



Re-looking at our Approach to a “Healthy Weight”

Engaging Employees for Sustainable Behavior Change



National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value



Speakers



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Taking Action to Address Obesity

- overview of emerging science and what
employers can do

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Goals

Tell the story:

- Obesity is best considered as a disease which causes other diseases.
- These diseases, and the health economic costs involved, are destructive to the health and well being of our population.
- The solution involves identifying effective treatments, and problem solving around the barriers to effective solutions.

Case Study – “Jill”

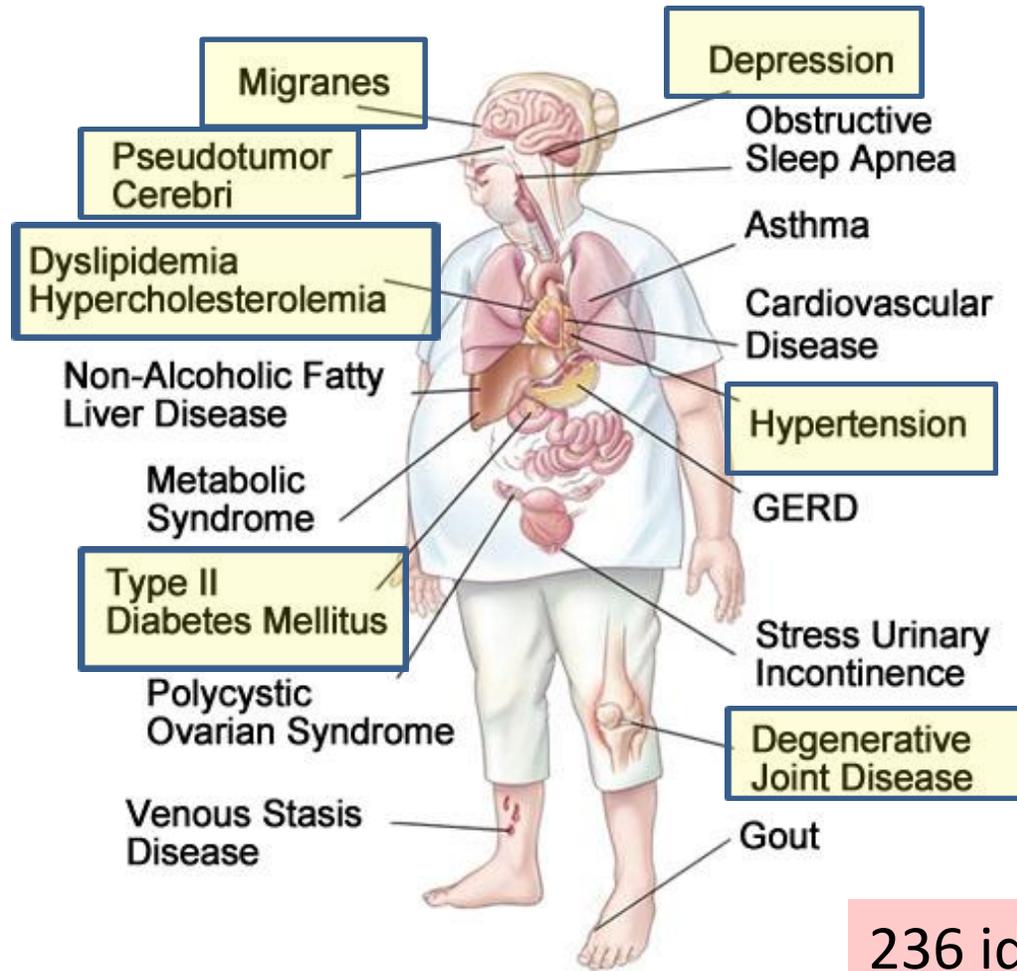
- 42 yo female Office Manager
- 9 years as employee
- Gradual increase in absences, 8 *excess* absences in prior year
 - Headaches, back and knee pain, diabetes management
- *What is happening?*

Case Study – “Jill”

- Hypertension, Diabetes, Elevated Lipids, Knee pain, Back pain, Depression, Headaches
- Medications: 2 blood pressure meds, one diabetes med, a statin, headache relievers
- Body Mass Index - BMI 38 (Class 2 Obesity)
- Several prior “good faith” attempts at weight loss including Weight Watchers, TOPS, and calorie counting

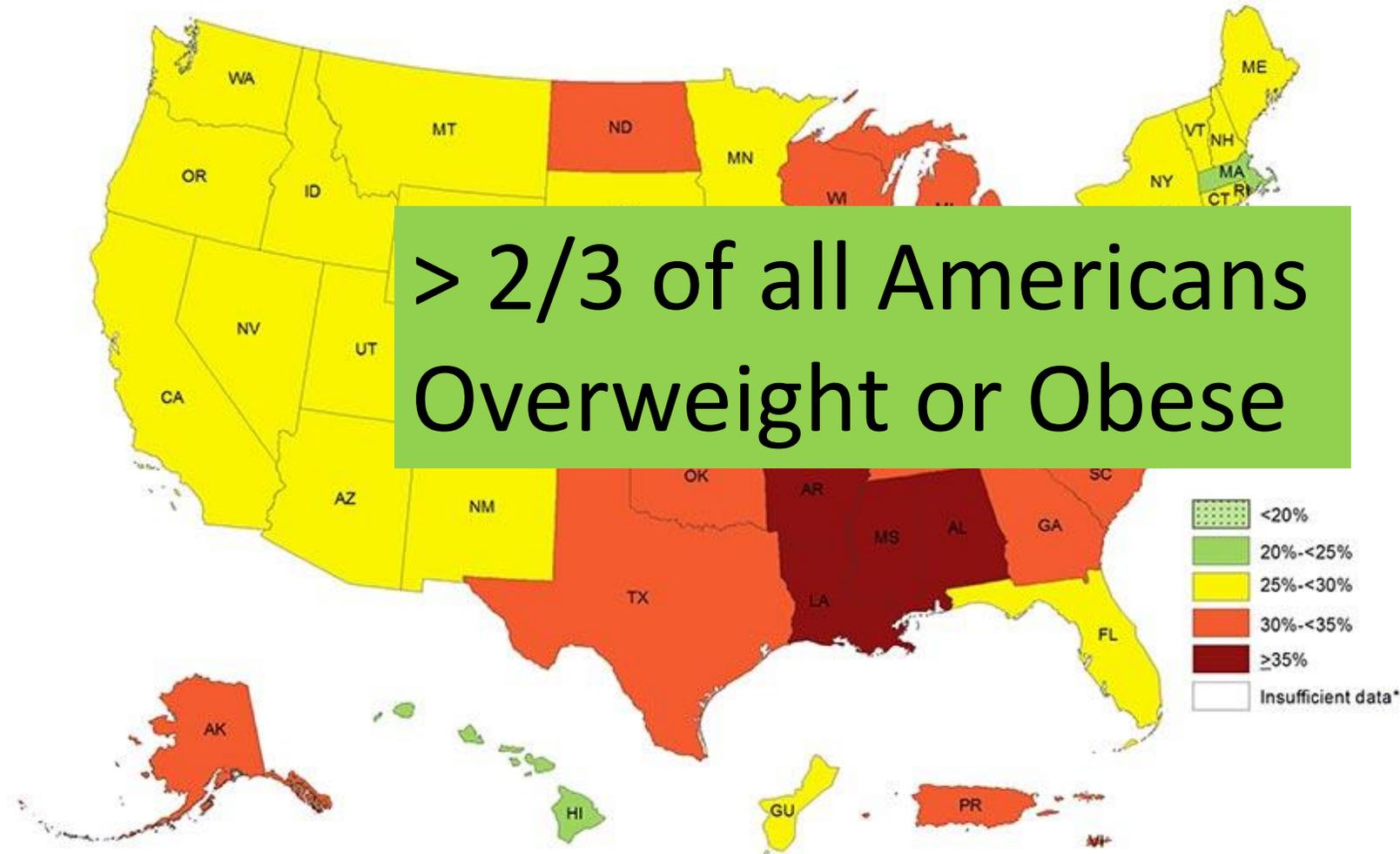
- *What is happening?*

Comorbidities caused by or associated with Obesity



236 identified comorbidities
Lee Kaplan MD (Mass General)

Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2016

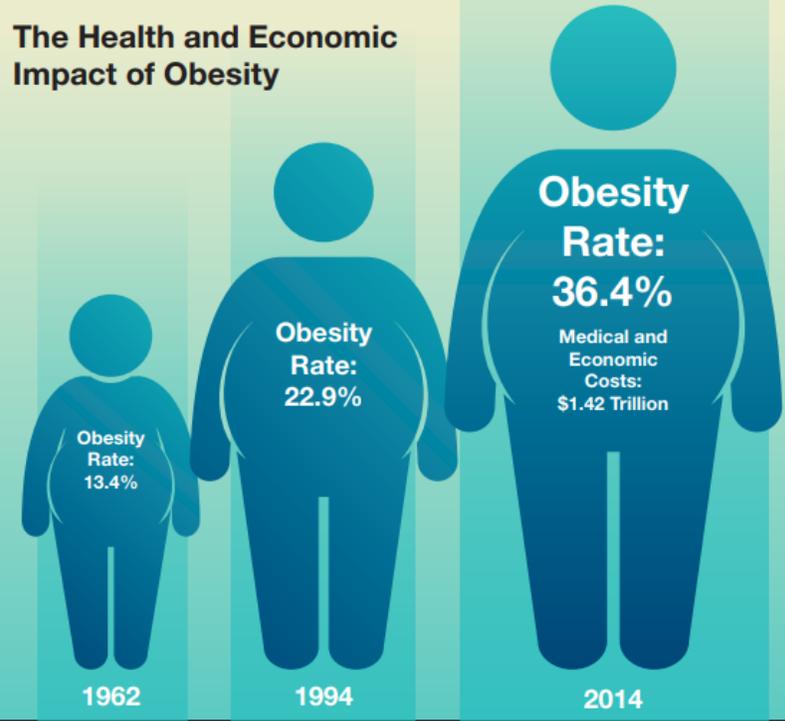


Centers for Disease Control and Prevention www.cdc.gov/obesity/data/adult.html
Accessed July 8, 2018

November 2016

Weighing Down America

The Health and Economic Impact of Obesity



Hugh Waters and Ross DeVol



MILKEN INSTITUTE
LYNDA AND STEWART RESNICK CENTER FOR PUBLIC HEALTH

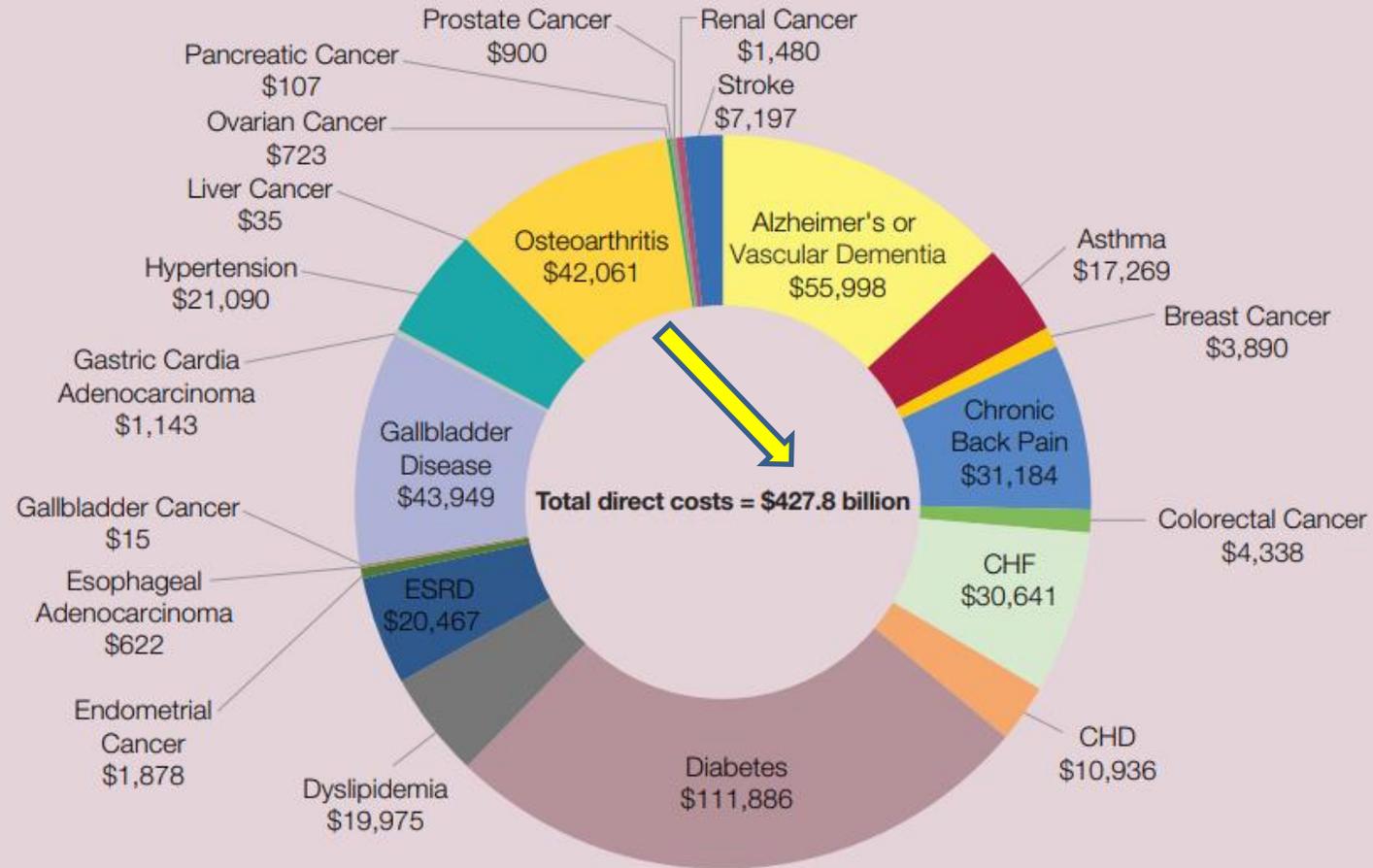
- > 60 % Americans Overweight and Obese (40% Obese)
- **1.42 Trillion \$ yearly** (2014 data)
- Includes Direct and Indirect costs of all health conditions
- Includes Absenteeism, Presenteeism, loss of productivity (988 Billion \$)

Waters and DeVol, Nov. 2016.

www.milkeninstitute.org/publications/view/833. Accessed July 8, 2018

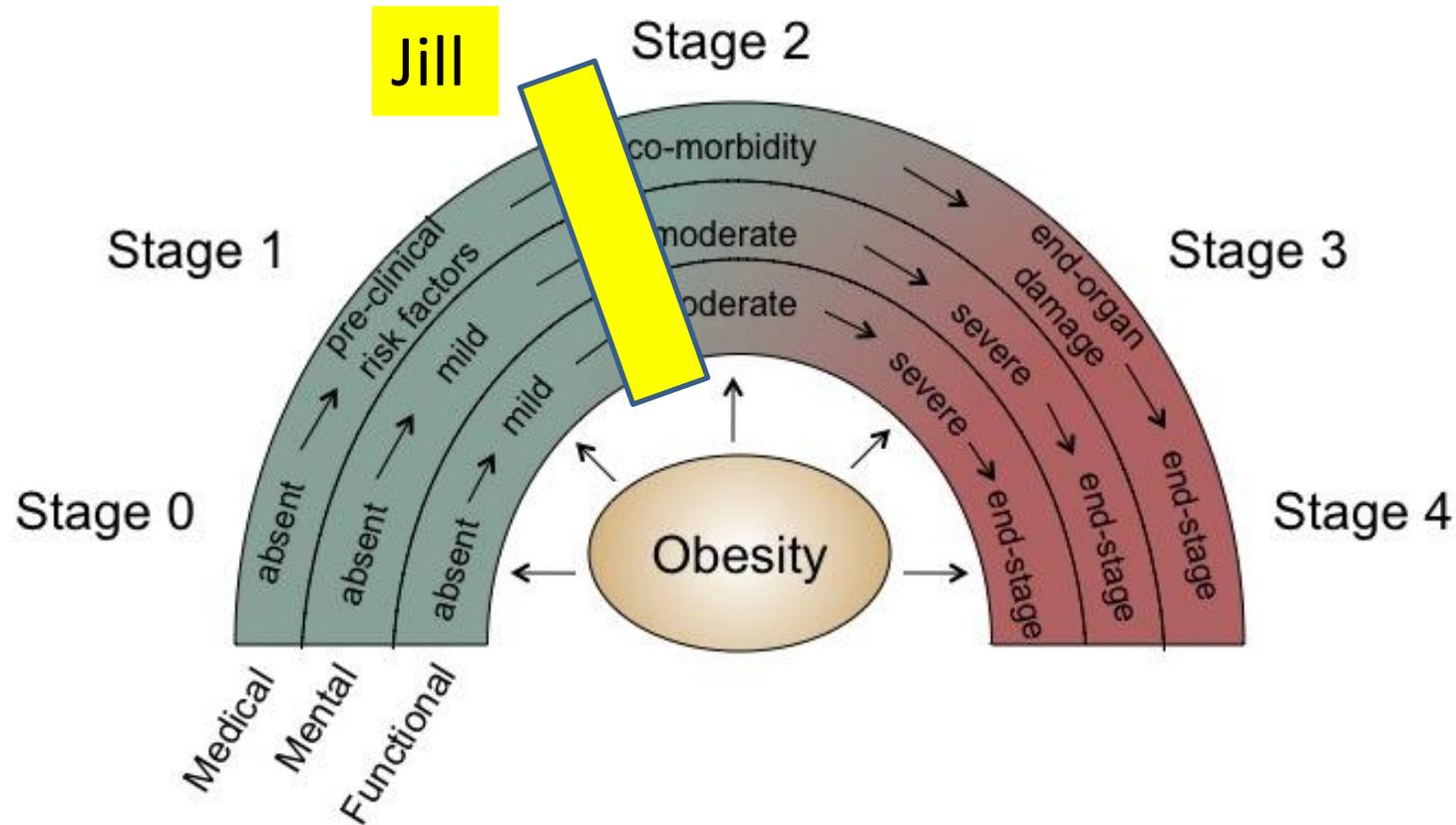
Total *Direct* Costs

Figure 9. Total Attributable Direct Costs (\$ Millions), by Condition, 2014



How advanced are Jill's problems?

Edmonton Obesity Staging System (EOSS)

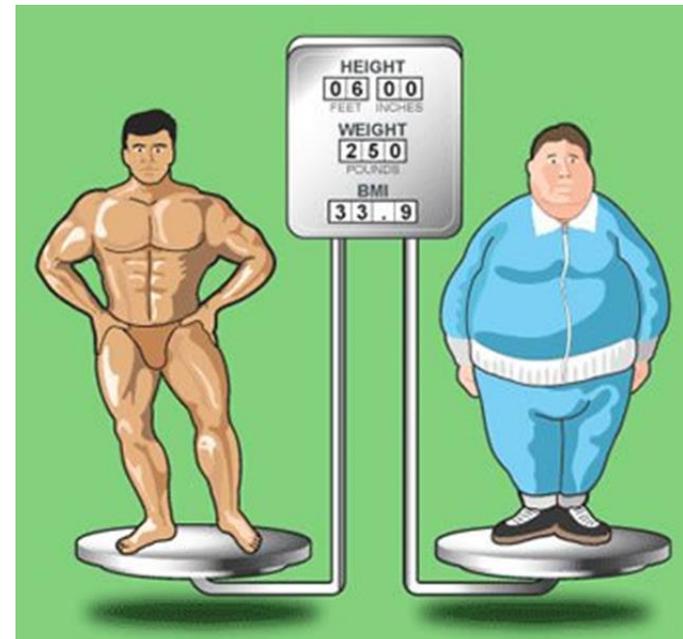


Assessment – How to Stage for Treatment?

- Identify medical conditions
- Ask about Quality of Life and Function
- Look at objective metrics
 - Lab exam
 - Blood pressure, Pulse –typical vital signs
 - Height and Weight – BMI
 - (Body Mass Index = Wt/Ht^2)
 - Physical Exam
 - Body composition

Emerging Science - Why Body Composition?

- Disease progression of co morbidities is more closely related to amount of malfunctioning fat than to total weight or BMI!
- BMI shows the Weight and Height relationship, but not what that weight is composed of
- How much is fat?
- How much is lean?
- Both have BMI 34



Emerging Science - Measuring Body Composition - multiple methods

- DEXA (Dual Energy X-ray Absorptiometry)
- Underwater weighing
- MRI (Magnetic Resonance Imaging)
- CT (Computerized Tomography)
- Calipers
- BIA (Bioelectrical Impedance Analysis)

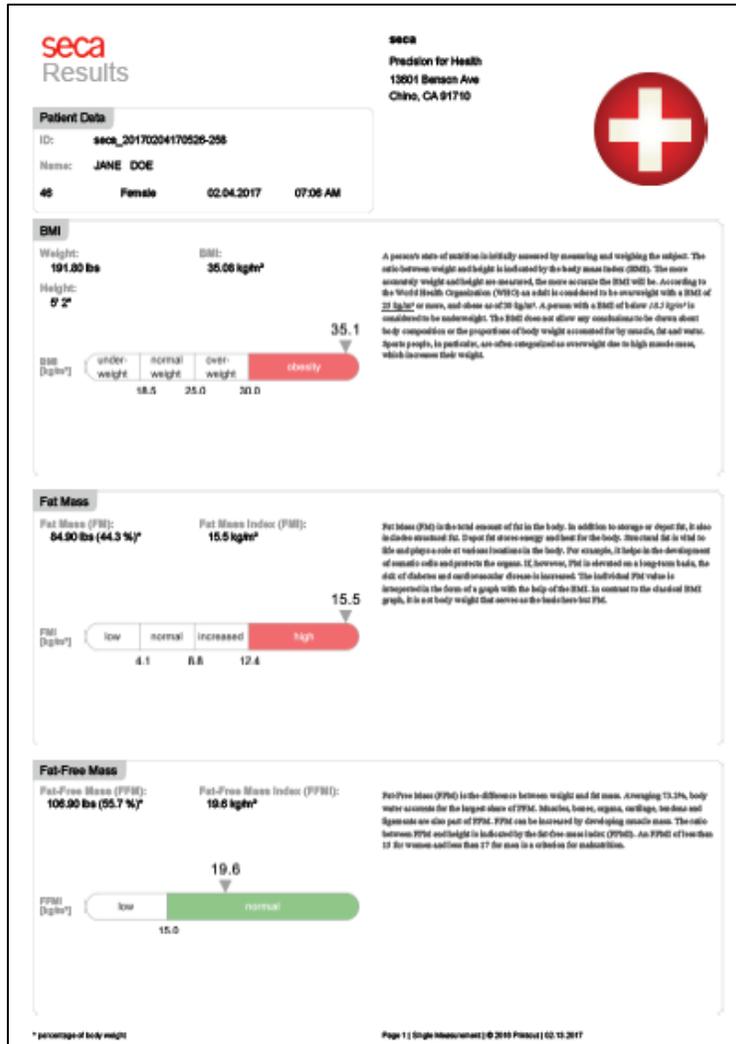
Body Composition Testing Devices



Seca mBCA Medical Body Composition Analyzer

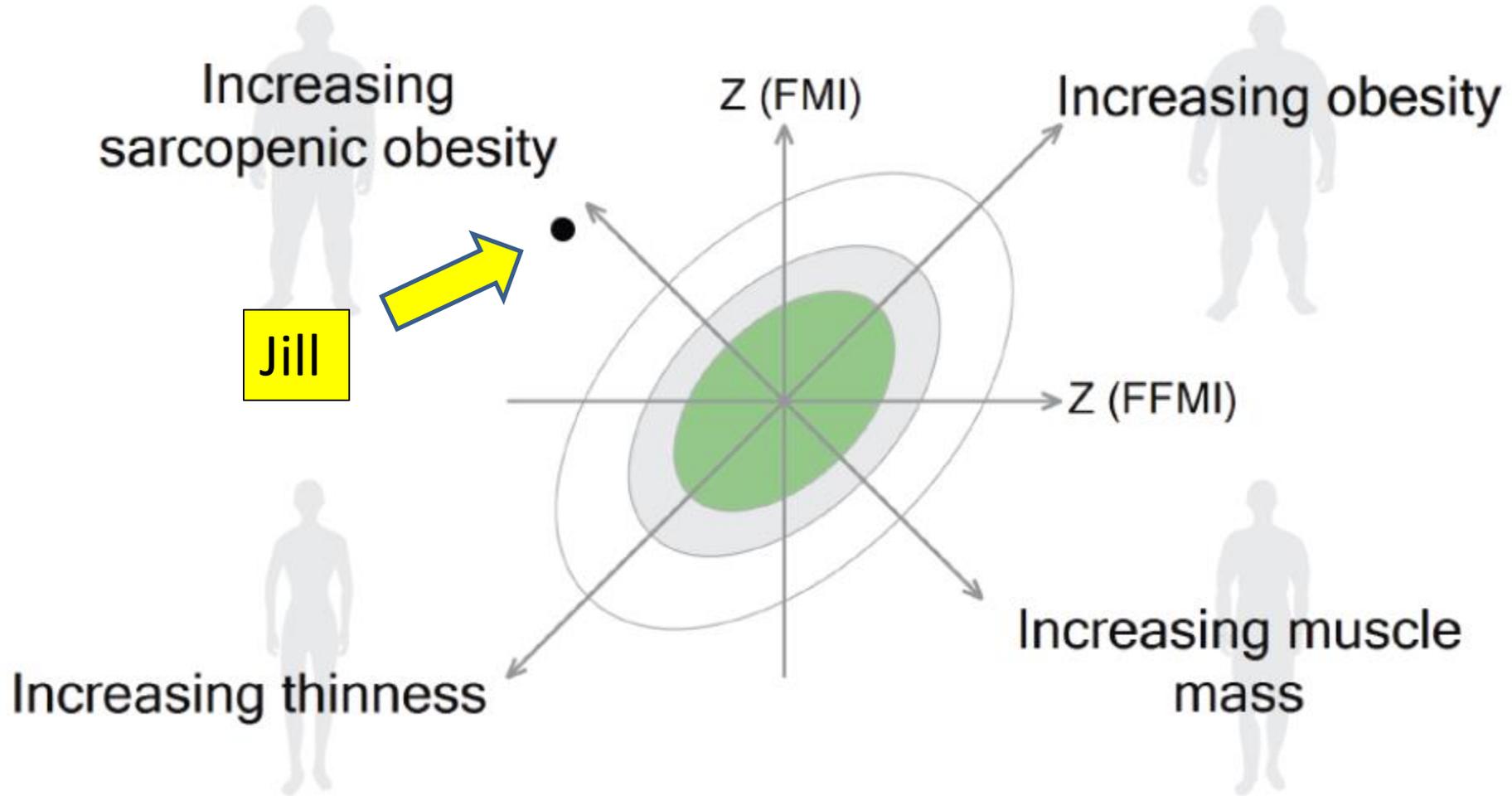
BIA (Bioelectrical Impedance Analysis)

Jill



- Weight 220# (Height 5' 4")
- 38 BMI (Body Mass Index)
- 118# Fat Mass
 - (54% of total weight)
- 102# Fat Free (Lean) mass
 - (46% of total weight)
- Hydration status
- Comparative standards for visual assessment

Visual representation of Fat Mass/Lean Mass relationship

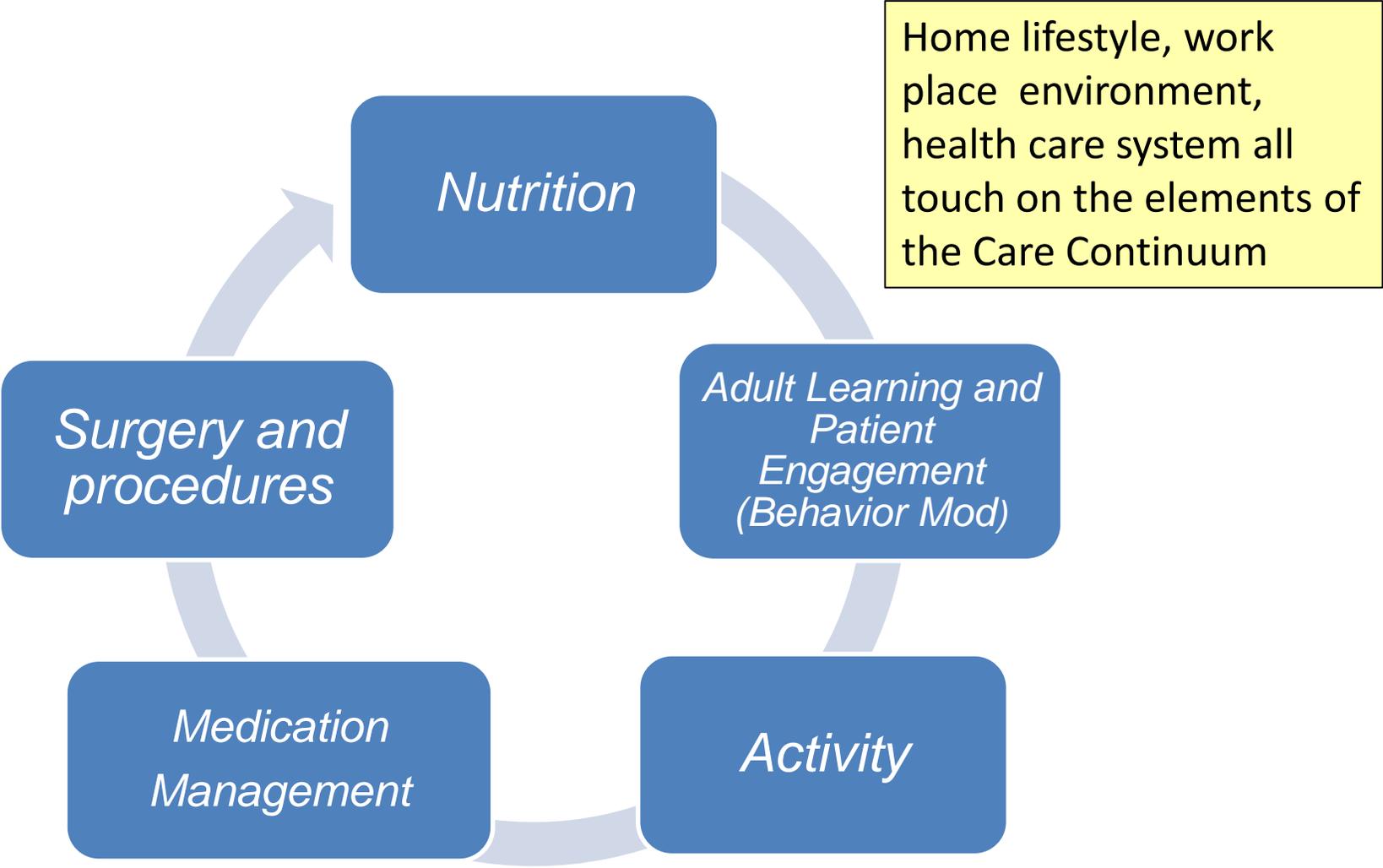


“Workplace obesity opportunities”

- Many more articles identify problems than effective solutions
- Employer based (from Anthem site):
 - Introduce incentives
 - Encourage preventive screenings
 - Form activity groups
 - Provide fitness gadgets
 - Offer discounted gym memberships
 - Organize weight management seminars
 - Community based resources – WW, YMCA, TOPS
 - Improve vending machine options
 - Provide healthy choices in cafeterias
 - Digital coaching programs
- Provide obesity care as part of medical benefits
 - Not covered in most plans, must “opt in”

Which of
these would
work for Jill?

The “Care Continuum” is a useful framework



Barriers to Care:

Current “standard care” of weight is insufficient

- **Weight loss is not easy**
 - Multiple failed attempts common
- **Reluctance to seek help**
 - Felt to be a personal problem
- **Inadequate diagnosis**
 - Not identified and listed in medical problems list
- **Insufficient dialogue and follow up**
 - Few follow up visits scheduled
- **Misaligned perceptions of wellness programs**
 - Employers perceive a benefit; Patients with obesity do not
 - No demonstration of efficacy

Kaplan, et. al. ACTION Study. Obesity (2018) 26,61-69.

www.actionstudy.com

Is Treatment Effective in a Primary Care Setting?

DiRECT Study Outcomes

- 49 primary care centers in UK, 2 groups of 149 each
 - Adults w/ t2DM (no insulin)
 - Intervention:
 - withdrawal antidiabetic and antihypertensive meds
 - meal replacement (825-853 calories/day for 3-5 months)
 - stepped food re-introduction (2-8 weeks)
 - structured support for long term weight loss maintenance
 - Primary Outcome measures:
 - weight loss 15kg+ and remission of diabetes at 12 months
-
- Outcomes: 12 months about 50% achieved diabetes remission.
 - Conclusion: Remission of t2DM is achievable target in primary care practice

Summary

- The diseases of obesity affect a large segment of our US population, including our workforce (and military)
- The costs are staggering and often overlooked
 - often hard to show ROI or value proposition
- No one group or agency has the solution
 - Employees, employers, 3rd party administrators, health care providers
- There do exist approaches and treatments to improve the situation
- Even 5-10%weight loss has major health benefits

Thank You!

Richard “Rick” Lindquist M.D.

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Obesity Prevention and Treatment: How Employers are Part of the Solution

**Jenny Bogard, MPH
Founder & Managing Partner
Commonality**

bipartisanpolicy.org



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Prevalence[†] of Self-Reported Obesity Among U.S. Adults by State and Territory, BRFSS, 2015

[†]Prevalence estimates reflect BRFSS methodological changes started in 2011. These estimates should not be compared to prevalence estimates before 2011.



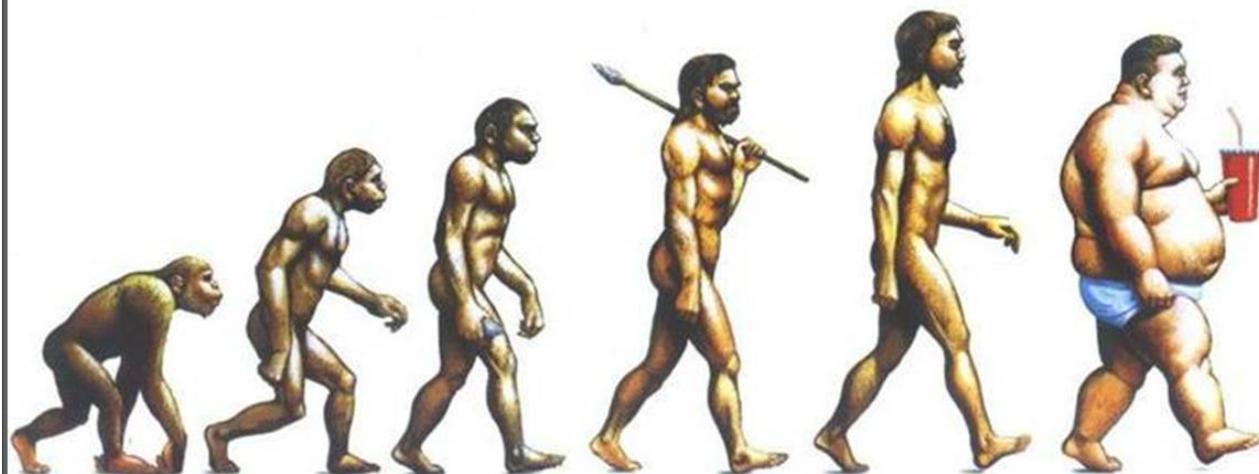
*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥ 30%.





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The shape of things to come

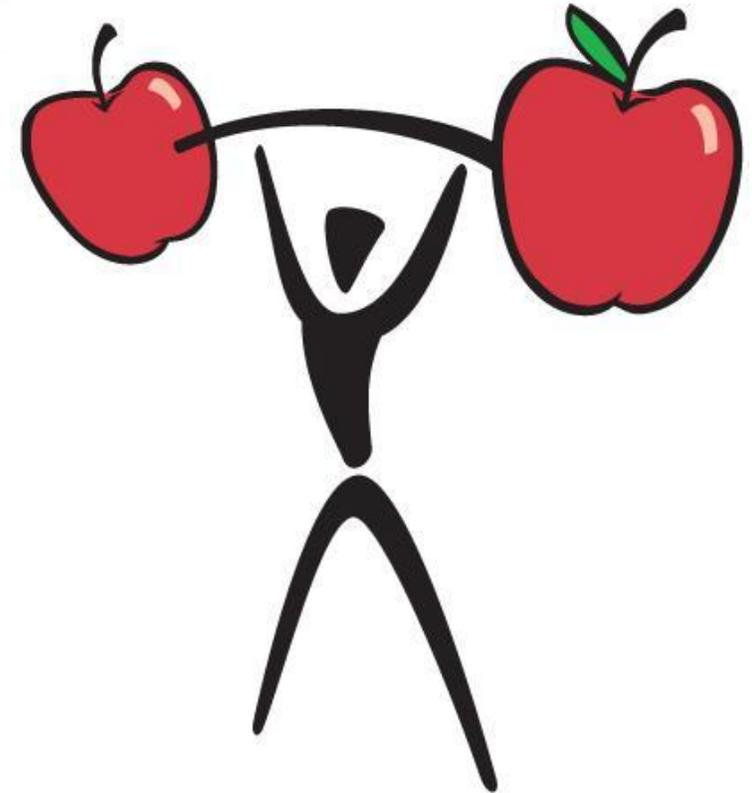




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My Healthy Weight (MHW)

The first-ever collective initiative offering insurance benefits to cover obesity prevention and treatment for both children and adults.





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Why is MHW needed?

- Physical Inactivity
- Obesity
- Related Chronic Diseases:
 - Diabetes
 - Cancer
 - Hypertension

Overweight population
in America

66%+

Annual spending on obesity
related disease

\$210 B



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History

Healthier Generation and the Bipartisan Policy Center developed My Healthy Weight as a public-private initiative with support from the Robert Wood Johnson Foundation.

October
2016:
Taskforce
launches

January 2018:
Pledge
implementation
begins

November
2017:
Founding
Members
join MHW

January
2019:
Coverage
becomes
available





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MHW Founding Members

State of Alaska Department of Health and Social Services

Blue Cross and Blue Shield of Kansas City

Blue Cross and Blue Shield of North Carolina

Blue Shield of California

Capital District Physicians' Health Plan

Connecticut Department of Social Services

Delaware Division of Medicaid and Medical Assistance

Nestlé

Novo Nordisk

South Carolina Department of Health and Human Services

Texas Health Aetna



Kansas City



BlueCross BlueShield
of North Carolina





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Key Pledge Components

- At least **12 visits** (with a qualified healthcare provider) for *adults* with a **BMI \geq 30**
- At least **6 contact hours** (with a qualified healthcare provider) for *adults* with a **BMI \geq 25 and one or more risk factors** for cardiovascular disease
- At least **12 visits** for *children* ages 3 years or older with a **BMI \geq 95th percentile**
- At least **8 visits** for *children* ages 3 years or older with a **BMI 85th - 95th percentile**



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Community Programs

- **Adult-focused programs:** Qualifying programs should have a previously demonstrated ability to achieve *at least a **five percent** weight loss in adult participants.*
- **Child-focused programs:** Qualifying programs should have a previously demonstrated ability to achieve *a **BMI percentile decrease** in child participants.*



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Optional Pledge Components

MHW members are also encouraged to voluntarily implement the following optional pledges:

- At least **1 nutrition or physical activity counseling visit** for all members, with or without a qualifying diagnosis
- Utilization of **outcomes-based payments** for weight management



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Benefits of Joining MHW

- Reduce short- and long-term healthcare costs and productivity loss
- Support company health commitments and goals
- Increase reputation as employee-centered and health conscious
- Access support for company commitments and goals



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Member Feedback

"Creating meaningful health change requires good partnerships. In South Carolina, our focus on promoting healthy weight brings together dietitians, physicians, data analysts, task forces and community champions. The My Healthy Weight initiative expands the reach of this work with new partners."

- Amanda Q. Williams,
South Carolina Department of HHS

Join!

We're inviting you to join an elite group of businesses providing comprehensive healthcare services to employees and their families for the prevention and treatment of obesity.





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Thank You!

For More Info:

<https://bipartisanpolicy.org/events/my-healthy-weight/>

Join Today – Contact:

Jenny Bogard

Jenny@drivecommonality.com