2019 National Alliance Annual Forum

Employers driving innovation, health and value

November 11-13 | Washington, DC

#NatAllForum

Leveraging Evidence-based Practices for Obesity, Health & Wellbeing

November 11| 1:00 PM - 2:30 PM ET

Ted Kyle
Principal
ConscienHealth

Bill Dietz
Chair
Redstone Global Center for Prevention and Wellness

Christine Gallagher
Research Project Director
STOP Obesity Alliance

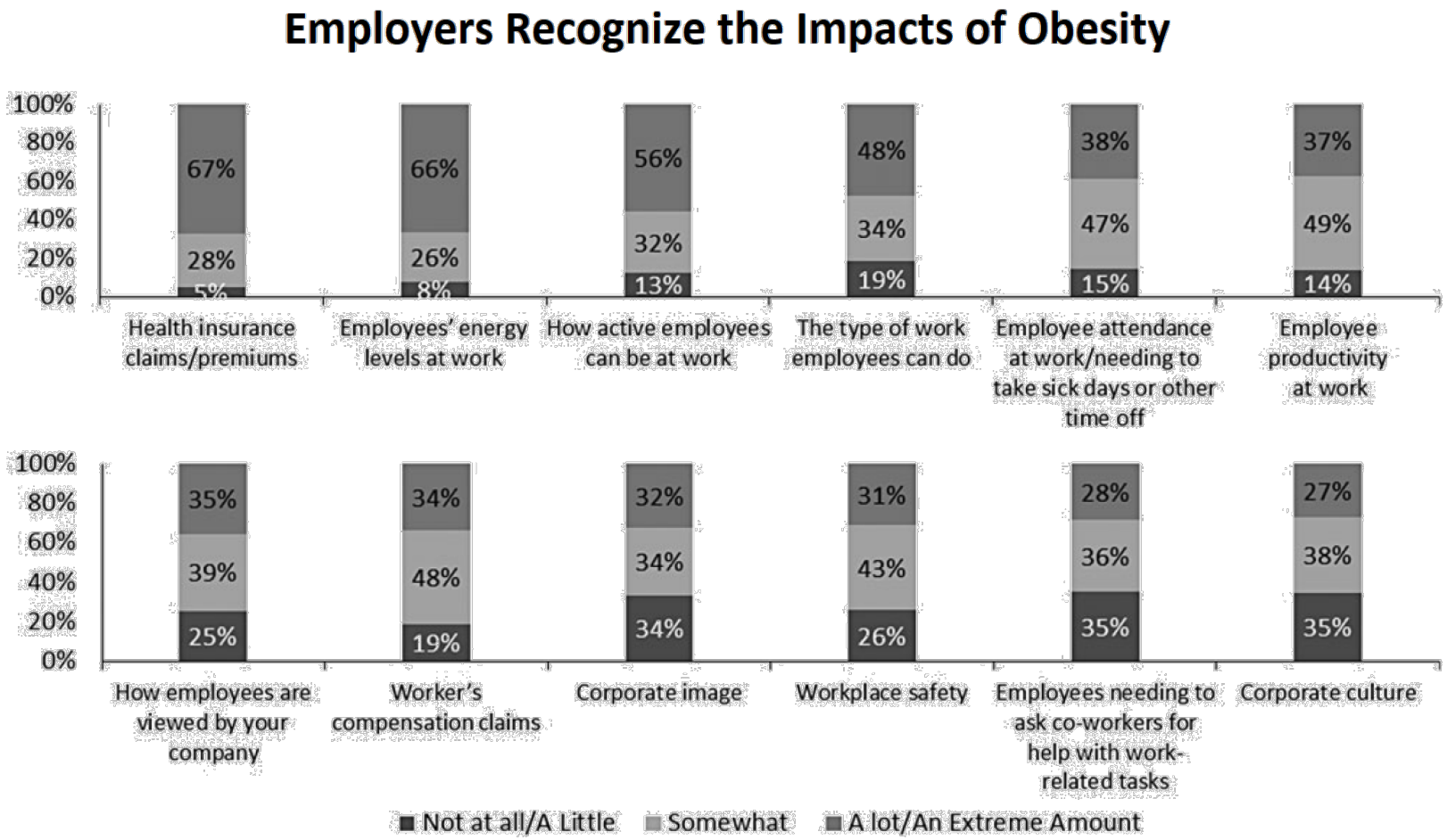
Abby Ammerman
Manager Health and Wellness
H-E-B, LP

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



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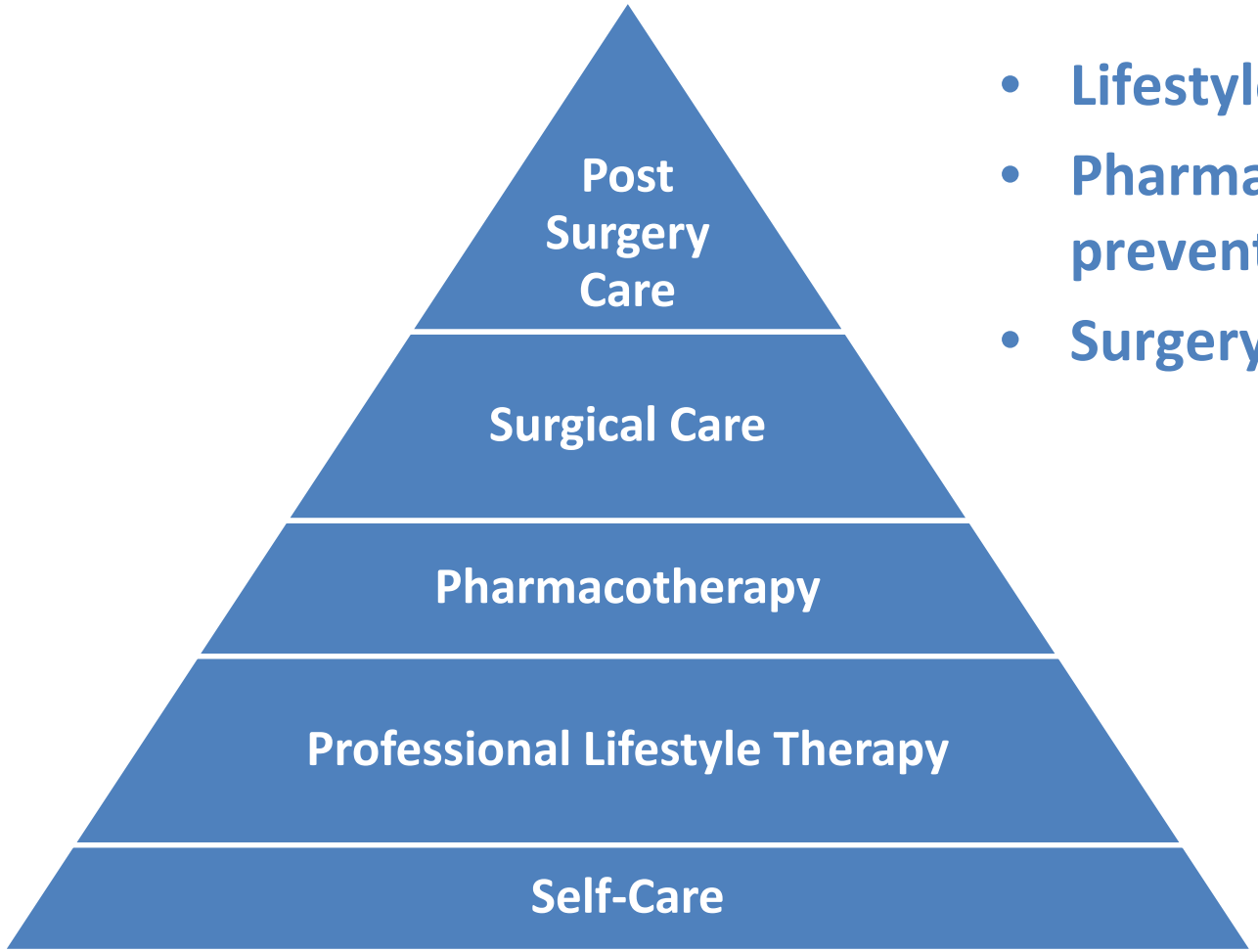
Source: Jinnett et al, *Pop Health Mgmt,* 2018

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

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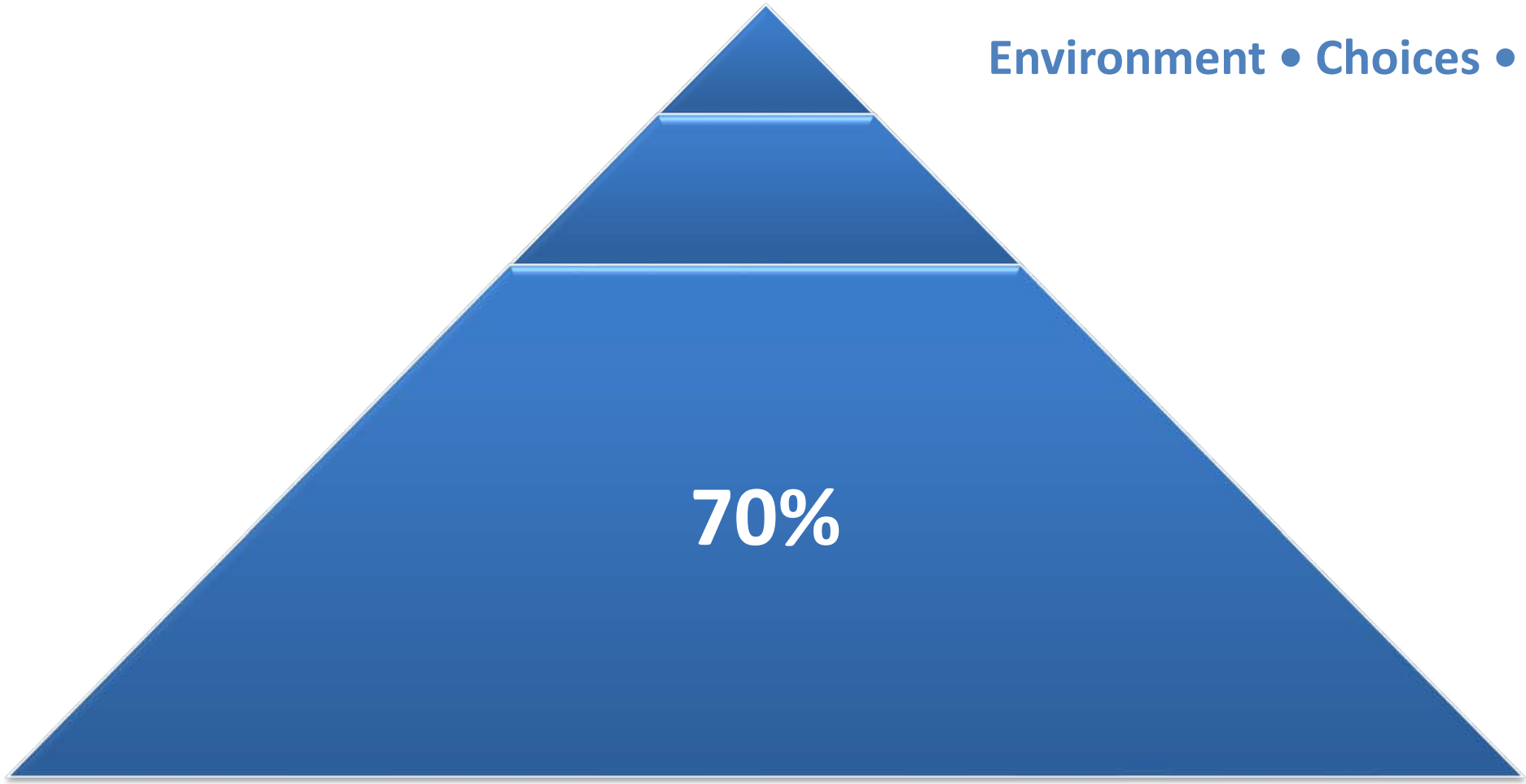
Sources: DPP Research Group, 2002; le Roux et al, 2017; Rubino et al, 2016

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



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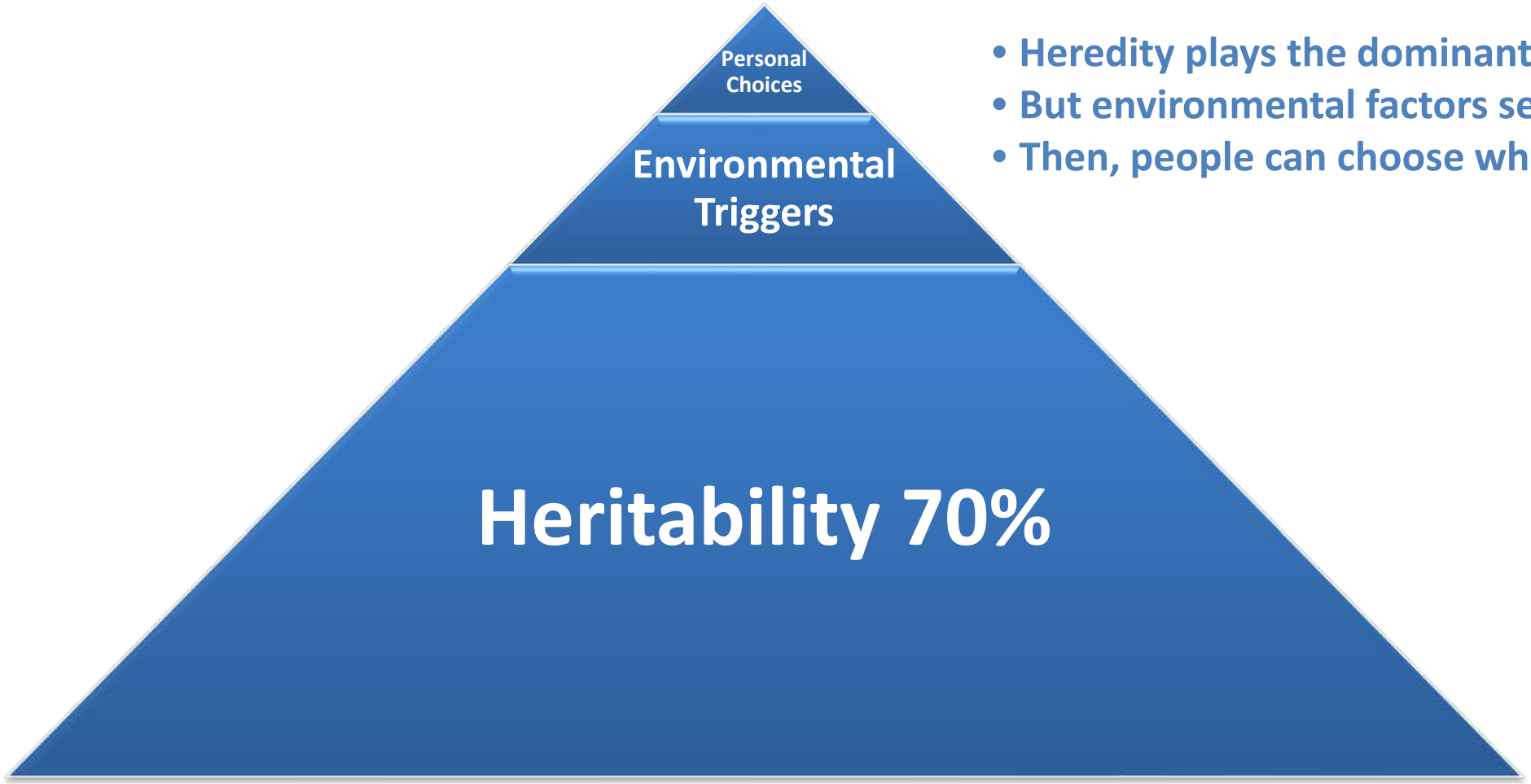
The Truth Is

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

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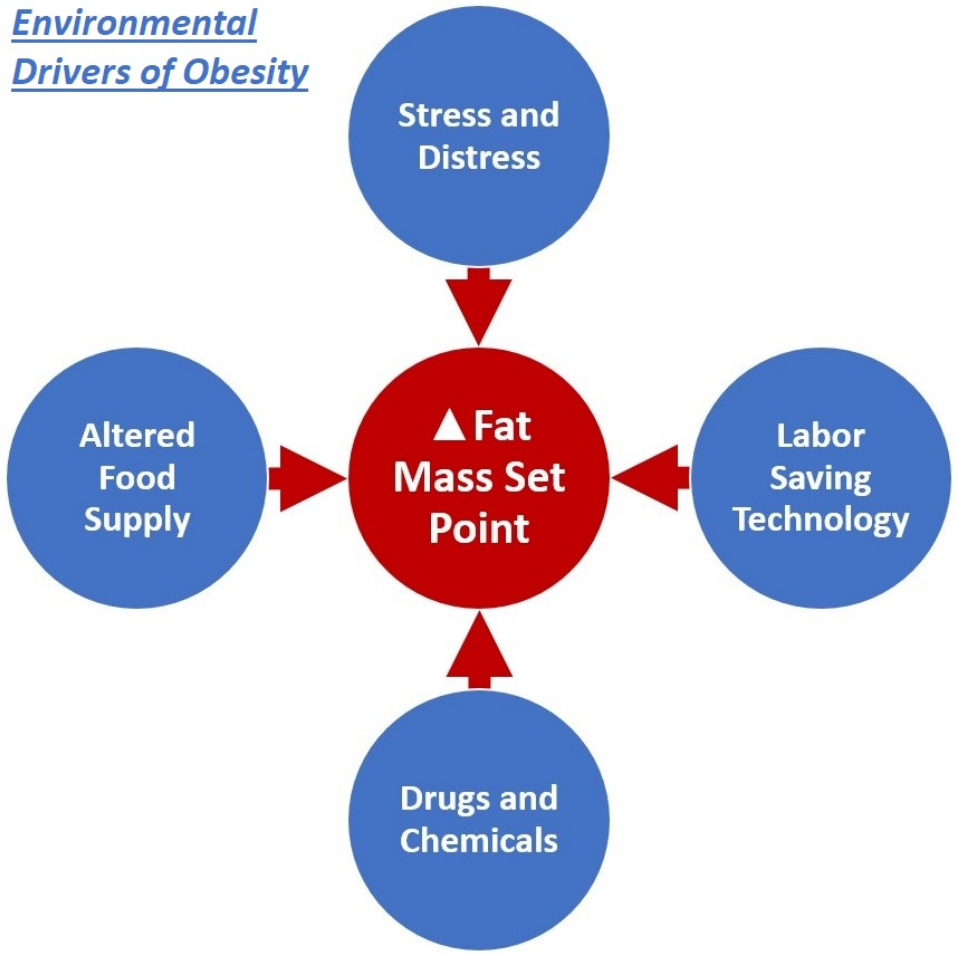
Source: Musani, Erickson, and Allison, 2008, *AJCN*

Ever More Obesity from A Perfect Storm of Environmental Triggers



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

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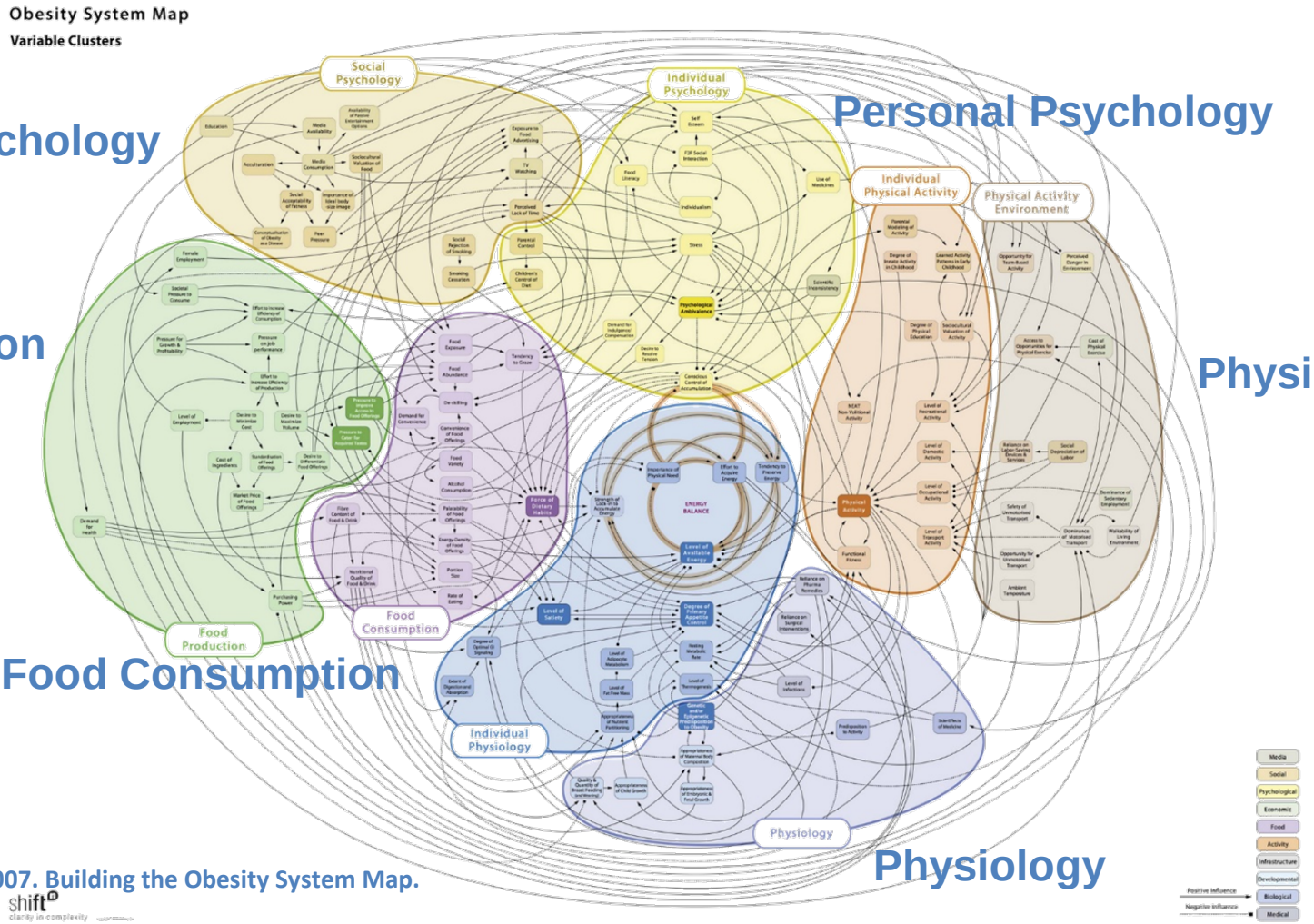
References: Ravussin & Ryan, 2017, What's Behind the Obesity Epidemic?; Kaplan, 2018, Harvard Blackburn Obesity Course

Rocket Science May Be Complicated . . .

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

. . . But Obesity Is Far More Complex



Social Psychology

Personal Psychology

Food Production

Physical Activity

Food Consumption

Physiology

Source:
Vandenbroeck IP, Goossens J, Clemens M. 2007. Building the Obesity System Map.

shift
clarity in complexity

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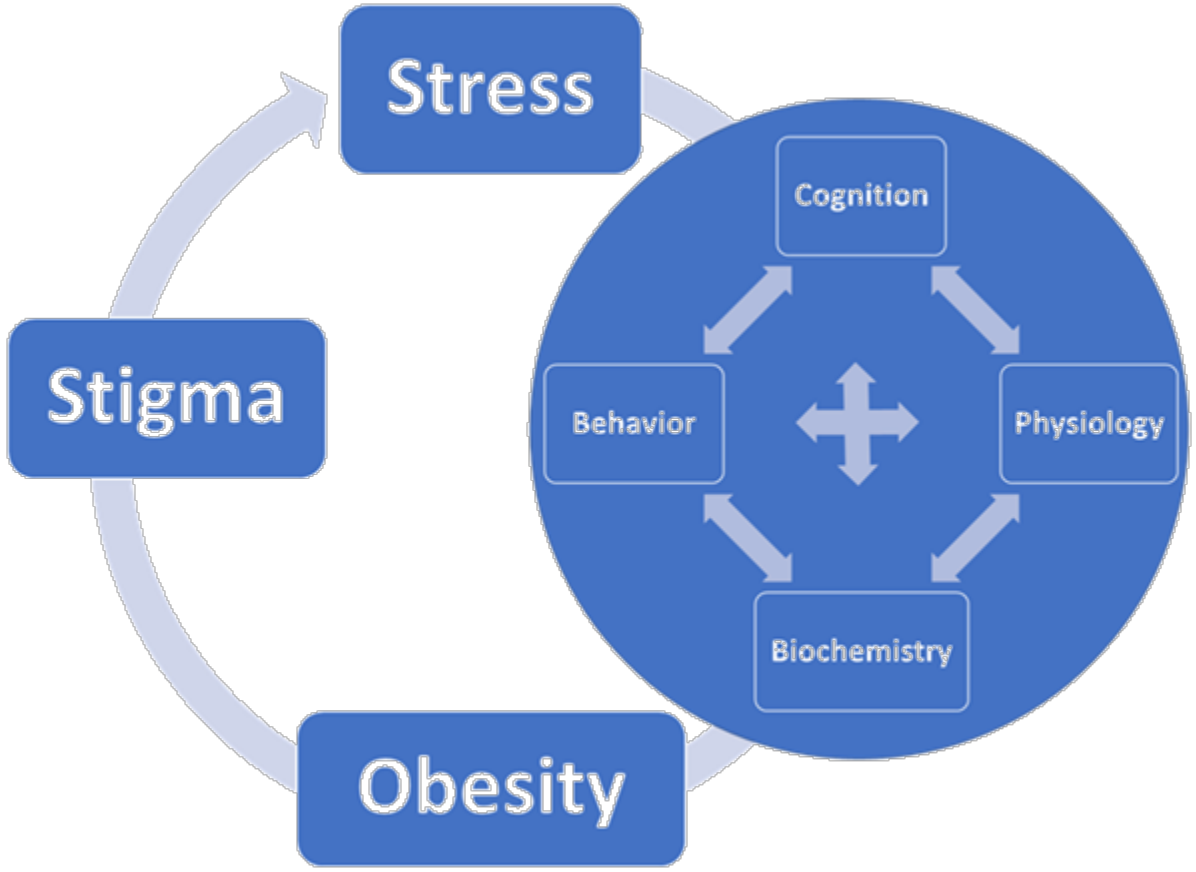
Weight Bias Flows from Demeaning Stereotypes About People with Obesity

- 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*

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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

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

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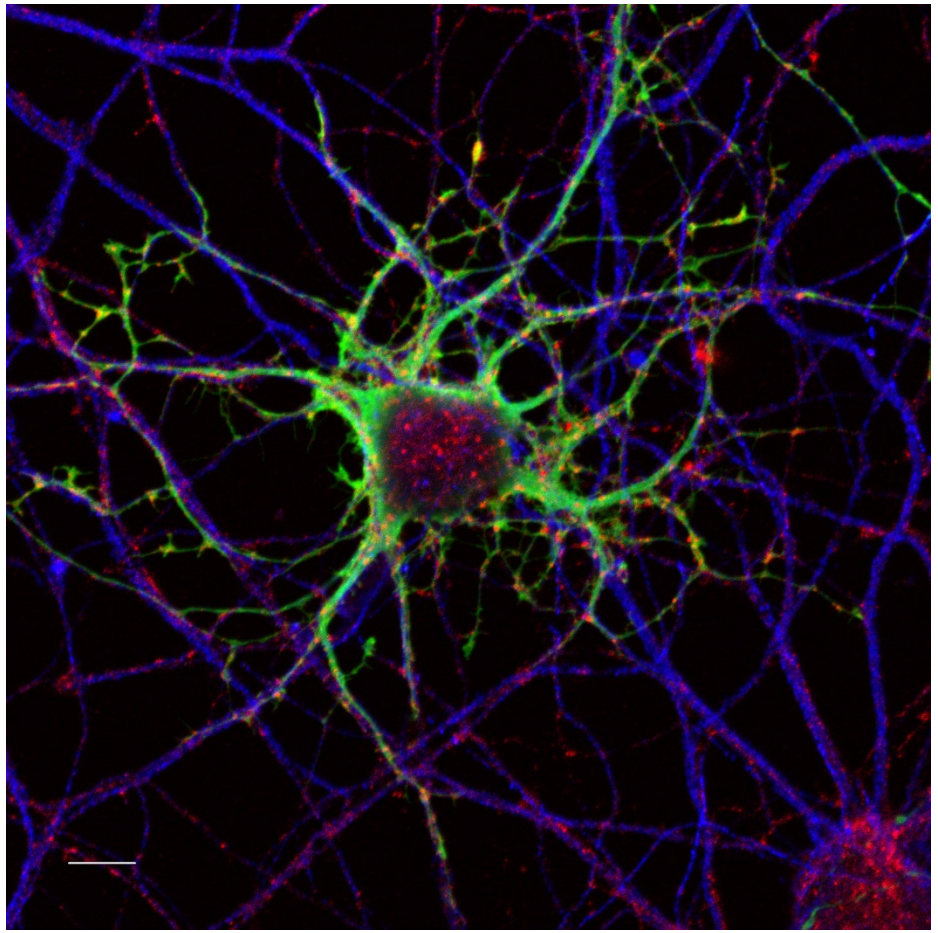
Obesity Science
Is Bringing Better Insights and Solutions



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

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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

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Facebook.com/ConscienHealth

For these slides:

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

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WASHINGTON, DC

Leveraging Evidence-based Practices for Obesity, Health & Wellbeing

Christine Gallagher, MPAff,
Research Project Director

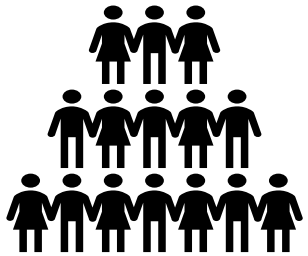
Milken Institute School of Public Health
THE GEORGE WASHINGTON UNIVERSITY

Sumner M. Redstone Global Center for Prevention & Wellness

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



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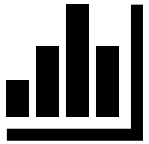
What we do…



- 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 ≥ 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

Turner et al. *Obesity* 2018; 26:665

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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

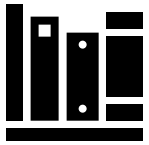
56% Improved coverage/ reimbursement process

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 tor 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

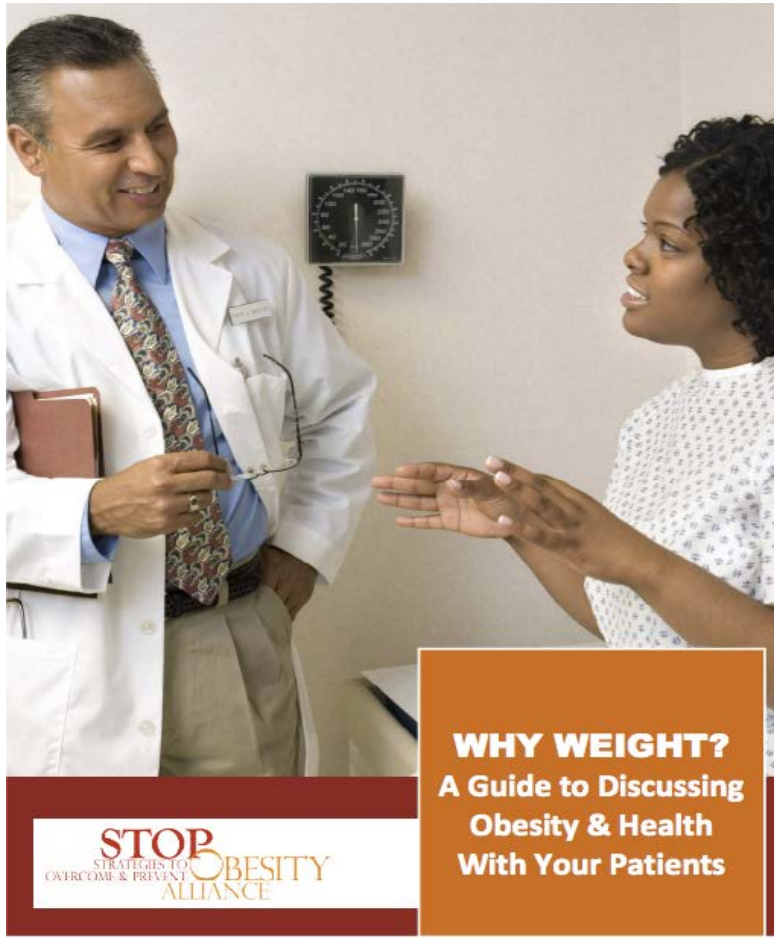
Engage in active listening

Build trust

Shared-decision making by patient and provider

Address culture and social barriers and supports

www.whyweightguide.org



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Leveraging Evidence-based Practices for Obesity, Health & Wellbeing

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

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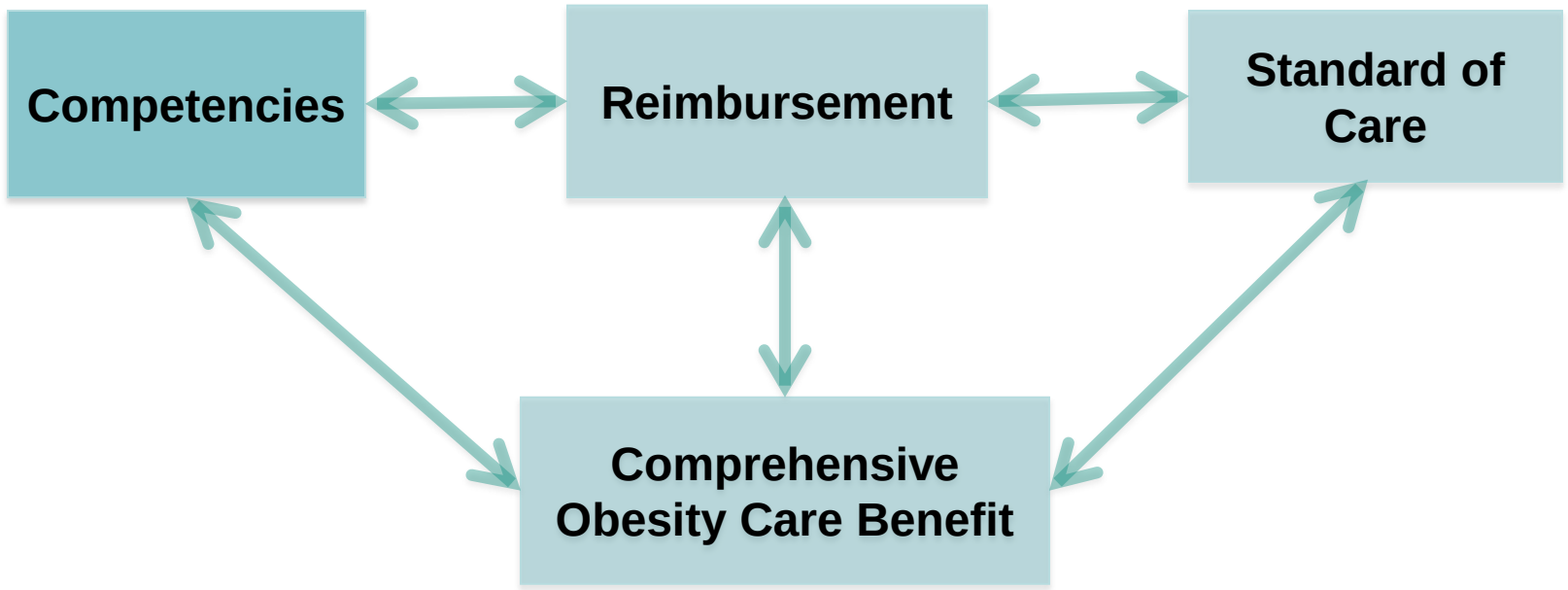
The Path to Developing a Comprehensive Obesity Care Benefit



Competencies Development Working Group

BIPARTISAN POLICY CENTER

ALLIANCE FOR A HEALTHIER GENERATION

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

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

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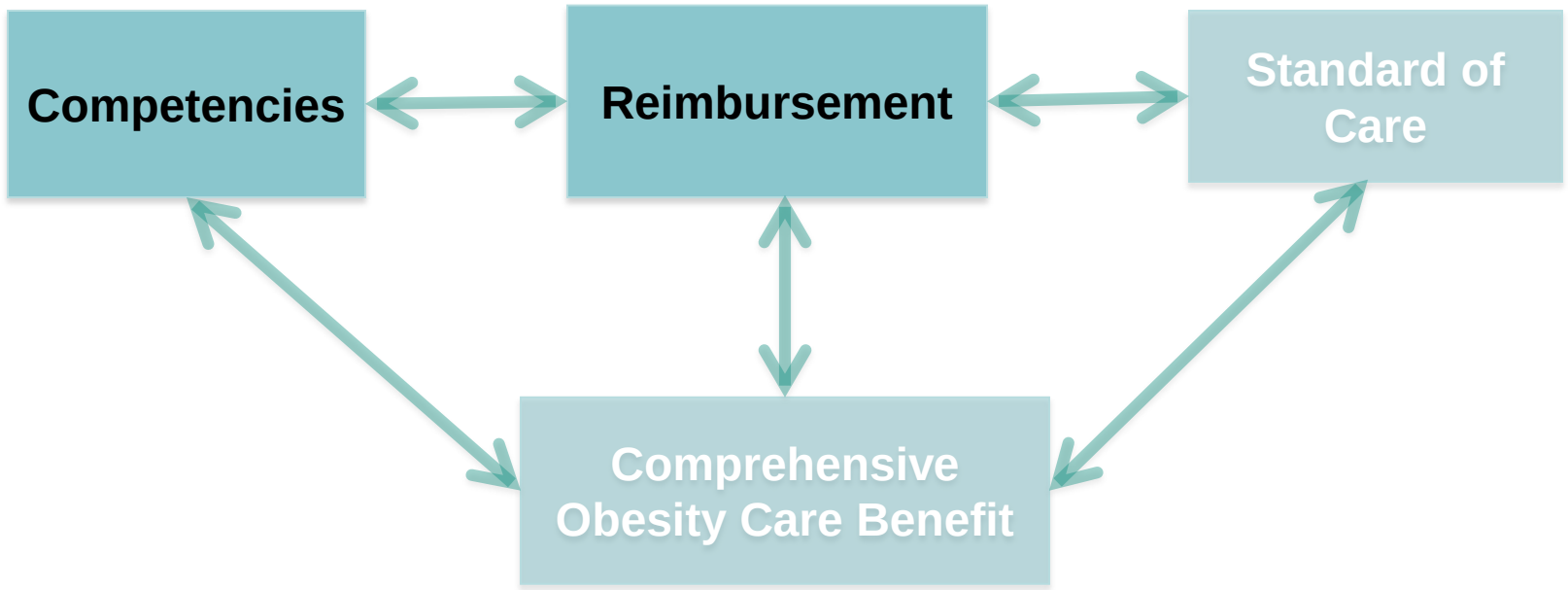
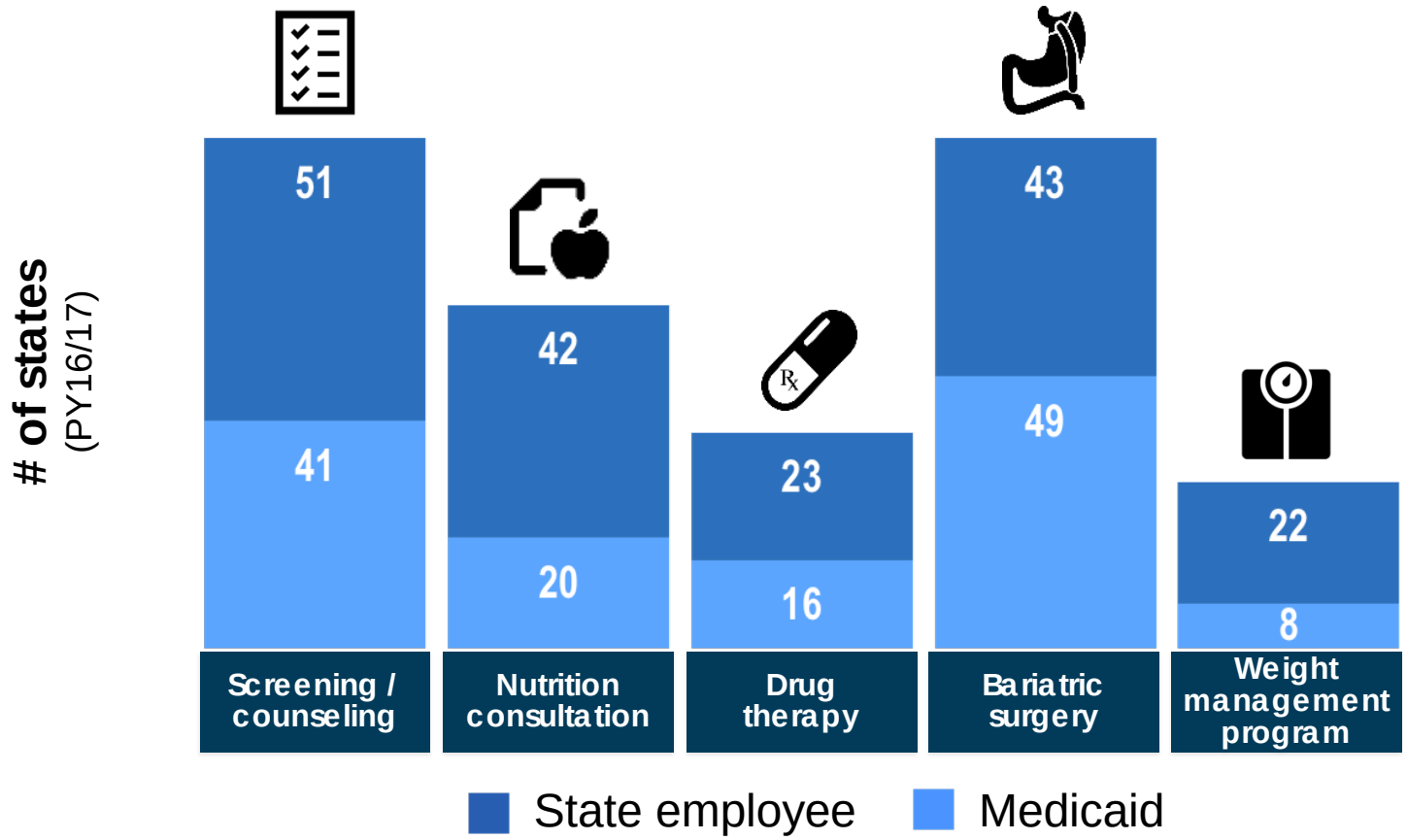
The Path to Developing a Comprehensive Obesity Care Benefit



Obesity Coverage in State Medicaid and State Employee Plans



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

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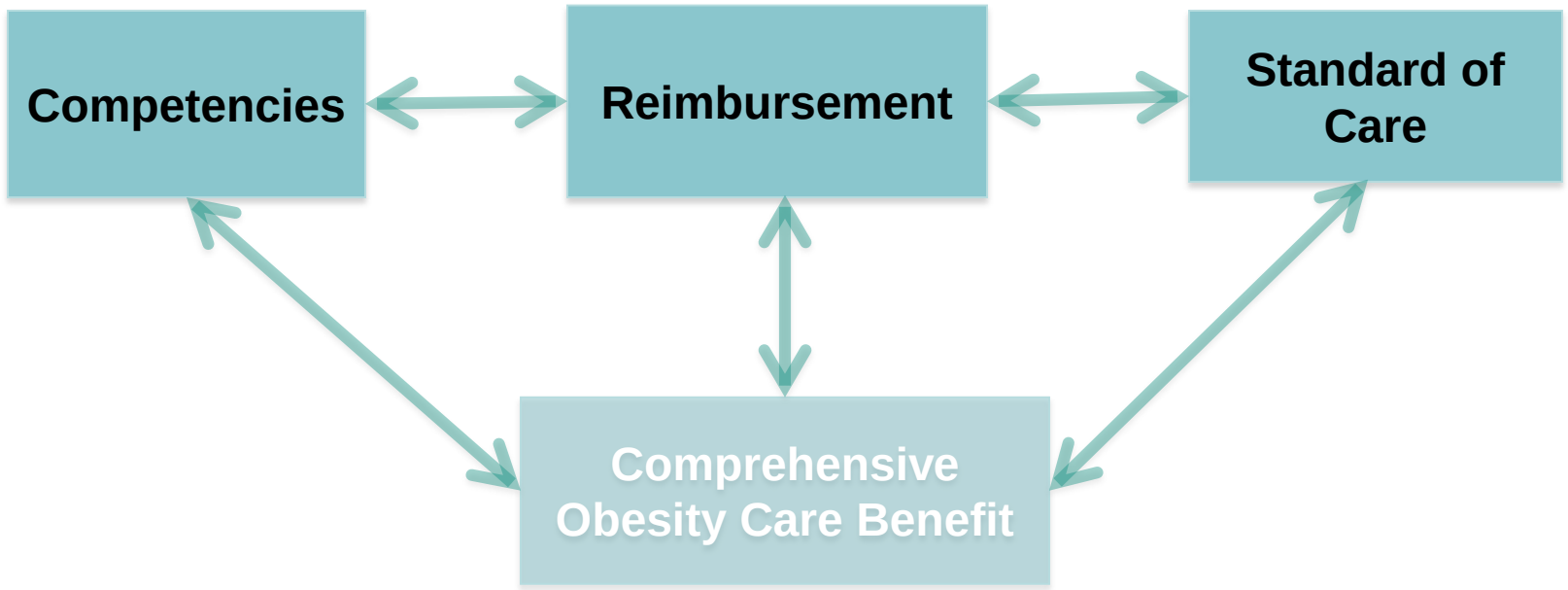
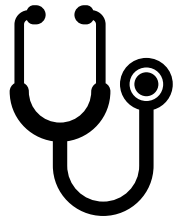
The Path to Developing a Comprehensive Obesity Care Benefit



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.

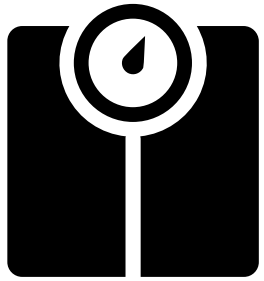
Core Principles of Care

- 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

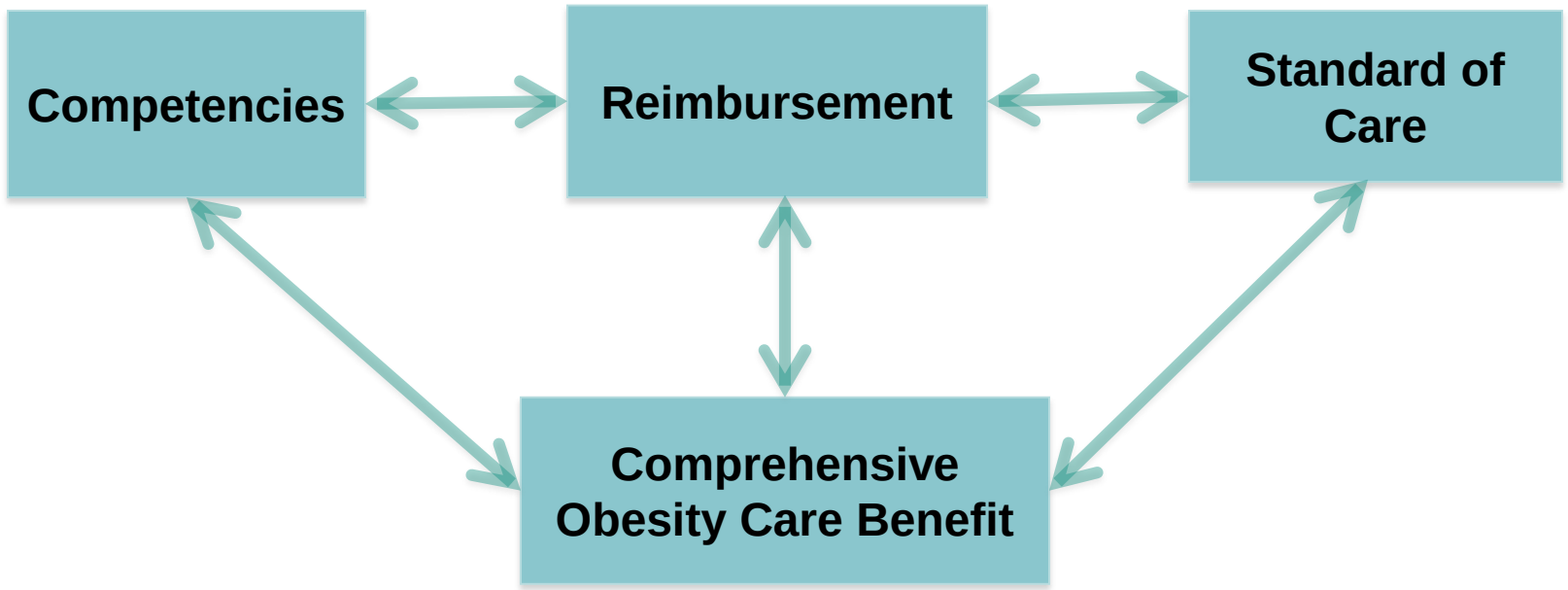
- 3-5% weight loss



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 (≥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 ≥ 30 kg/m2), 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 <u>all three</u> 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

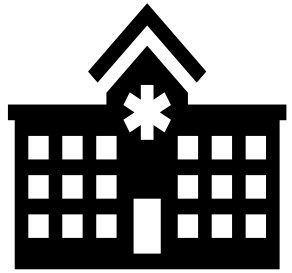
Access to all FDA-approved medications, prescribed in conjunction with behavioral interventions

- 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

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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

STOP OBESITY ALLIANCE
STRATEGIES TO OVERCOME & PREVENT

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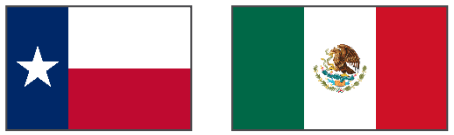
Leveraging Evidence- Based Practices for Obesity, Health, & Wellbeing

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

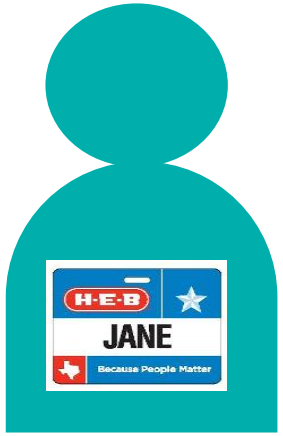
Transportation

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

Who We Are

Screening Demographics

2019 Health Screening Cohort



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

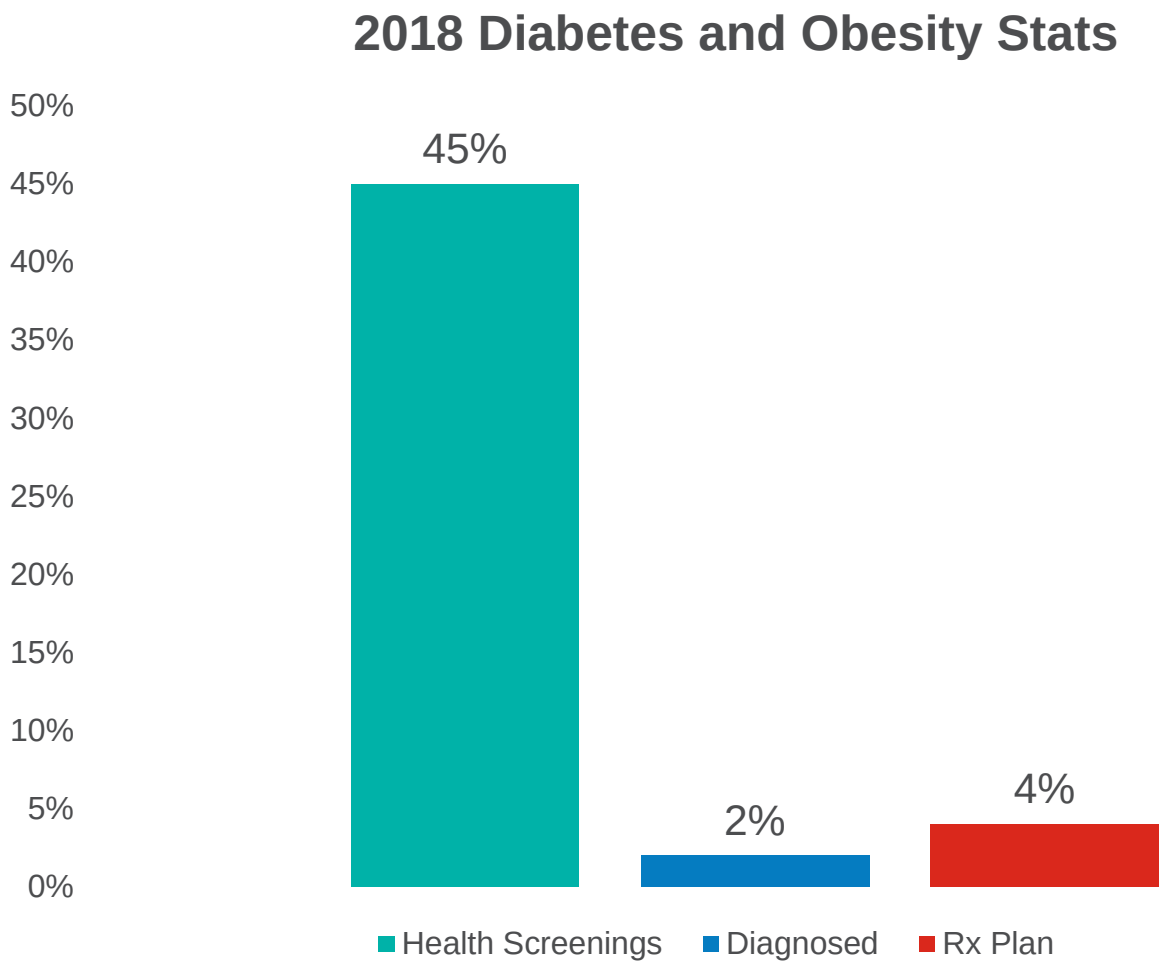
2019 Fasting Glucose Cohort

- 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

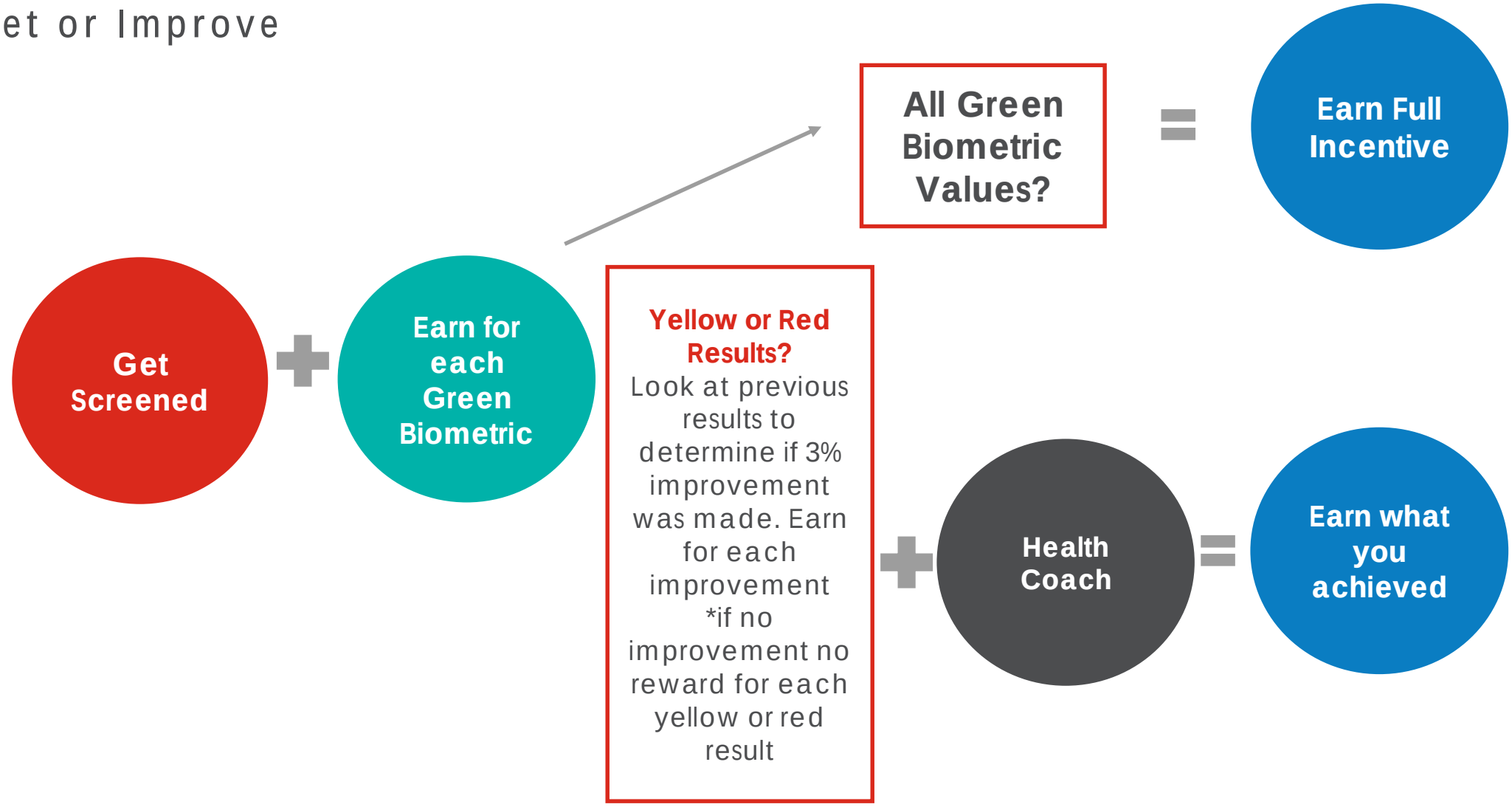


What We Know:

- **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



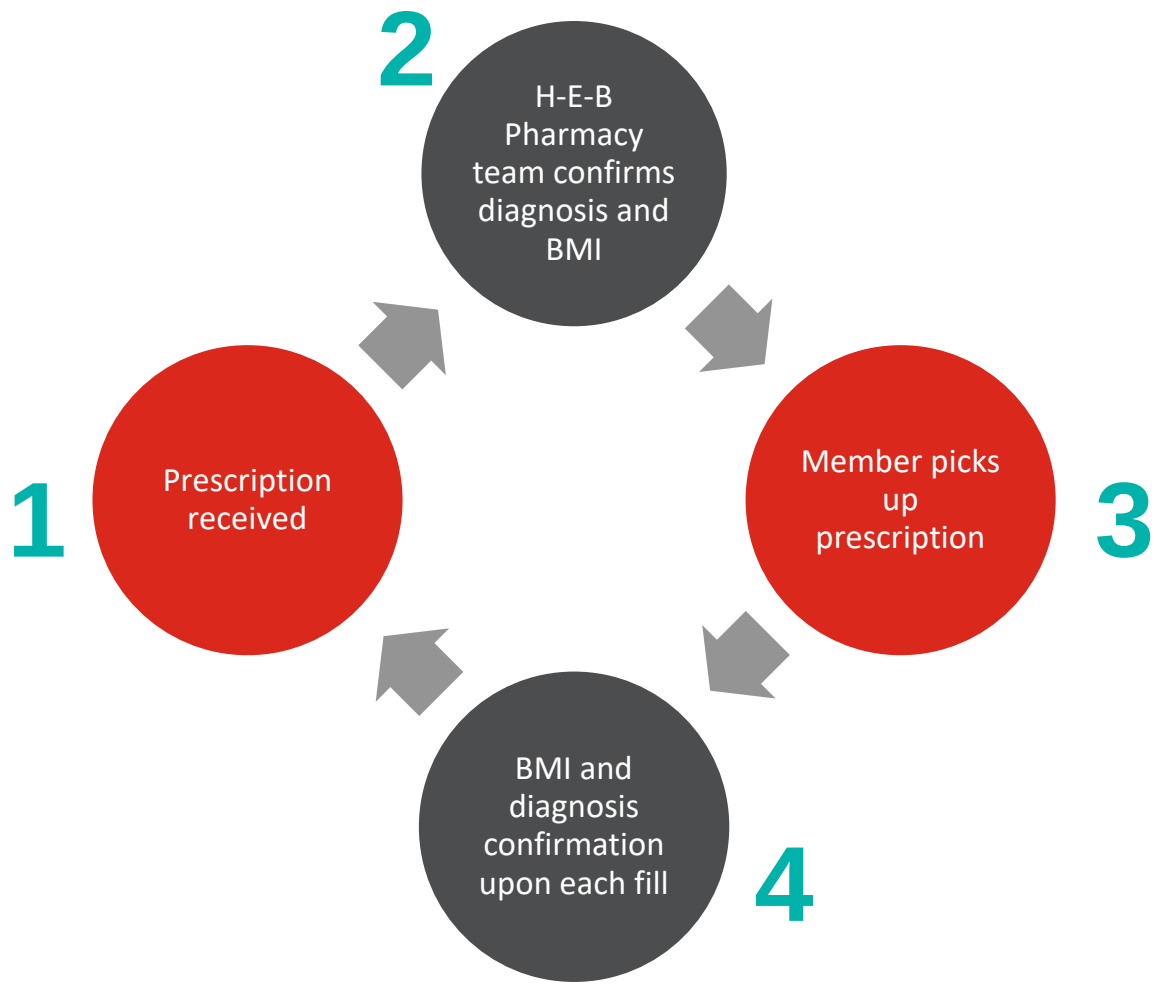
Supportive Plan Design Offerings

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
PA Status	PA Required	No PA
Tier	Tier II Copay	Tier I Copay
Copay	25% (Min $35 / Max $65)	10% (Min $4 / Max $35)
Medications	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 

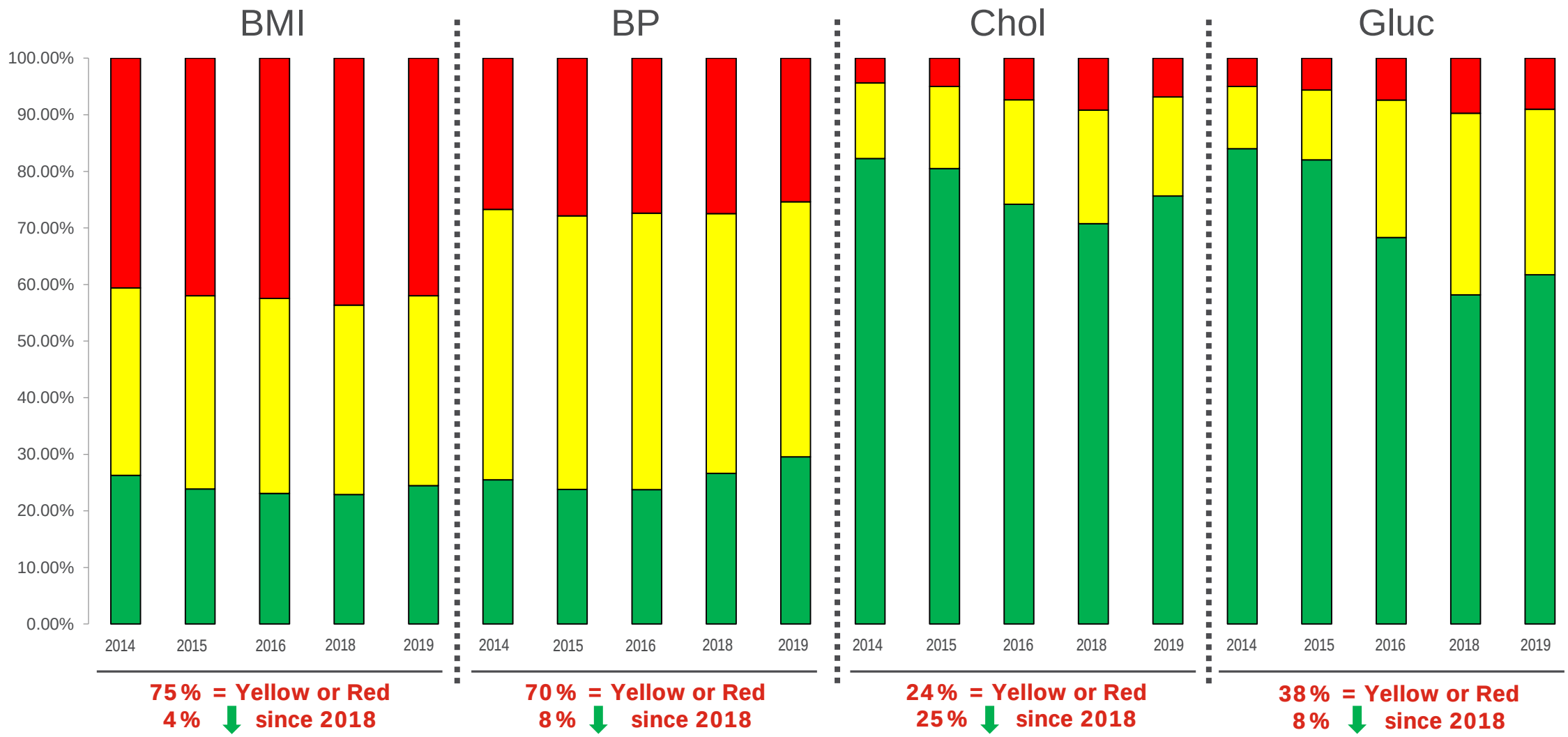
4.5% avg weight loss

Behavior Change Counselors  Network Identified by EAP

Digital Health Coach  28% Completion Rate

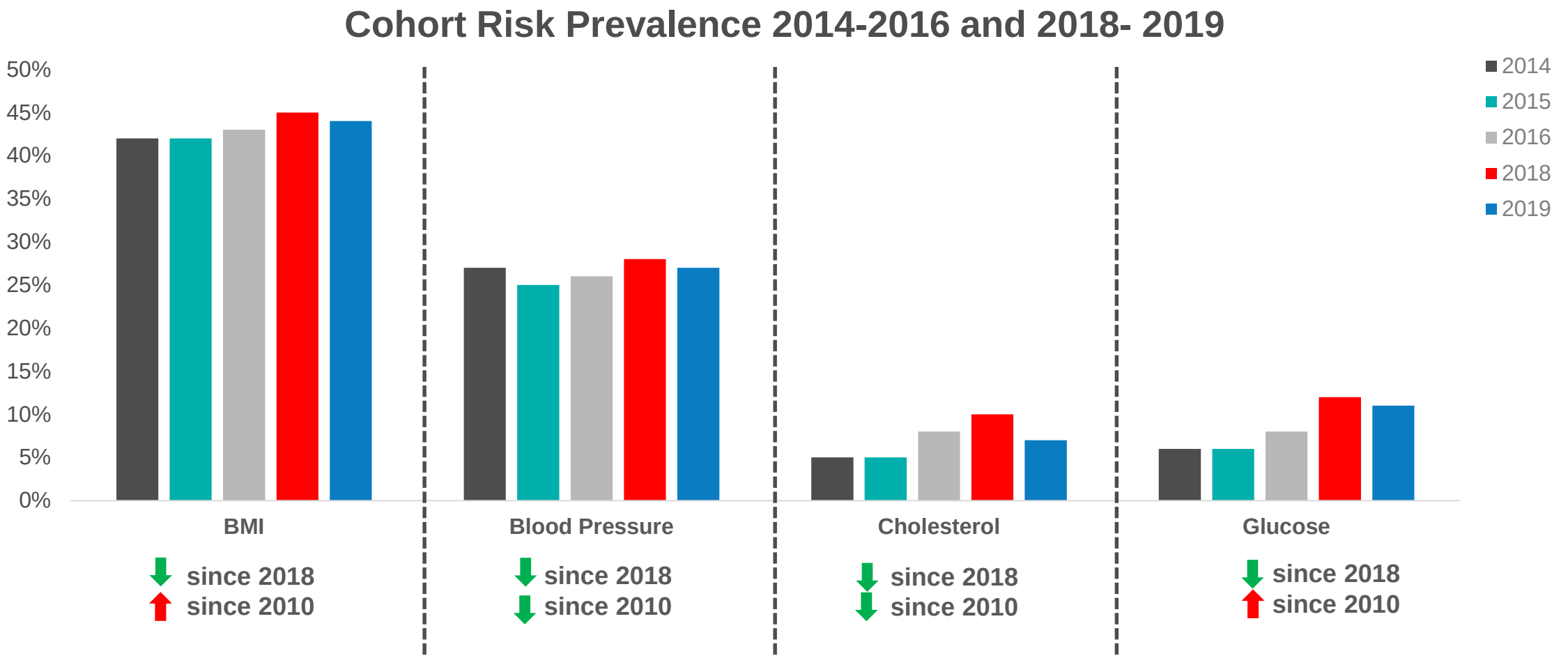
Results

Screening Health Risks – Total Population



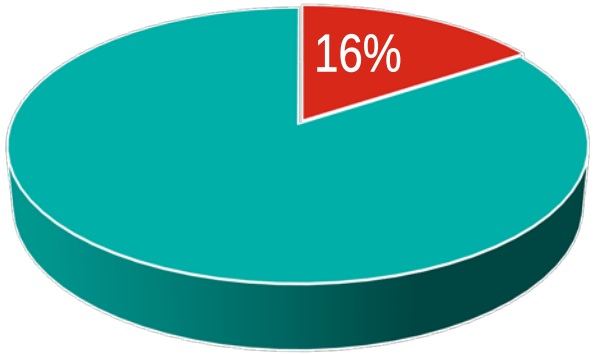
Results

Screening Health Risks – Cohort Population

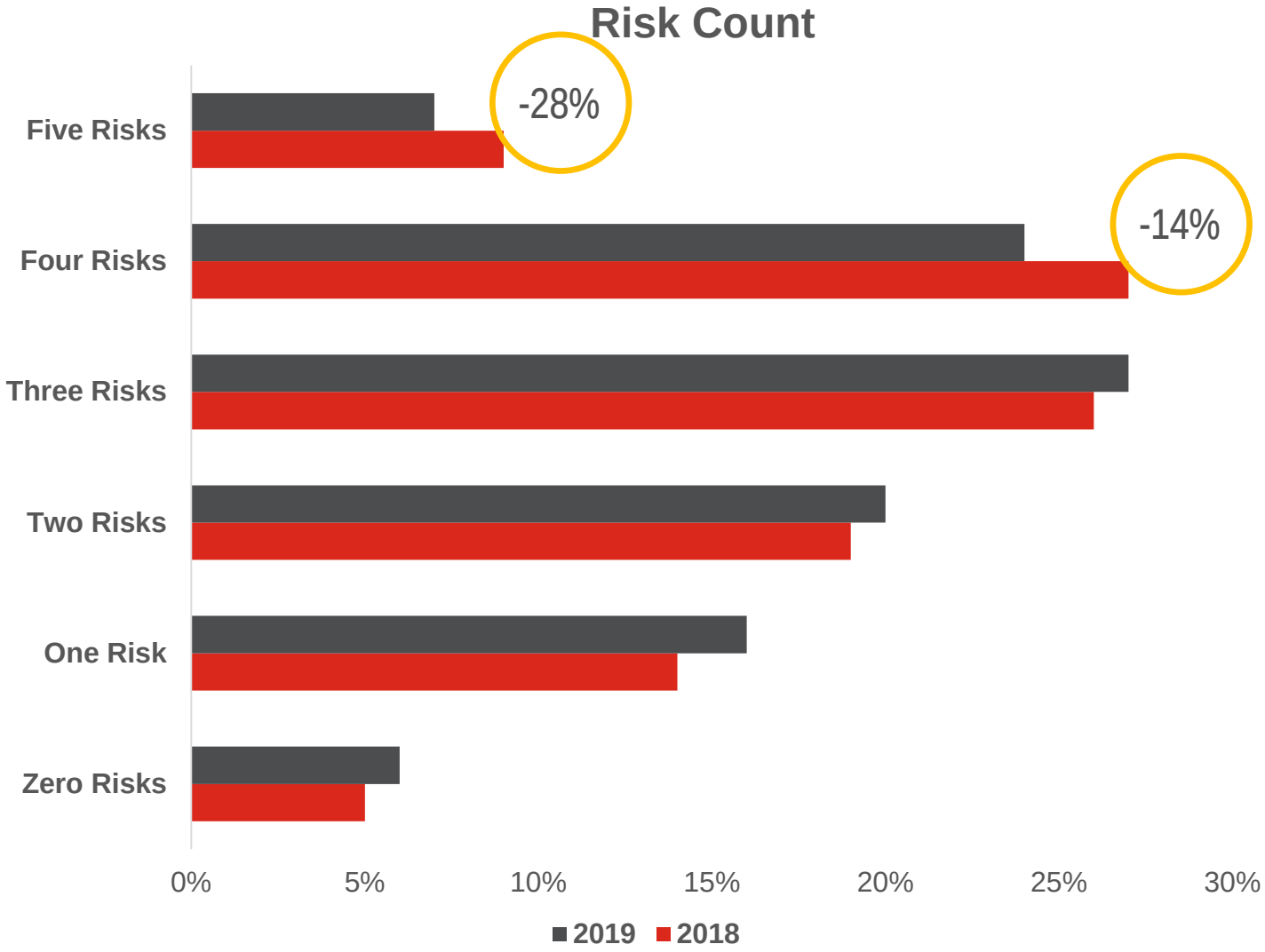


Results

Improvement Bonus



Risk Count



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**

Thank You!