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# Obesity: Chronic Condition, Not a Character Flaw

## Weight-loss programs take a more holistic, personalized approach that embraces both medical and behavioral treatment

**BY GERI ASTON**

Eat less and exercise more.

For decades that was the conventional wisdom on obesity treatment. But a deeper understanding of the condition, new medications and individualized medicine have begun to spark change in the way providers approach medical weight loss.

"We now know that obesity is a multifocal chronic disease that has genetic and social factors, as well as comorbidity issues that promote more weight gain," says Angela Fitch, M.D., medical director of medical weight management at the UC Health Weight Loss Center in West Chester, Ohio.

UC Health started its weight-loss program in 2013, the year the American Medical Association adopted its policy that recognizes obesity as a disease. A big driver at UC Health and other hospitals with medical weight-loss programs was growing patient demand for treatment. According to the Centers for Disease Control and Prevention survey data, 36.5 percent of Americans are obese.

Physician demand also was a factor, Fitch says. Beyond the desire to improve health in general, doctors needed patients to lose weight before undergoing procedures such as joint replacement and transplant surgery.

Treating obesity as a chronic disease means that the goal is no longer weight loss for the sake of weight loss any more than the goal of diabetes treatment is to lower blood sugar simply for the sake of lower blood sugar, says W. Timothy Garvey, M.D., chair of the department of nutrition sciences at the University of Alabama at Birmingham.

Rather, obesity treatment should help patients lose a sufficient amount of weight to improve or reverse related complications. "When somebody has complications, that tells you that that degree of [excess weight] is impairing the patient's health," Garvey says. Those complications include diabetes, high blood pressure, coronary artery disease, obstructive sleep apnea, osteoarthritis, gastroesophageal reflux disease and stress incontinence.

Evidence-based clinical guidelines that the American Association of Clinical Endocrinologists issued in July 2016 reflect this shift in thinking. "It's really the presence and severity of complications that determine how aggressive you are with therapy," says Garvey, chair of the AACE Obesity Scientific Committee. "We think it's a better medical model for treating obesity as a disease."

### Primitive roots

Research has found that losing 5 to 10 percent of body weight can significantly improve obese patients' health, Fitch notes. However, losing more than that, and keeping weight off, is extremely challenging. One big reason: human biology.

For our ancestors, "If you were losing weight, you were dying in the wilderness, you were starving," Fitch explains. "So your body is constantly protecting itself from losing weight."

Weight loss triggers a drop in the hormone that tells the body when it's full and increases the hormone that tells the body it's time to eat. The brain reacts to weight loss by intensifying the feeling of reward from food and diminishing the desire to avoid eating. The muscles begin to burn fewer calories, and the extra calories are stored as fat so the body can return to its previous weight.

"Many patients regain weight over time," Garvey says. "It's not their fault. It's the path of physiology."

The Food and Drug Administration in recent years has approved a handful of medications that interfere with the biological changes that make it hard to keep weight off. These

newer drugs are OK'd for long-term use, a development that fits well with the understanding of obesity as a chronic condition, Fitch says. "If you're going to have surgery to treat your obesity, that's lifelong," she says. "So why should we think of it differently as it relates to medication?" Fitch counsels patients that they might be on a weight-loss drug for six months to a year but that the goal is for them to go off it eventually.

Nevertheless, for some patients lifelong use could be the best option. "If they're able to get rid of five of their diabetes medications by being on one weight-loss medication for the rest of their lives, that might be something they would accept," Fitch says.

## New models of care

The recognition that obesity is a chronic disease has spurred changes in hospital weight-loss programs. The new model focuses on helping patients make permanent lifestyle changes that increase their chance of succeeding long term. Hospitals now staff their weight-loss centers with multidisciplinary teams who understand and can address patients' varying medical, dietary, behavioral and physical activity needs.

The idea of putting people on a "diet" is passé. "It can work against people if they think, 'I'm on a diet. When am I going to get off that diet?'" says Ann Cobau, a behavioral therapist with St. John Providence Weight Loss in southeast Michigan.

Often, hospital weight-loss programs start with intensive therapy. Many clinicians put patients on meal replacement for several weeks so they can't make their own food choices. Then providers gradually reintroduce regular food based on a sustainable meal plan that meets the patient's medical needs, and fits their cultural and personal preferences. Physical activity is tailored to the patient's medical needs, physical condition and preferences.

Adopting a new lifestyle isn't easy. "It's making changes in their eating, their activity, perhaps even their sleep," Cobau says. The sweeping nature of the task makes the behavioral health component of care critical to patients' success.

"It's very hard to separate food and behavior," Cobau says, so patients in the St. John Providence program see the dietitian and behavioral therapist together.

Many obese patients have eating disorders, such as binge or stress eating. "It's important they have the help of a professional to be able to look at what is really at the base of those behaviors," Cobau says.

At UC Health, providers teach patients how to be mindful of the biological changes working against weight loss. Knowing that biology is behind a craving helps them to respond by making a different choice, Fitch says.

To help patients keep off their weight for the long term, many hospitals give patients the opportunity to continue their programs but at a less-intense level. Also, providers encourage patients to come back whenever they falter. "Just because somebody has been on track a certain amount of time doesn't mean they won't get off track," Cobau says. "Any time there are significant stressors or life changes, people need support."

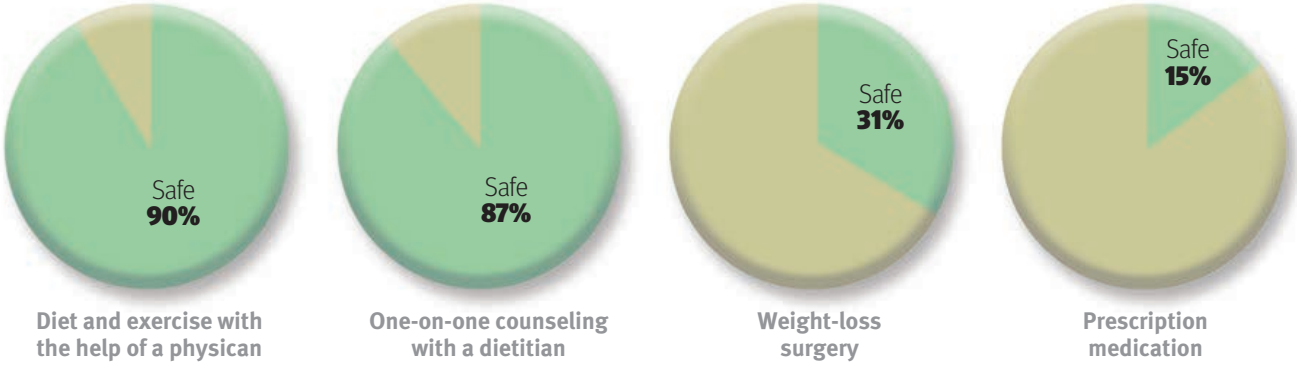
Hospital medical weight-loss programs typically work hand in hand with surgical weight-loss programs because their services are so intertwined and because they want to give patients choices. Dietary, exercise, and behavior therapy; medication; and surgery are all different tools in the weight-loss toolbox, Fitch explains.

Bariatric surgical patients still need dietary, exercise and behavioral therapy to succeed. Offering the full range of services produces economies of scale by allowing the various professionals to see both medical and surgical weight-loss patients. Also, they're better equipped to meet both types of patients' long-term needs than surgeons, who often aren't experienced at providing chronic care management.

## Payment & perception problems

Although providers have started to adapt to the idea that obesity is a chronic disease, many health insurers are lagging behind and don't cover many weight-loss services or medicine. As a result, hospital weight-loss centers typically charge patients and encourage them to research whether they have coverage and submit a claim if they can.

## Americans' perceptions of safe weight-loss methods




Source: "New Insights into Americans' Perceptions and Misperceptions of Obesity Treatments, and the Struggles Many Face," American Society for Metabolic and Bariatric Surgery and National Opinion Center at the University of Chicago, October 2016

# **Preventing childhood obesity:** Promote healthy lifestyles early

Community involvement and a shared belief that obesity is a preventable disease developed over a lifetime prompted HealthPartners, a seven-hospital integrated system in Minnesota, to launch a community initiative to prevent childhood obesity.

The idea started in 2011 when community representatives advising Lakeview Health Foundation's board picked the issue as a problem its Stillwater, Minn., community could rally around and solve. The initiative began in three communities served by Lakeview Hospital in 2013 and grew to seven communities associated with additional HealthPartners hospitals by 2015.

The childhood obesity arm of the effort involves two similar programs, PowerUp and BearPower, which focus on improving nutrition, increasing physical activity, reducing screen time and discouraging consumption of sugar-sweetened beverages. Another program, yumPower, is a healthy eating campaign for people of all ages in the Minneapolis-St. Paul metropolitan area.

A major emphasis is changing the food environment so that eating healthy is easier for families, says Marna Canterbury, the Lakeview foundation's director of community health.

For example, the PowerUp team has worked with food pantries — known locally as food shelves — to find new sources of fresh fruits and vegetables. Those sources include grocery stores pitching in produce near the end of shelf-life, community gardens, farmers and even home gardeners. "If we want the highest-risk kiddos in our community to be able to eat well, we need to know they have a steady supply of fruits, vegetables and good food, regardless of whether their families rely on a food shelf," Canterbury says.

The pantries also redesigned their layouts to display fresh produce and whole-grain foods prominently and attractively. Eighty percent of people served by the food shelves have children, and a survey showed that their customers count on them for almost all their fruits and vegetables, Canterbury says.

Another part of the effort features elementary school "challenges" in which kids learn about nutrition, track how many fruits and vegetables they eat, taste vegetables, and take a "veggie vote." In 2015, the program reached 22,000 kids in 60 schools. "The best way to encourage children to change their food behavior is to allow them to try something new in a really safe way," Canterbury says.

On the initiative's provider side, pediatricians, nurse practitioners and physician assistants ask families about their food consumption. If buying fresh produce is a challenge for families, the provider gives them a fruit and vegetable "prescription" — a $10 voucher that can be used to buy fresh produce at local grocers.

Plans are in the works for a similar project promoting exercise, Canterbury says. Families with economic barriers will get a prescription for physical activity in the form of a vastly reduced membership to their local YMCA.

The program has had many other successes. It worked with the Stillwater Public School District to change its wellness policy so that sweets are no longer used as a reward and recess denial is no longer used as punishment. School sporting event concessions now feature healthy options. Many schools hold open gyms in communities that don't have a place where families can exercise in winter.

Businesses are embracing the initiative. When Great Harvest Bread Co. opened a bakery two years ago, it opted not to offer sugar-sweetened beverages. "It's one relationship at a time building that momentum," Canterbury says.

The initiative isn't old enough to have made a measurable impact at the population level, but HealthPartners is tracking clinics' body mass index data with an eye on the long term. In the meantime, it relies on surveys of its partners and families to measure success. A 2016 survey found that 93 percent or more of community members say the initiative is very important or important to their community, Canterbury says.

**KID COOKS**: Stillwater, Minn., grade schoolers participate in hands-on, healthy eating, cooking classes with local chefs.

Photograph courtesy of HealthPartners

In addition to a staff investment, the effort costs HealthPartners about $350,000 annually, mostly for outreach, she says. Its partners chip in, too. For example, the grocery chain Cub Foods funds the fresh produce prescription, and the YMCA donates part of the reduced membership.

"This is not work that we as a hospital can do alone," Canterbury says. "This is work that we do outside of our offices, building relationships with local restaurants, schools — anybody who wants to be part of this." — GERI ASTON

One reason for the lack of coverage is that insurers still aren't accustomed to paying professionals, such as dietitians and behavioral therapists, in a bundle, Fitch says.

Another reason is that there isn't widespread acceptance yet of obesity as a disease. "Most employers will cover things like Weight Watchers — and there's nothing against Weight Watchers — but a lot of people need a more medically based program, something that is going to take into account all the other factors that go on and the biology of this disease," Fitch says.

In some quarters, the perception persists that obesity is a personal failing. "There is just not an uproar from the people who struggle with obesity because it's [considered] shameful," Fitch says. "It's like where we were with depression treatment

## FACT:

Obesity is defined as a body mass index of 30 or more.

By some estimates, obesity is responsible for $147 billion in annual U.S. health care spending.

Estimates of the annual costs of obesity-related absenteeism in the U.S. range from $3.38 billion ($79 per obese individual) to $6.38 billion ($132 per obese individual).

The medical field now recognizes obesity as a preventable and treatable disease, not a character flaw or a consequence of poor willpower.

Obesity is at the core of many other chronic illnesses, including type 2 diabetes, heart and cardiovascular disease, some types of cancer, depression, osteoarthritis, disordered breathing and gastrointestinal disorders.

## Weight-loss barriers reported by obese people

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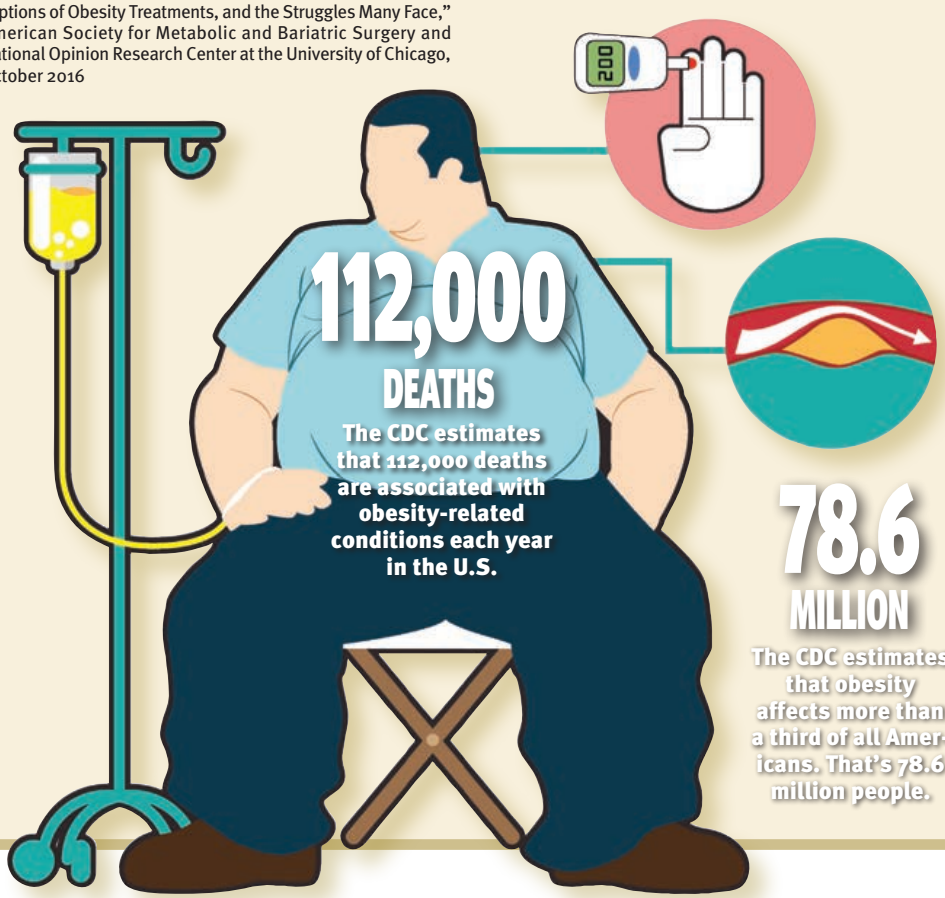
|---|---|
| Lack of willpower | 81% |
| Unhealthy foods too convenient, affordable, available | 81% |
| Too much time in front of TV/video games/computer | 70% |
| Healthy foods not convenient, affordable, available | 67% |
| Methods for losing weight too expensive | 61% |
| Genetically predisposed to be overweight/obese | 56% |
| Methods for losing weight not covered by insurance | 51% |
| Not enough safe/low cost places to be physically active | 49% |
| Don't have enough information on how to manage weight | 38% |
| Not getting enough support from family/friends | 36% |
| Not getting enough support from spouse/partner | 30% |

Source: "New Insights into Americans' Perceptions and Misperceptions of Obesity Treatments, and the Struggles Many Face," American Society for Metabolic and Bariatric Surgery and National Opinion Research Center at the University of Chicago, October 2016



20 years ago. Now we have ads on TV and billboards that say, 'If you're depressed, talk to somebody.' We just have to get there with this struggle as well."

Some UC Health patients have succeeded in getting reimbursed, but they're typically individuals who have gone directly to their employers' human resources department or insurer asking for coverage. Some patients are able to pay for services out of health savings accounts.

At UAB Medicine, Garvey had discussions two years ago with senior leaders about the need for a multidisciplinary weight-loss clinic and for insurance coverage. They agreed to create UAB Weight Loss Medicine, now in operation for a year and a half, and to offer insurance coverage for weight-loss services through the health system's insurance branch, Viva Health. The insurer covers UAB employees and is available to area employers.

## A chronic condition

Garvey hopes the new American Association of Clinical Endocrinologists clinical guidelines will prompt more employers and health insurers to cover weight-loss care by providing a rational construct that treats obesity in the same way as other chronic conditions.

"You're treating disease here, and you're also targeting more aggressive therapy for those patients who need it the most," he says. "It's a framework that should provide some kind of confidence and comfort that any investment in patient care will work to the benefit of the covered lives in a way that enhances benefits, risk and cost-effectiveness."

While progress is being made toward accepting obesity as a chronic disease, much work needs to be done at the physician practice level.

Thirty-five percent of Americans who are obese haven't spoken with a doctor or health professional about their weight, according to a University of Chicago survey for the American Society for Metabolic and Bariatric Surgery.

"When a patient comes into the office, usually health professionals don't bring up obesity," Garvey says. "It doesn't get the same kind of attention as diabetes and hypertension, which professionals would not let go unattended. We think obesity should be put on the same par with other chronic diseases."

*— Geri Aston is a contributing writer to* H&HN.

## EXECUTIVE CORNER

A September 2015 article in the journal *Health Affairs* lays out the Chronic Care Model in which providers and community organizations work together to optimize obesity treatment and to make healthy choices an easy option for residents.

### CARE DELIVERY

Obesity treatment is best provided by an integrated mix of health care practitioners, such as dietitians, nurse practitioners, social workers and psychologists. Community health workers and community leaders could play an important role in effective, integrated efforts to combat obesity.

### CORE SKILLS

The prevention and management of obesity will require a clear and common set of competencies, including the ability to foster behavioral change. Training in behavioral change must become part of provider education.

### INTEGRATED EFFORTS

Health care and community systems must move beyond parallel activities to more fully integrated interaction in which their goals are mutually reinforcing and their roles and interdependencies are defined and agreed upon by key stakeholders. Stakeholders include individuals, providers, medical systems, health departments, parks and recreation departments, community organizations and the business community.

### Trusted leader

Successful integration of care delivery and community services requires a trusted convener who commands mutual respect and shares stakeholder values. The convener's roles include engaging clinical and community partners, coordinating efforts, effecting policy change, organizing and sharing data, identifying and accessing funding, and establishing open, ongoing stakeholder communication.

### DATA EXCHANGE

Shared data are essential for communicating with providers about their patients' progress in community programs. The YMCA's Diabetes Prevention Program can serve as a model. It's supported by an online, real-time, nationwide, HIPAA-compliant data system that allows for participation monitoring, claims processing and communication with clinical providers.

### FINANCING

The chronic care model requires the alignment and coordination of funding from multiple traditional and nontraditional public and private sources. Because payers, employers and government are expected to accrue the savings of improved outcomes, they are important and logical financing sources.