Chronic Care Roundtable

Cardiometabolic Care Post Pandemic: Emerging Guidelines & Innovative Therapies for Patients with CVD and Obesity

November 9, 2022

Meeting Summary

On November 9, 2022, AMGA Foundation's Chronic Care Roundtable participants, including industry partners and leaders from health systems and medical groups across the country, convened in Arlington, VA. The meeting's focus was innovative therapies and new strategies for improving health outcomes for the populations of patients with cardiovascular disease (CVD), obesity, and other chronic conditions.

John W. Kennedy, MD, chief medical officer of AMGA and president of AMGA Foundation, served as the host of the meeting and clarified the meeting's purpose was "to examine strategies for reducing risk factors related to CVD and obesity and to identify solutions to increase health equity."

In presentations, panels, and breakout sessions, participants explored challenges in the current healthcare climate, learned about new guidelines and treatments for CVD and obesity, and shared strategies.

Icebreaker:
Challenges in the Current Healthcare Climate

One significant obstacle is the need to bring patients back into care after COVID. According to one attendee, "They're missing out on screenings, prevention, and coming in for acute care of advanced and complex illnesses." Fragmentation of care is still a challenge for patients with cardiometabolic and renal diseases, and better screening is needed in areas like the underdiagnosis of peripheral artery disease. "People often don't know they might lose a limb until they are in the ER."

Participants highlighted a "systems problem of not providing patients with all the options," such as access to evidence-based exercise strategies. Telehealth "meets patients where they are," but not all services are amenable—particularly those that require a detailed physical exam or diagnostic studies to fully assess the presenting condition. And when care teams focus on acute needs rather than chronic needs, "we miss out on preventative screenings, laboratory work, and weight checks."

Health systems need to improve their consolidation and coordination of care, from adequate follow-up and transitions to collecting data and putting them into action. "We are starting to track race and ethnicity in health records, but we don't know what it takes to address the disparities," one participant shared. "We need to understand what patients need," another declared.

How can we help patients sort out information and develop their trust? Organizations are also challenged to identify disparities and issues to access, then work across sectors and with communities to address them. "How do we truly transform our communities with poverty, high crime rates, and food deserts being prevalent?" Participants also mentioned "the mental health aspect" of obesity and CVD, which "shouldn't be underestimated."

The bottom line was an ever-present concern. “Remarkable new treatments exist for CVD and obesity, but cost of care is a barrier,” one participant noted. “From a policy angle, everyone is pushing equity, but no one is willing to fund it,” another remarked. “Health systems are not going to solve it alone. There are things we can do, but we need the funding to do it.”

From “knowing what levers to pull first” to identifying the actions with the greatest value and impact, “there is no one easy solution. With limited resources, you need to figure out how to fix it.”

The challenges are many in metabolic disease care today: behavioral health factors, social determinants of health, clinical inertia around diabetes, hypertension, obesity, and more. But so are the opportunities.

Now is the time to “be compassionate and educate,” to collaborate across industries, to “unearth the great work being conducted,” and to develop a framework for sustainable solutions. Organizations also have the opportunity to take a holistic view of patients, marry personalized medicine with population health, and take cardiometabolic care to the next level. “When there is a sense of urgency, we get a lot accomplished.”

Keynote:

Emerging Guidelines for Patients with CVD

Pam R. Taub, MD, FACC, FASPC, *Director of Step Family Foundation Cardiovascular Rehabilitation and Wellness Center Professor of Medicine, UC San Diego Health System, Division of Cardiovascular Medicine*

Affecting one-third of the U.S. population, metabolic syndrome is “the tipping point of high-risk primary prevention,” Taub said. It’s a multifaceted condition, and healthcare organizations need to intervene earlier on the risk continuum.

“If a patient has had a heart attack or stroke, it’s too late for prevention interventions,” she said. “Identify the person who is at high risk for having an adverse event.” Call out risk factors such as tobacco use, diabetes, or high blood pressure when seeing patients and engage the patient in shared decision making to reduce risks. Use biomarkers, physical exams, and tools such as a cardiac calcium score to prevent the evolution to an advanced event. “Once you start educating and addressing the risks, patients can see results very quickly,” she said.

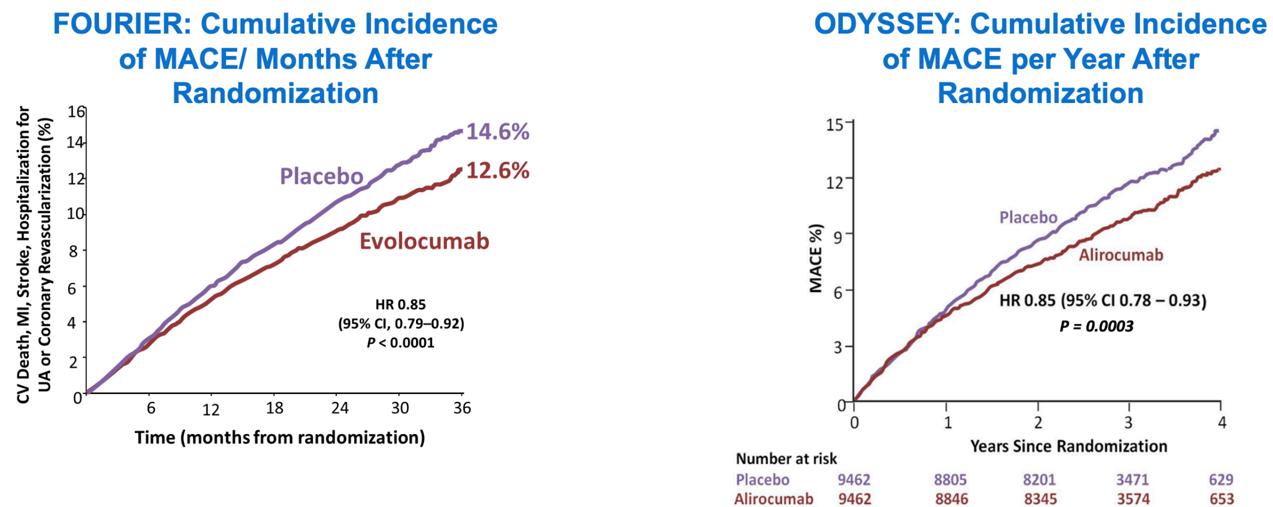
Finally, explore the full range of therapies. Lifestyle, nutrition, physical activity, and behavioral change are the cornerstones of therapy. Evidence-based medications are often indicated as supplemental treatment where proven to enhance health outcomes.

Taub walked through the evolution of CVD treatment, starting with the long-term no-activity-and-bed-rest prescriptions of the 1960s. “This is no longer the case,” she said. “Exercise is an important component of recovery following an acute event.”

The 1980s delivered a “breakthrough” with the use of statins for reducing atherosclerotic cardiovascular disease (ASCVD), then non-statin agents, and most recently a “revolution in cardiometabolic care. Identifying and targeting

PCSK9, the protein that blocks and inhibits LDL receptors breakdown, has been revolutionary," she said. PCSK9 inhibitors have a favorable safety profile, reduce both LDL and non-HDL cholesterol as well as Lp(a), and may be an important tool in reducing residual risk (Figure 1).

Figure 1: PCSK9i Cardiovascular Outcome Trials



Efficacy	FOURIER	ODYSSEY OUTCOMES
Change in LDL-C (Absolute – mg/dL)	56	53
% change in LDL-C (on-treatment arm)	↓59%	↓61%

Schwartz GG, et al. N Engl J Med. 2018;379(22)2097–2107; Sabatine MS, et al. N Engl J Med. 2017;376(18):1713–1722;

Taub considers inclisiran, approved in 2022, "an exciting new adjunctive therapeutic option for patients with a history of heterozygous familial hypercholesterolemia (HeFH) or clinical ASCVD and who require additional lowering of LDL cholesterol to achieve guideline directed goals despite diet and maximally tolerated statin therapy." The medication is administered subcutaneously as a single injection initially at three months, then every six months thereafter.

Furthermore, when treating patients with ASCVD, ezetimibe has been proven effective in lowering LDL levels in patients not at goal despite maximally tolerated statin therapy. Taub also noted a phase 3 trial examining bempedoic acid and ezetimibe, alone and in fixed-dose combination. "There was a significant decrease in LDL when given together," she said. She noted the "strong safety profile" and higher representation of women among the trial participants providing another therapeutic option for patients with established ASCVD who remain above goal for LDL control despite diet and maximally tolerated statin therapy.

Given encouraging outcomes in very high-risk patients with established ASCVD, people with ASCVD often need a combination therapy. "We need to change the paradigm to ensure patients with ASCVD are prescribed high dose or maximally tolerated statin and are considered for combination therapy to achieve guideline directed control of their LDL cholesterol when necessary," she said.

Diabetes, renal conditions, and obesity should be looked at through a cardiovascular lens and treated accordingly, she said. “Metformin is an effective medication for patients with type 2 diabetes and is inexpensive. SGLT-2 inhibitors have become more accessible to a broader population of patients as patents expire and the medications are available in less expensive generic formulations. They’re not just a drug for diabetes; they help heart failure and are protective of the kidneys.”

SGLT-2 inhibitors are indicated for use in heart failure, managing blood pressure and A1C control, and providing renal protection, and they can help reduce CV risk in patients with diabetes. GLP-1 analogues also have received cardiac and renal protective indications and may often be the medications of choice in patients who are overweight and obese and have uncontrolled diabetes and cardiovascular disease despite lifestyle changes and maximally tolerated metformin therapy.

“We’re not doing a good job nationally of getting many of our patients with ASCVD to achieve guideline directed LDL goals,” Taub said. According to the 2022 ACC Expert Consensus for very high-risk patients with established ASCVD, LDL should be lower than 55 and ideally lower than 40.

Dr. Taub highlighted that the decision to advance therapy is not always straightforward. Obtaining a cardiac calcium score in patients at moderate risk of ASCVD may help inform shared decision making and risk stratification, with an elevated reading prompting further consideration of additional interventions.

“Obesity medications may one day be proven to be as effective as bariatric surgery at achieving weight loss and improved patient outcomes,” she said. On the flip side, “How many drugs can a patient take? Options can be overwhelming, and access is a challenge, especially for women and minorities.”

Figure 2: Comparison of Different Classes of Diabetes Medications

	A1c Reduction	Weight Change	CV Benefit	Renal Benefit	Cost
Metformin	1.0–2.0%	Neutral	Potential benefit	Neutral	Low
SGLT2 inhibitors	0.5–1.0%	Loss	Benefit	Benefit	High
GLP-1 agonists	0.8–2.0%	Loss	Benefit*	Neutral	High
DPP-4 inhibitors	0.5–0.8%	Neutral	Neutral–potential harm in CHF	Neutral	Moderate-High
Pioglitazone	0.5–1.4%	Gain	Neutral–potential harm in CHF	Neutral	Low
Sulfonylureas	0.4–1.2%	Gain	Neutral	Neutral	Low

Source: https://www.uchealth.org/integratednetwork/provider_insider/pharmacy-integration-2/

What factors should care teams consider when personalizing CVD management? Start with the issue that impacts the patient the most. If the patient was recently hospitalized, what was the reason? Patients are most engaged in improving risk factors that are directly linked to their most recent acute illness, including adopting new lifestyle and behavior changes that promote tobacco cessation, blood pressure control, diabetes management, and cholesterol control. When choosing therapies, use evidence based guidelines and readily available data, such as LDL, renal function, blood pressure, and HbA1c, to guide the way.

Session:

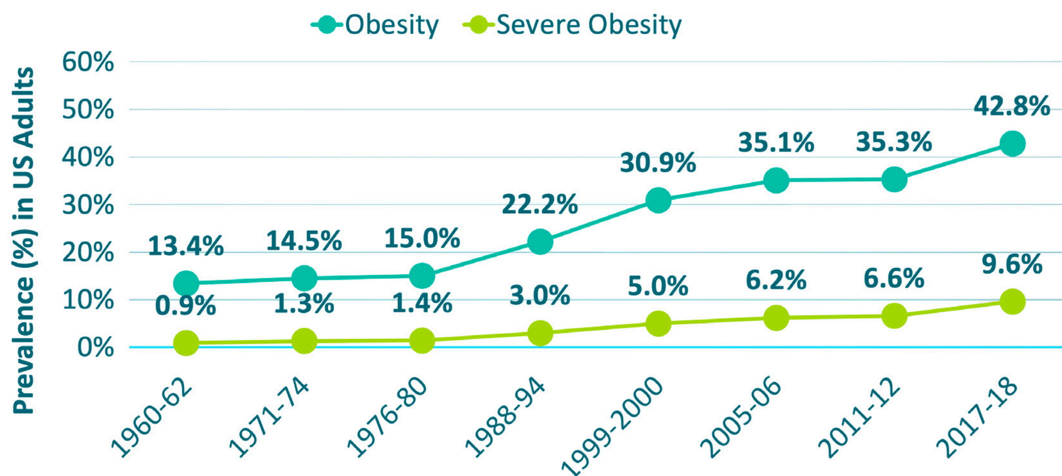
Innovative Therapies for Patients with Obesity

Joe Nadglowski, *President and Chief Executive Officer, Obesity Action Coalition*

Nadglowski framed the session and the nation's challenge by talking about what obesity is—excessive fat accumulation or distribution that negatively impacts health and quality of life—and what obesity is not: a cosmetic condition, lifestyle choice, or character flaw.

"When we talk about obesity being bad, we vilify the patient," he said. Furthermore, while the body mass index (BMI) is used in FDA labels and by insurance companies that may have some utility for initial screening, this measure "should not replace clinical judgement," he said. "Obesity is about health, not body weight or size. Communications around obesity need to be health-focused to avoid adding to stigma and bias."

Figure 3: Prevalence of Obesity (BMI >30 kg/m2) and Severe Obesity (BMI >40 kg/m2) among U.S. Adults 1960–2018



SOURCES: National Center for Health Statistics, National Health Examination Survey, and National Health and Nutrition Examination Surveys.

Treating obesity "isn't just about eating less and moving more," Nadglowski explained. "We need more understanding on what is disrupting the endocrine system."

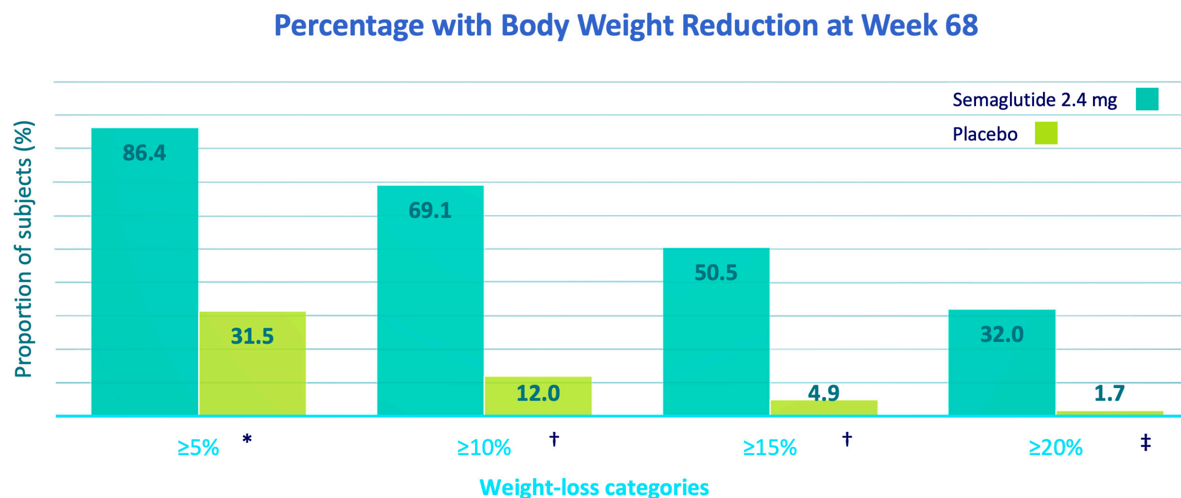
Many variables impact obesity, including stress, distress, lack of sleep, altered food supply, drugs, chemicals, and technology. With this in mind, teams must take a comprehensive approach to obesity care, Nadglowski said, from self-care and professional lifestyle therapy to pharmacotherapy and surgical procedures. Start first with nutrition, activity, behavior and mental health counseling, and anti-obesity medications, he said, then think about devices and surgery—and with surgery, follow-up is essential.

Despite the growing array of treatments, only about 10% of people with obesity seek a healthcare provider and only 4% actually see a doctor. "Most people think they need to do it on their own." While some employers provide obesity care, these services are often hidden across wellness, employee assistance, medical, pharmacy, and surgical benefits. The data indicate that they are underutilized.

"As long as treatment is evidence-based, we should encourage the treatment," Nadglowski said.

He then talked about the growing area of anti-obesity medication and how recent outcomes are challenging beliefs that only a small percentage of patients can benefit. In a study of semaglutide, for example, half of patients lost at least 15% of their body weight and 32% had at least 20% weight loss at 68 weeks.

Figure 4: Greater Effectiveness



Mean weight at baseline: 230 lbs
*Primary endpoint; †Secondary confirmatory endpoint; ‡The ≥20% threshold was a supportive secondary analysis.

Wilding JPH, et al. *N Engl J Med* 2021;384:989-1002.

Current anti-obesity medications include liraglutide and semaglutide. Tirzepatide is also approved for patients with uncontrolled diabetes despite diet and behavioral modification and is currently undergoing studies in patients with obesity. Among the 40 agents in development, many will impact other conditions, Nadglowski pointed out, concurrently addressing areas such as satiety, hunger, metabolism, and the development of lean muscle mass. Yet price remains a barrier for many. He pointed out that Medicare patients don't have access to obesity medications, and there are no drug assistance programs yet for these therapies.

"Innovation in obesity care is rapidly expanding, and new medications are changing both public and payer interest in obesity care," he said.

Throughout the obesity care continuum, it's important to recognize that "treatments fail people, people don't fail treatments," in Nadglowski's words. Treatment response varies by individual, and just because you start with one treatment doesn't mean it will be effective for a lifetime.

"Addressing obesity is hard. We don't have a solution for everyone, which is hard for us to admit," he concluded. "But through good communication and comprehensive care, people have a better chance for improved health."

Q&A

Why is obesity care used by some patient groups and underutilized by others?

Participants noted that upper middle class White women are more likely to seek obesity treatment, possibly due to bias, stigma, and social pressures. Yet other groups underutilize such care. Economics plays a role, as does access to treatment, participants said. What is the aha moment for men? Are they not going to the doctor? "It's a great opportunity for more research."

How do we make a case that anti-obesity medications are worth the money?

One brand may be covered by a patient's insurance while another may not. Meanwhile, Medicare patients do not have access to obesity treatment at all. And millions of patients currently lack health insurance with medication benefits, further limiting access to effective treatments.

Moving forward, the situation is "like the chicken and the egg. You need more patients on the meds to do the study, but there are barriers to accessing the meds," one participant observed. People deserve access to these medications, participants declared. People deserve consistent care.

What can medical systems do to try to change this dynamic? Start with serious conversations about how to cover treatments. Show that treatments are effective and challenge payers and companies to make access more equitable. Use hypertension medications as an example. In the beginning, they were prohibitively expensive, but now they're accessible. "We have to fix this system—one payer, one insurer, and one legislator at a time."

Panel:
Upstream Health Equity Strategies to Prevent CVD and Obesity

Moderated by **John W. Kennedy, MD**, *President, AMGA Foundation, Chief Medical Officer, AMGA*

- **Scott Berkowitz, MD, MBA**, *Chief Population Health Officer, Associate Professor of Medicine, Johns Hopkins Medicine*
- **Diane George, DO**, *Chief Medical Officer, Primary Care, Henry Ford Medical Group*
- **Tony Hampton, MD, MBA**, *CPE Regional Medical Director, Advocate Aurora Medical Group*
- **Verlyn Warrington, MD, MS**, *Director, Bariatric Medicine, Guthrie Medical Group*

Using Team-Based Approaches to Address CVD

Internally, Guthrie Medical Group has been networking across the team to leverage resources for patients not eligible to see a specialist, and Johns Hopkins Medicine enlists cross-functional teams—primary care physicians, caregivers, psychologist-overseen behavioral health workers, nurses, social workers—to care for patients with multiple chronic conditions.

In terms of external partnerships, Guthrie has connected with community gardens, community outreach projects, and school nutrition projects to support patients with diabetes and food insecurity. They've also started a food pharmacy that is able to feed 40 persons for 10 weeks for $600. Warrington cited a two-point drop in both obesity and diabetes.

Advocate Aurora Medical Group has been uniting its efforts around access to nutrition, with food pantries, a food app, and education for patients and clinicians alike "meeting patients where they are and helping them get to their goals with nutritional support," Hampton said.

Henry Ford Medical Group uses both new technologies and time-honored techniques. Risk stratification tools show where resources are needed—for example, which patients should be prioritized for proactive outreach and which neighborhoods require a clinical pharmacist. Meanwhile, much of their work surrounding social determinants of health starts with a simple question: Do you have food? "If not, here's food, and we're starting to think more about the nutritional value of that food," George said.

Leveraging Resources to Address Health Equity

At Henry Ford, a health equity dashboard stratified by gender, race, ethnicity, and other metrics to monitor major HEDIS targets as well as diabetes, hypertension, and cancer screenings. "We apply confidence limits to look more meaningfully at the numbers," George said. "Is this a statistical significance difference? We then look site by site to see if it is a problem everywhere."

Henry Ford is also using pharmacists "to look at who is not in control, tweak the meds, and free up the docs while increasing patient touches." George called this "a game changer."

At Advocate Aurora, waist circumference—which Hampton calls "the biggest indicator of metabolic syndrome"—has become a standard for identifying patients in need of care. Other screening measures include calcium score studies for ASCVD, blood pressure for diabetic health and CVD, and a rising focus on fasting insulin in the next 5–10 years.

Warrington explained how Guthrie is using its Epic EHR to pinpoint the highest incidences of A1C and obesity. "How do we implement lifestyle changes? How can we utilize our services?"

Johns Hopkins is looking at A1C and lipids, with a focus on health equity and better reporting and accountability around these areas. "As you're identifying something, make sure there is an opportunity to solve the issue," Berkowitz said.

Resources Currently Being Utilized in Health Systems and Medical Groups

Berkowitz explained how John Hopkins uses health tools to help patients get the referrals and the help they seek. "A certain set of resources aren't going to be free. Sometimes they require unique funding or a billing mechanism."

Warrington stressed the importance of "becoming conveners" in helping Guthrie address conditions like obesity, heart disease, diabetes. "Bring those community organizations together and brainstorm options."

Henry Ford has been using such partnerships "to get in front of more people at a low cost. You can link patients to resources in ways you haven't done before," George said. Both Henry Ford and Advocate Aurora have focused on engaging with faith-based organizations and community partners and on efforts like high blood pressure care for high-risk populations.

Hampton talked about Advocate Aurora's "social determinants of health wheel" to connect patients to resources in areas like food and transportation. The key with any program is "justifying to those with the budget that this is worth it," he said, and sometimes a pilot is necessary "to prove it works" before scaling up.

"A lot of population health is the delivery system, not programs," George declared. It's important to standardize across the entire system as much as possible, and many process changes cost nothing to implement.

What Does the Future Hold in Store?

Berkowitz talked about Johns Hopkins' heart failure clinic. Led by a nurse practitioner, it offers advanced onsite care for cardiology patients in acute heart failure—care usually delivered in an ER—and has expanded access to care for Johns Hopkins' Black patients. Similar models could be applied to patients with complications from chronic CVD or obesity to reduce preventable admissions and deliver patient-centric care.

Hampton talked about Advocate Aurora's work to leverage the talent and perspectives of underrepresented groups, such as Black men and young White men with limited resources. "How can the organization make them feel valued and encourage them to share what they're thinking?" Once this information has been verbalized, the healthcare system is better positioned to deliver the right care to the patient closer to where the patient lives.

Breakout Sessions

Strategies for Positively Impacting Health Outcomes among Patients with CVD

Facilitator: **Edward Yu, MD**, *Medical Director and Chief Quality Officer, Palo Alto Medical Foundation*
Panelist: **Scott Berkowitz**

Barriers to CVD Outcomes

Challenges to care delivery run the gamut, including fragmented delivery models, complex stakeholder partnerships, and complicated guidelines for medication use, including "the need for slow titration." Some cardiologists and other specialists are hesitant to prescribe SGLT2/GLP1 drugs, and some patients are hesitant to take them. Participants also cited inadequate training ("medical schools need to catch up with the times"), inadequate decision support tools at the point of care, and difficulties scaling up successful pilots.

Participants noted disparities in access to primary care for minority populations, patient engagement after surgeries, and more. "Race impacts treatment and physician behavior."

They cited the need for increased transparency and data sharing among clinicians and teams, in social disparities of health and in care delivery overall, such as what medications are on an organization's formulary.

Organizations need more data on the costs and coverage side of the equation as well. Participants noted challenges to get obesity services and medications reimbursed, especially for patients without comorbidities, and to get Centers for Medicare and Medicaid Services (CMS) payment for regional experimentations.

How do you quantify program and improvement efforts? How do you make it profitable to manage health and prevention? Answering questions like these requires resources for research and analysis, and these resources are often limited or nonexistent, according to participants.

Strategies and Solutions

Participants cited the value of standardization, the right processes, and incremental changes to move faster. "Develop great handoffs between inpatient and outpatient care teams to reduce the length of stay," one recommended. "Evolve disease specific-programs and interventions to include comorbidities and focus on whole person care," another suggested.

Organizations can use risk-based models to address the challenge of "making it profitable." How do you quantify outcomes as ROI? Accelerate these models to fine-tune patient segmentation and better define interventions.

Addressing Gaps and Social Determinants of Health

For patients, leverage segmentation models and phenotypes, focus on high utilizers, and use care navigators to improve communication and coordination about high-risk patients across care settings and teams. Try tools like videos to engage and educate patients about care processes, and deliberately ask them what your organization can do to support their care.

For care delivery, balance the focus on individual diseases with a holistic approach. Target specific solutions to specific populations while recognizing there will seldom be one solution that fits all situations. Use mobile health and telehealth to improve access to targeted populations, and make sure these platforms integrate with the patient's clinical record.

Expand primary care access to more team members, such as nurse practitioners, physician assistants, and pharmacists. Make pharmacy costs and coverage available at the point of care. Insist that providers follow guidelines and implement tools in the EHR to support guideline-based care.

Strategies, Through a Health Equity Lens, to Positively Impact Health Outcomes among Patients with CVD and Obesity

Facilitator: **Leon Jerrels, MBA, MHA, RN, CPHQ**, *Director Quality Improvement, Kelsey-Seybold Clinic*
Panelist: **Diane George, DO**, *Chief Medical Officer, Primary Care, Henry Ford Medical Group*

Overcoming health equity barriers for patients with CVD and obesity requires "meeting them where they are—virtually, in the office, through community centers or faith-based organizations—and providing a consistent cadence of education." Participants shared ways to bring this mission to life.

Listening and trust: Understand the right questions to ask. Are there deeper questions that need to be addressed? Track how often you ask and listen. Create an environment of trust. "If you truly listen, the patients are telling us what's standing in the way of access, care, and better health," Jerrels said. "In health equity, there's a different journey, with different barriers, for each patient," one participant noted.

Cultural humility: Better listening requires "learning the world view" of the population. "It's about that person and where they're coming from." Physicians need to see the importance of, and take the time to be, culturally competent. Actively work to learn the population's culture. Understand where you're privileged and where patients might have challenges. Come into the relationship with humility.

Access to care: "Until we change our healthcare delivery, the people with the biggest medical problems don't have access." Where transportation is a barrier, participant organizations are working with pharmacy providers like Walgreens to take trailers to neighborhoods. George talked about "designing with equity in mind" at Henry Ford, with emergency department reduction strategy, paramedics, physicians, MyCare On Demand video visits, and community health workers who make home visits.

Patient engagement: How can organizations encourage patients on an ongoing basis? Start with engagement.

For example, healthcare providers traditionally don't follow up at home, and EHRs have also created issues in this area. Send mailers and reminders, participants suggested. Align triggers with activities like lab work, and enlist others on the care team, like clinical pharmacists. "Instilling accountability encourages patients long-term," one participant noted.

Examine how the message is delivered. When teaching people how to "eat well," what does that actually mean? Frame it positively: "what you can do versus things you need to stop doing." Take advantage of every opportunity to engage.

Finally, who "owns" the patient? Is it the primary care provider until risk is identified, then a specialist? And how does the provider determine if the patient did or did not follow instructions? Allocate resources around accountability as well.

Community partnerships: Community health workers can be a bridge to the healthcare system, but they need training. Community partners can be an extension of your care team, but they can be hard to identify and engage. Who should organizations reach out to? "Everyone who has a vested interest in that population needs to be there," was one participant's response. "Health policy is national. Care policy is local."

Revisiting healthcare systems: Finally, organizations can address many obstacles and gaps by looking at how they get their work done.

- Amid staffing shortages, identify, engage, and empower the team members you have. "There are many you aren't aware of," one participant noted.
- Unite team members behind a shared goal and standardized messages and practices—even though standardization can be hard to do in real time.
- "Serve up information immediately" so team members can operate at the tops of their license.
- Know your patients, especially your high-risk ones. "It all goes back to segmentation."
- Leverage data mining and predictive modeling to prioritize and customize care.
- Move fundamental care further upstream.
- Make decision making as easy as possible.
- Ensure mobile technology and devices can speak to each other.
- Make health and pharmacy care available at the point of service.
- Change the healthcare system to "be a convener, not a solver."

In all the above areas, Jerrels challenged the group to look at outcomes. If these haven't changed, look into the "why."

Strategies to Positively Impact Health Outcomes among Patients with Obesity

Facilitator: **Barbara Hodne, D.O. FAAFP**, *Chief Quality Officer, The Iowa Clinic*
Panelists: **Tony Hampton, MD, MBA**, *CPE Regional Medical Director, Advocate Aurora Medical Group;*
Verlyn Warrington, MD, MS, *Director, Bariatric Medicine, Guthrie Medical Group*

What practices have been working in obesity care? Participants mentioned apps. "The next generation is looking for the shortest route to get them where they want to be," one noted. They also suggested payer-covered health coaches, engaging the support of family members, and "getting to the root cause of the struggle."

Patients responded well to accountability, and it's important for care teams as well. "You need to reward success and recognize failure to create the best possible solution." At the same time, "spark interest and innovation with providers, so they can see their ideas come to life." Participants noted the importance of "sharing passion and stories" and integrating diversity, equity, and inclusion (DEI) into the organization and its purpose.

In terms of teams, "have the right voices at the table." Organizations found cost-efficiencies when expanding skill sets to meet their needs, but one barrier was "learning what your structure looks like."

To overcome strategies that didn't work:

Look at the patient population: Figure out what don't you understand about the target audience, whether this be education, cost, culture, language, or patient needs. One participant cited a nutrition class in which "patients didn't understand the issues, and there was no real discussion about what was needed," like portions and how to cook certain recipes.

Look at the organization: Is a program's lack of success a matter of adoption, not including the full team of care, failing to move measures into action? "Have a mindset of continuously tweaking and improving," one participant advised. "Be comfortable with failure and learn to do the right thing."

Look at access: After years of advocating, organizations are adding obesity medications to their formularies. The challenge now is to get more adults covered and connected to internal and community resources, like food pharmacies and food gardens. "How can you work with the system?"

Invest in training: Too many providers today are "treating the symptoms and not the roots" and parroting the "less calories in, more calories out," and "small meals throughout the day" guidance they learned in medical school. They're not asking patients about the issues behind the disease or life events that cause weight gain, like menopause or being sedentary due to COVID-19.

Teaching people to have these conversations and do them authentically, compassionately, and well requires "reeducation, retraining, and realizing that patients see the world differently." Examine word choices with an eye toward avoiding stigma and shame. Make it simple. Address mental health, lifestyle, family behaviors, and other root causes, and keep people empowered. Overall, "create an environment where the needs of the people who struggle are front and center."

Be a convener: Leadership also has a role in shaping these conversations, addressing systemic barriers, and making obesity care a wider discussion with employers, educators, city planners, and communities. "We cannot solve this alone. It is our job to be leaders and conveners."

Insight Showcase and Closing

Christina Taylor, MD, *Chief Medical Officer, McFarland Clinic, Past Chair, AMGA Foundation*

Dr. Taylor closed the session with key takeaways from the day's sessions:

- Meet patients where they are. Be open, build trust, and ask questions to be culturally competent.
- Shift the paradigm to help patients understand their condition and the treatment. "People don't want to be sick." Create a culture where health systems understand why people struggle and how the system can help.
- Consider statins a starting point for patients with ASCVD, along with diet, exercise, and behavioral lifestyle modifications. Focus on LDL for secondary prevention and use evidence-based medications to lower cardiovascular risk for patients with diabetes.
- Remember that BMI is simply a screening tool. You can't judge someone's health based on this one measure alone.
- Focus obesity-related communications on health to avoid added stigma and bias, and stop making people "earn the right" to obesity care.
- Addressing obesity is hard, but through good communication, good design, and comprehensive care, people have a better chance for improved health.
- A health equity dashboard with HEDIS, A1C, and social determinant of health metrics—stratified by gender, race, and ethnicity—can help organizations focus in on care gaps and risks.
- Partnerships are key for leveraging limited resources and connecting patients with valuable services. We need to be conveners!

Thank you to our Chronic Care Roundtable Corporate Partners

Mission:

AMGA Foundation enables medical groups and other organized systems of care to consistently improve health and healthcare.

Vision:

AMGA Foundation serves as a catalyst, connector, and collaborator for translating the evidence of what works best in improving health and healthcare in everyday practice.

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