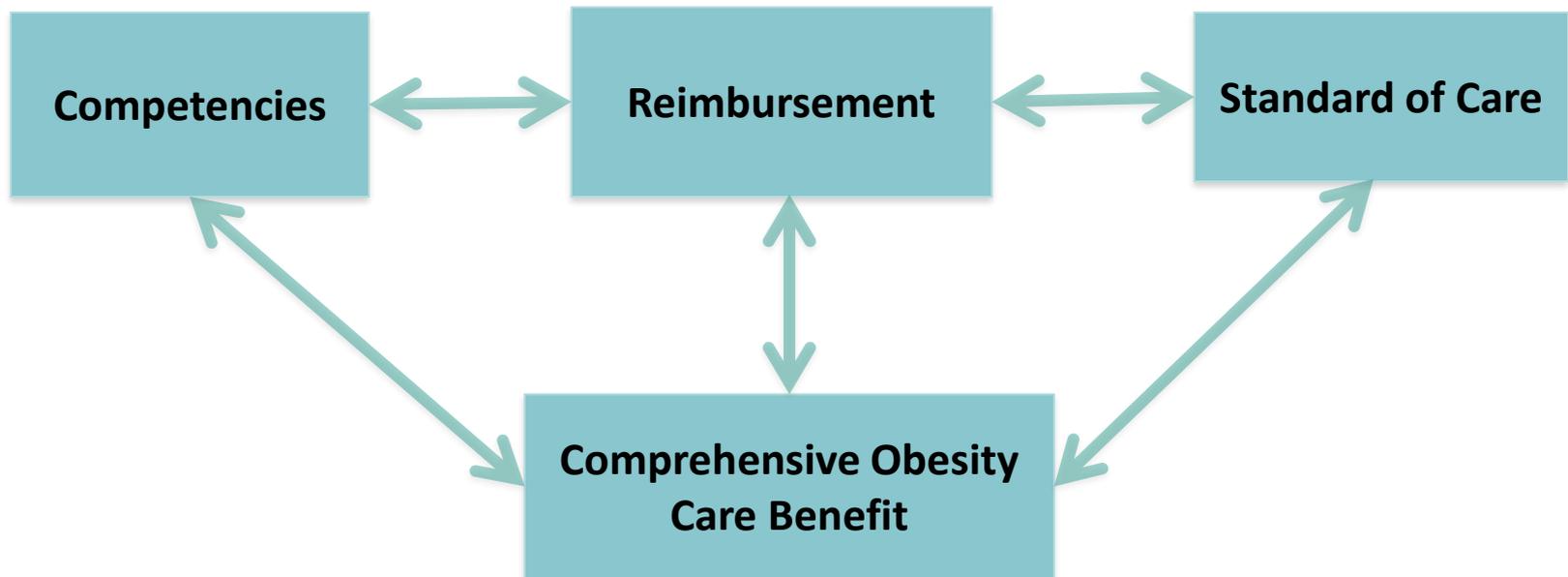
- 3-5% weight loss

## Clinical obesity intervention

- 5% or greater weight loss
- Decrease in the co-morbidities of obesity
- **Outcomes should be sustained over 6 months**
- **Consider activities of daily living**



# Elements Relevant to the Comprehensive Obesity Care Benefit



# Elements of a Comprehensive Obesity Care Benefit

- Identifies **evidence-based obesity treatment** that can support clinically significant weight loss ( $\geq 5\%$  reduction in body weight)
- Provides guidance on the appropriate **amount, scope, duration, and delivery of obesity-related benefit offerings**
- Highlights **real-world examples** from plans that cover obesity treatment modalities
- Supports efforts to **standardize the scope and availability of obesity treatment** that are covered across plans/systems

# Elements of a Comprehensive Obesity Care Benefit

## Prevention and Screening

All adults should be screened annually for obesity



For adults with obesity (BMI  $\geq$  30 kg/m<sup>2</sup>), waist circumference > 102 cm (> 40 in) for men / > 88 cm (> 35 in) for women, or BMI 25-29 with obesity-related risk factors:

- Offer or refer to intensive lifestyle intervention
- Screen for obesity-related complications

# Elements of a Comprehensive Obesity Care Benefit

## Intensive Behavioral Therapy (IBT)

IBT for obesity should include all three of the following:



- Cognitive component: intervention using evidence-based educational and behavior-change techniques (e.g. CBT, MI, 5As)



- Physical activity component: physical activity plan that includes personalized recommendations for aerobic (150 min/week) and muscle strengthening activity.



- Nutrition component: program or dietary intervention that targets intrapersonal-level factors to assist with changing energy balance behaviors

***NOTE: There should be low or no out-of-pocket costs to actively-engaged patients, regardless of weight loss***

# Elements of a Comprehensive Obesity Care Benefit

## Pharmacotherapy

Access to all FDA-approved medications, prescribed in conjunction with behavioral interventions

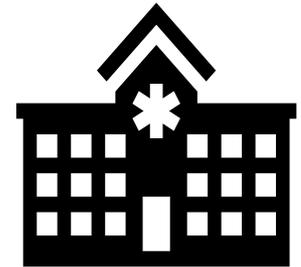
- Short-term: i.e. Phentermine
- Long-term: i.e. Saxenda, Contrave, Belviq, Qsymia
- Weight-centric prescribing: plan should authorize coverage for an alternative medication that is not associated with weight gain for a covered condition



# Elements of a Comprehensive Obesity Care Benefit

## Surgery

- Coverage of primary bariatric procedures:
  - Laparoscopic sleeve gastrectomy
  - Roux-en-Y gastric bypass
- Revisional procedures to correct complications or when inadequate weight loss achieved despite adherence to prescribed post-op treatment regimen.



# Elements of a Comprehensive Obesity Care Benefit

## Weight Maintenance

Strategies to prevent and mitigate weight regain are integral to the obesity care plan.

- **Monitoring & Prevention:** Continued tracking and documentation of weight status
- **Follow-Up & Intervention:** Re-initiation or intensification of obesity treatment plan when patient: begins to regain weight, presents with a new or worsening obesity complication, or requests intensification of treatment (as medically appropriate)

# Expanded Components of a Comprehensive Obesity Care Benefit

**Additional options for the delivery of the core benefits based on anecdotal or emerging evidence**

- IBT – cognitive component, physical activity component, nutrition component
- Bariatric surgery – i.e. travel expenses and supplements
- Weight maintenance – i.e. gym access, fitness trackers, community programs



# Adoption of the Comprehensive Obesity Care Benefit

- **Create demand**
- **Identify model programs**
- **Demonstrate the ROI**
- **Share with policymakers**

**go.gwu.edu/obesitybenefit**

Please send any further comments/questions to:

[Obesity@gwu.edu](mailto:Obesity@gwu.edu)

**STOP**  
STRATEGIES TO  
OVERCOME & PREVENT **OBESITY**  
**ALLIANCE**

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# Leveraging Evidence- Based Practices for Obesity, Health, & Wellbeing

Abby Ammerman, MPH

Manager of Health and Wellness-H-E-B

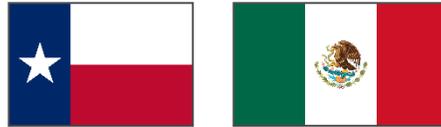
# Who We Are



H-E-B serves an average of **10.6 Million customers/week** in **390+ stores** with **100,000+ Partners**.



113 Years in  
Operation



\$24 Billion  
Global Sales

## H-E-B Operations

### Stores

- H-E-B
- H-E-B Plus!
- Central Market
- Mi Tienda
- Joe V's Smart Shop
- H-E-B Mexico

### Manufacturing

- 12 plants
- 1,700+ products
- 20,800+ H-E-B brand products

### Warehousing

- \$500 million in inventory
- 6.5 million sq. ft. warehouse space
- 16 distribution centers

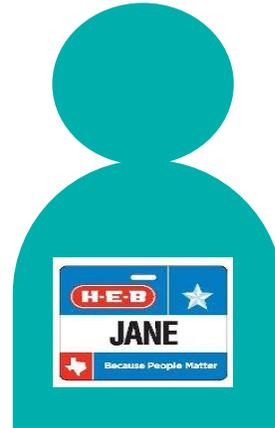
### Transportation

- 427 tractors
- 2,830 trailers
- 60 million miles/year

# Who We Are

## Screening Demographics

### 2019 Health Screening Cohort



### 2019 Fasting Glucose Cohort

- Partners who have screened every year since 2010
- 50.6 years old
- 56% Female, 44% Male

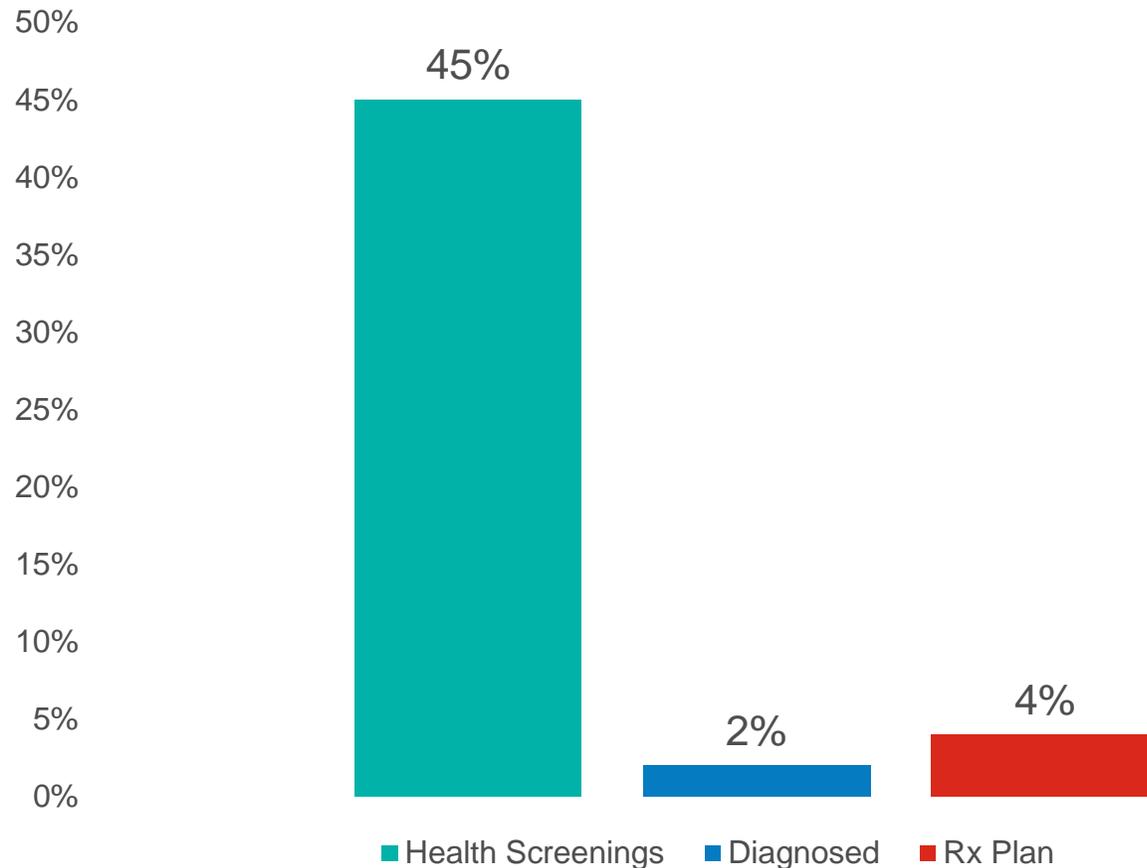
- Partners who have had a fasting screen every year since 2011
- 49.8 years old
- 55% Female, 45% Male

*\*No Partner Health Screenings in 2017*

# Who We Are

## Obesity Prevalence

### 2018 Diabetes and Obesity Stats

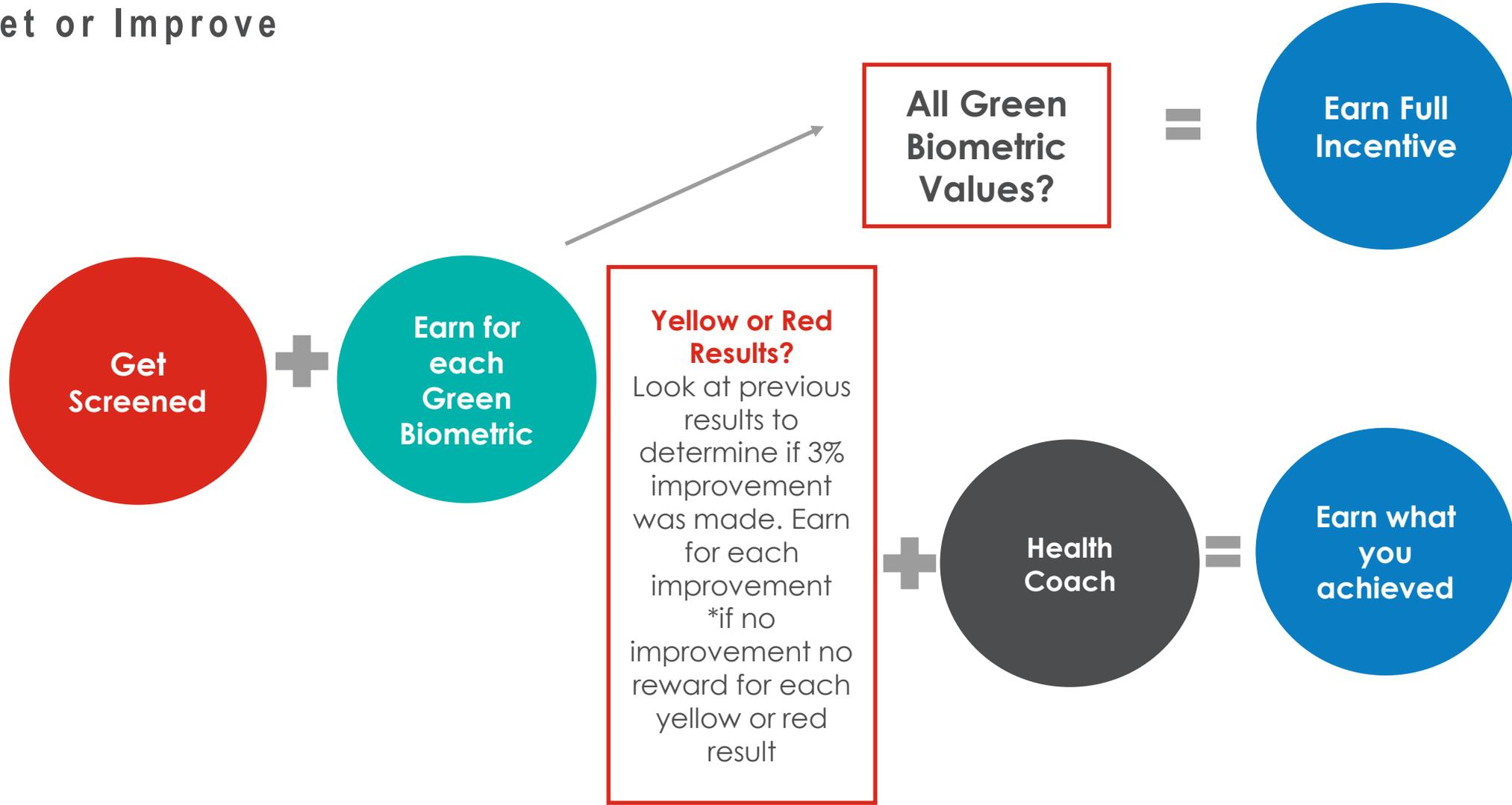


### What We Know:

- **Obesity Dx is used sparingly by physicians in TX**
- **Based off our health screening data (Partners only) our risk prevalence is significantly higher for body mass index than diagnosis rate indicates**
- **Average BMI in 2018 was 30.2**
- **600+ members were taking Anti – Obesity Medications prior to the class being covered**

# Outcomes Based Program Design

Meet or Improve



# Supportive Plan Design Offerings

## Anti-Obesity Medications – TO cover **or** NOT to cover?

1

Determine the need

- Review utilization
- Identify the population that meets the prescribing criteria

2

Educate the team

- Basic education on the entire class of medications

3

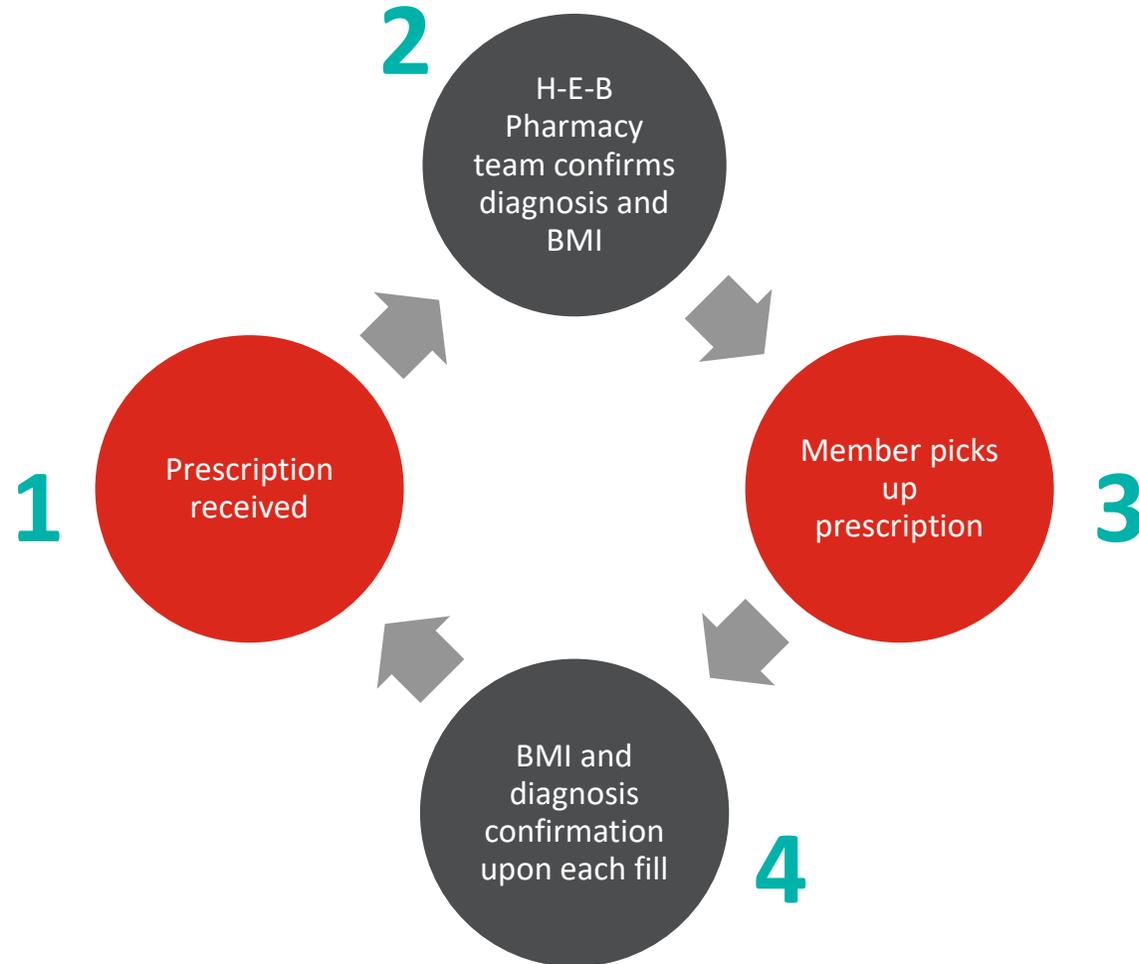
Build a financial models

- Consider your co-pay structure
- Use market share to guesstimate how physicians will prescribe
- Don't forget UM edit expenses
- How will you treat generics?



# Supportive Plan Design Offerings

## Pharmacy Weight Management Program



### AOM Copays

	Brand	Generic
<b>PA Status</b>	PA Required	No PA
<b>Tier</b>	Tier II Copay	Tier I Copay
<b>Copay</b>	25% (Min \$35 / Max \$65)	10% (Min \$4 / Max \$35)
<b>Medications</b>	Belviq Belviq XR Contrave Qsymia Saxenda	Benzphetamine Diethylpropion Diethylpropion ER Lomaira (phentermine) Phendimetrazine Phentermine

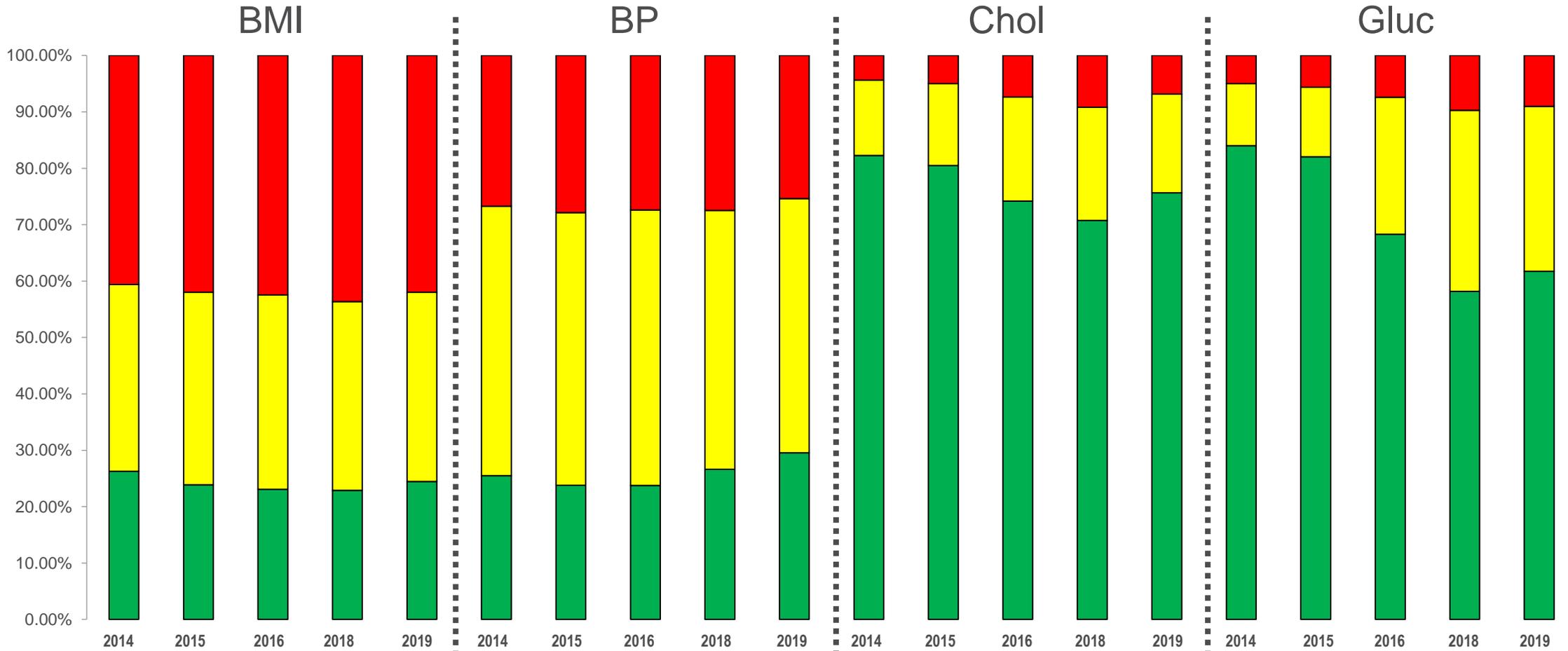
# Supportive Plan Design Offerings

## Plan Design to help Partners MEET their Improvement Goals:

- Weight Loss Medications  PA process managed by H-E-B Pharmacists
- Registered Dietician Consultations  Proven ROI/Health Improvement
- Digital Therapeutics  -4.5% avg weight loss
- Behavior Change Counselors  Network Identified by EAP
- Digital Health Coach  28% Completion Rate

# Results

## Screening Health Risks – Total Population



**75% = Yellow or Red**  
**4% ↓ since 2018**

**70% = Yellow or Red**  
**8% ↓ since 2018**

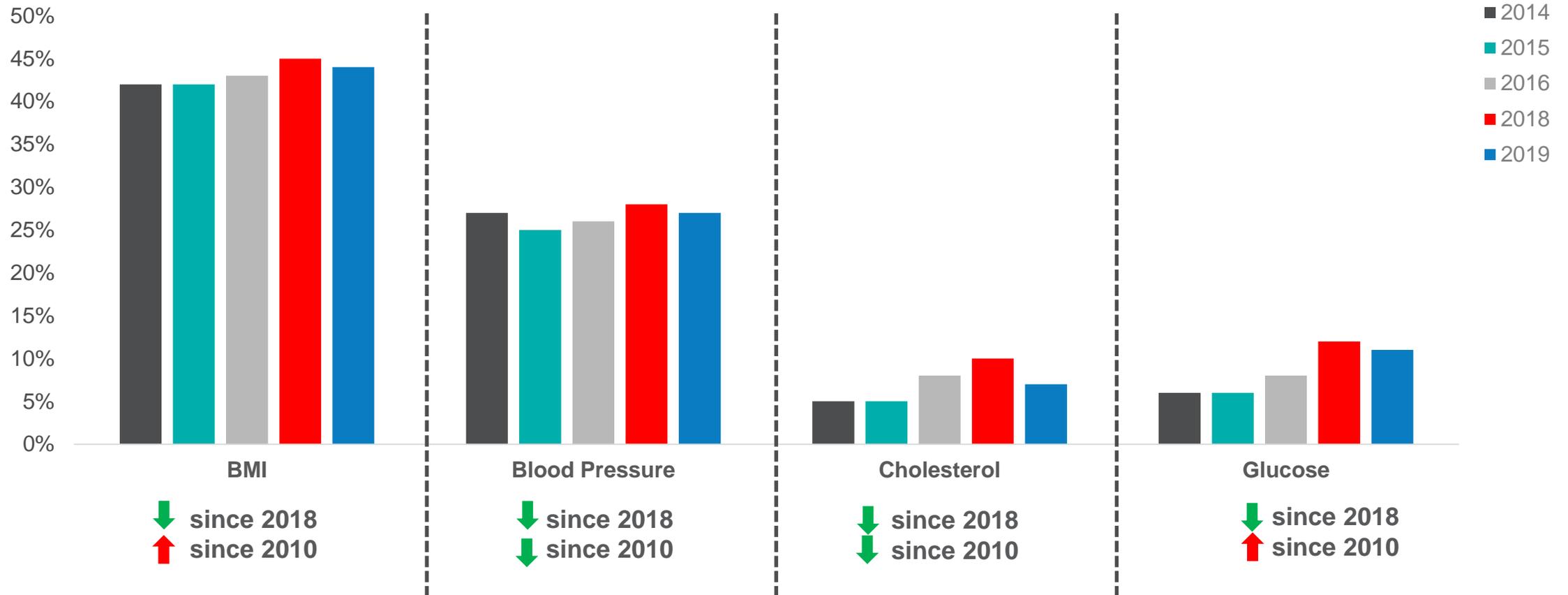
**24% = Yellow or Red**  
**25% ↓ since 2018**

**38% = Yellow or Red**  
**8% ↓ since 2018**

# Results

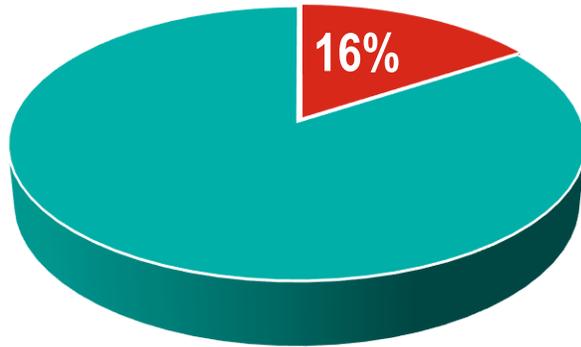
## Screening Health Risks – Cohort Population

### Cohort Risk Prevalence 2014-2016 and 2018- 2019



# Results

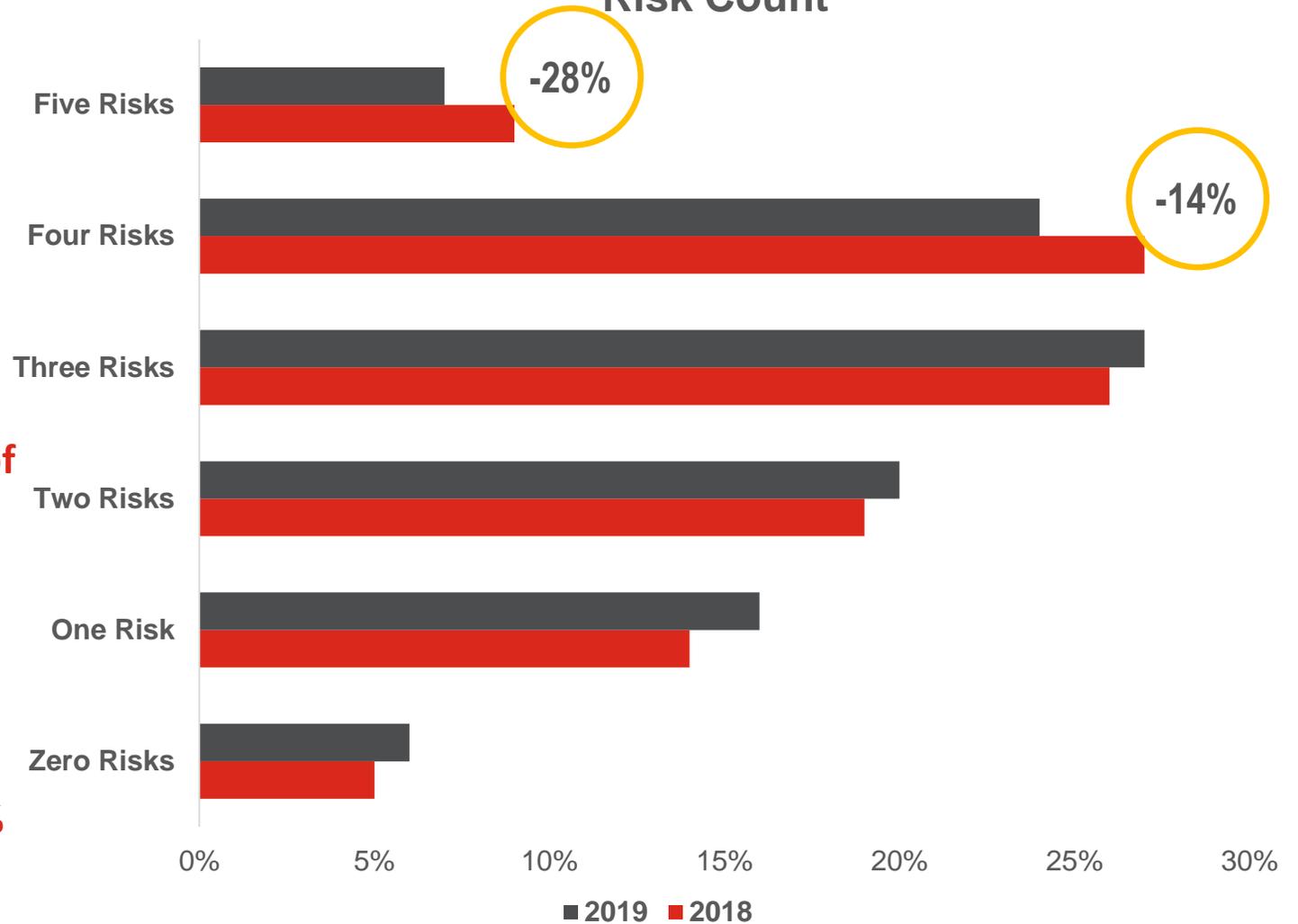
Improvement Bonus



Summary:

- 16% of the screened population met ALL of their Improvement Goals and earned the bonus
- Fewer Partners had 4 and five risk factors in 2019 vs. 2018
- Cohort Health Improvements for the first time since 2014
- Plan design changes for AOM's is only 25% of what was expected

Risk Count



Thank You!

