AMGA™ FOUNDATION

Chronic Care Roundtable

Tackling the Obesity Epidemic: Strategies for Addressing Diabetes, Cardiovascular, and Kidney Disease Comorbidities

November 8, 2023

Meeting Summary

AMGA Foundation

Chronic Care Roundtable

On November 8, 2023, healthcare leaders from organizations across the country convened for a full day of sessions in Arlington, VA. The focus: ensuring equitable access to the next generation of obesity therapies and equipping their organizations to address obesity comorbidities, such as diabetes, cardiovascular disease, and kidney disease.

> *"Obesity is a disease that fits within a typical chronic care model. Care should be administered equitably, without regard to income, social status, or other medical problems."*
>
> **—Patricia Nece, JD, Counsel for Regulations and Legislation at U.S. Department of Labor (ret.); Past Chair of the Obesity Action Coalition**

"We know obesity is an important chronic condition that's impacting millions of Americans and costing billions of dollars," AMGA Chief Medical Officer and AMGA Foundation President John W. Kennedy, MD, said. "Obesity is everywhere in the news, not just healthcare news. It's on the finance pages and in the popular press. So today, we want to go beyond the headlines. We want to dig deeper, learn, and connect so each participant walks away with actionable insights and takeaways to apply to your work immediately."

In presentations, panels, and breakout sessions, participants talked about challenges in the current healthcare climate, learned about new guidelines and treatments, and shared their stories, suggestions, and strategies for success.

An Introductory Icebreaker

Roundtable participants introduced their organizations, challenges, and goals with answers to the following question: What would make today worth it for you?

Increased collaboration ranked high as a desired takeaway, including developing networking relationships, furthering obesity research, gaining new perspectives, and discovering innovative ways to partner together in order "to solve this public health crisis." Organizations are interested in connecting the dots, identifying new opportunities to engage, and "finding out how everybody in the room may be aligned."

What's making an impact—and what's not—elsewhere? What lessons can be brought back? "I hope to hear about the successes of others and adapt what works best to our population of patients," one participant declared.

Equity was a priority for many: reaching as many patients as possible, elevating obesity as a population health priority, using and distributing medications in an equitable way, and advancing preventative medicine. "How do we think about prevention in a way that's 10 to 20 years ahead of the onset of chronic disease?"

Participants stressed the importance of "bringing value around obesity as a chronic condition." How can they convince decision-makers to make the investment today—"that they're going to reap the benefits down the line" in terms of reduced hospitalizations and costs and improved health and care?

Organizations are looking for "simple things that can lead to change" in obesity care services and the management of chronic conditions such as hypertension, cardiovascular disease, kidney disease, and diabetes. They're also challenged to close access and coverage gaps in rural areas, fight stigma and bias, and address pediatric obesity.

Finally, struggles with obesity, hypertension, and kidney disease are personal as well as professional for many healthcare providers. "As someone who had a family member suffer from a cardiac event just last week, I'm really looking for those kind of tangible solutions that will improve the health of individual patients today," one participant said.

Keynote:

Obesity: Blame It on the Brain—Supporting the Need for Pharmacologic or Surgical Treatment

Christopher D. Still, DO, FACP, FTOS, *Professor of Medicine, Department of Clinical Sciences, Geisinger Commonwealth School of Medicine, Medical Director, Center for Nutrition & Weight Management, Director, Center for Obesity and Metabolic Research, Geisinger Clinic*

Obesity is at the forefront of cardiometabolic conditions from obstructive sleep apnea to non-alcoholic fatty liver disease, and many factors have taken the blame over the years. In the 1990s, it was the fat content in food. Sugar in beverages followed, then a lack of sidewalks in city neighborhoods. But at the end of the day, Still declared, obesity really takes root in the brain.

A Complicated Etiology

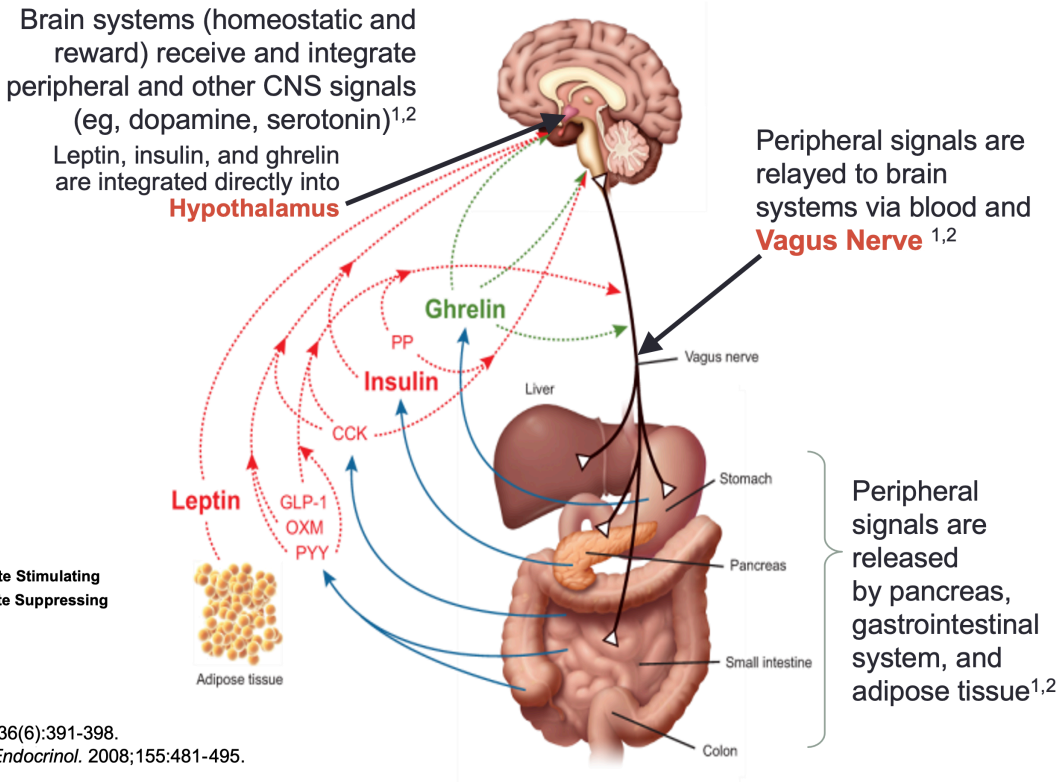
Still explained how obesity is a chronic and relapsing disease with a variety of contributing factors, including central nervous system signals, circulating hormones in the bloodstream, and locally produced neurons gastrointestinal peptides. Lifestyle factors such as a lack of sleep, food insecurity, and smoking cessation further complicate the disease. In addition, many patients take medications, such as steroids, or have other related conditions, such as polycystic ovary syndrome (PCOS) or type 2 diabetes, that contribute to weight gain.

This mix of physiological, behavioral, genetic, and environmental factors converge to create the visceral fat that sets off an inflammatory response and a host of cardiometabolic issues.

The good news is that weight loss can make a significant impact on visceral fat. In fact, a 10% reduction in weight can result in a full 30% loss of visceral adipose tissue, Still noted, but getting there isn't easy. Diet and exercise alone result in only a 3%–5% reduction in weight on average. Moreover, weight loss tends to plateau over time.

"It would be nice if we just decreased calorie intake and increased energy expenditure," Still said. "However, the central nervous system senses this change in weight, and weight loss elicits biologic and physiologic adaptation, decreasing energy and increasing hunger to get back to our set point."

Complex Peripheral Signals are Integrated Into CNS Systems to Regulate Body Weight



CNS, central nervous system
PfC, prefrontal cortex
NAc, nucleus accumbens
VTA, ventral tegmental area
PP, pancreatic polypeptide
CCK, cholecystokinin;
GLP-1, glucagon-like peptide 1
OXM, oxyntomodulin
PYY, peptide YY.
Primarily based on data from animal studies.

Appetite Stimulating
Appetite Suppressing

1. Yu JH et al. *Diabetes Metab J.* 2012;36(6):391-398.
2. Mendieta-Zerón H et al. *Gen Comp Endocrinol.* 2008;155:481-495.

How does this chain reaction play out? A 14% reduction in weight can cause a 65% reduction in levels of leptin, a hormone produced by adipocytes or fat cells, which regulates appetite, satiety, fat cell accumulation, and long-term energy balance, Still explained. In response the stomach produces ghrelin, a hormone that increases appetite. And this is only one of many hormonal adaptations, along with complex signals across the central nervous system, that can influence weight for months, or years, after a diet.

"As we lose weight, unfortunately, our metabolic rate goes down," Still said. Motivation to adhere to a restrictive regime like a diet often decreases as well.[1]

All of this has significant implications for obesity treatment.

"A combination of physiologic lifestyle modifications, effective medications, or bariatric surgery are often required to move to a new lower weight set point," Still said.

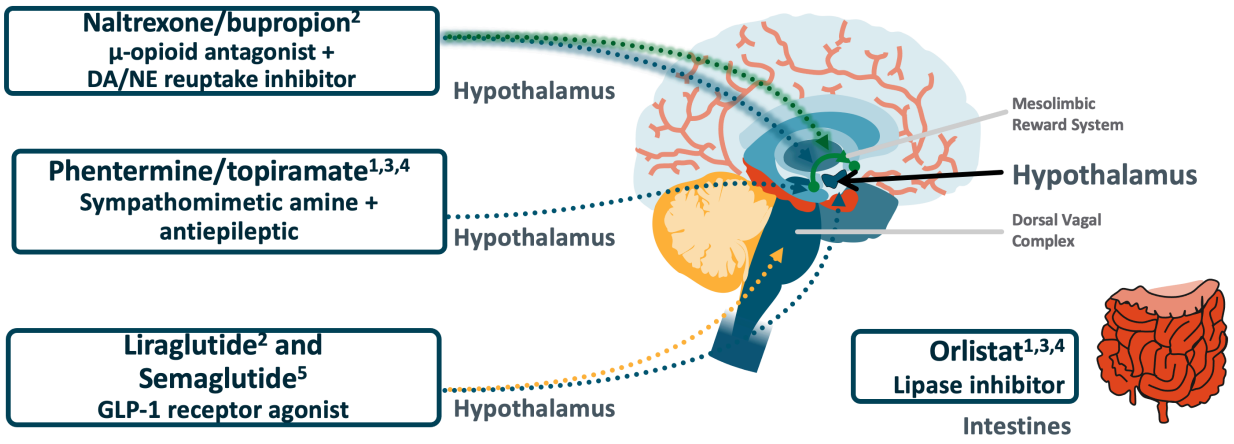
A Multifaceted Approach to Care

For adults with obesity who have not responded to lifestyle modifications, guidelines such as those from the American Gastroenterology Association support pharmaceutical intervention.[2]

Still walked through the characteristics, mechanisms, and strengths of the current "tools in our toolbox," as well as highlights from recent research.

Current Obesity Pharmacotherapy for Long-term Use

- Multiple pharmacotherapies with varying MoA currently approved in US for long-term treatment of obesity[1-4]



1. Yanovski. JAMA. 2014;311:74. 2. Apovian. J Clin Endocrinol Metab. 2015;100:342. 3. Kim. Clin Pharmacol Ther. 2014;95:53. 4. Dietrich. Nat Rev Drug Discov. 2012;11:675. 5. Christou. Obes Rev. 2019;20:805.

All but one of these medications—lipase inhibitors that decrease the gastrointestinal absorption of fats—target the brain. Tirzepitide, a dual-acting GLP-1/GIP medication, makes an impact on multiple fronts, including the endocrine and neurological systems and paracrine signaling between cells. Several GLP-1 medications are currently in use in the treatment of obesity and type 2 diabetes,[3] and cardiovascular care,[4] with a variety of dosing regimens. Liraglutide is taken daily,[5] for example, and semaglutide on a weekly basis.[6]

Options for pharmacological anti-obesity treatment also include combination drugs. CONTRAVE® combines naltrexone (used to treat alcohol and opioid dependence) and bupropion (used in depression and smoking

cessation treatment)[7] to inhibit the reabsorption of dopamine and norepinephrine, the hormone and neurotransmitter behind the "fight-or-flight" response. Qysmia® combines phentermine, a sympathomimetic amine used for weight loss, with topiramate, an anti-epileptic agent with weight loss as a side effect.[8]

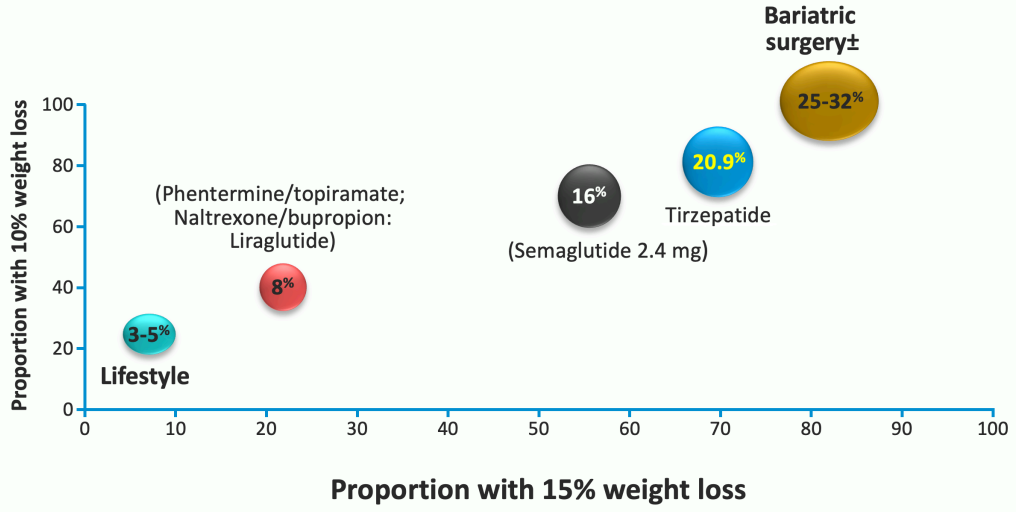
Which medications are best suited for which patient populations and circumstances? American Gastroenterological Association (AGA) guidelines suggest considering factors including but not limited to the clinical profile and patient needs, as well as complications, patient preferences, cost, and access.[9]

The final intervention Still walked through was bariatric surgery. This can result in weight loss of up to 30% through significantly reducing food intake and impacting a variety of other functions: calorie absorption, food preferences, gut microbiota, bile acids, and hormones. As GLP-1 and peptide YY (an appetite-controlling hormone produced by gut endocrine cells) increase, ghrelin (the "hunger hormone") decrease.

Still noted how activation of farnesoid X receptor signaling in the liver can improve fatty liver disease. "To date, bariatric surgery, specifically the sleeve and the bypass, have been shown to be the only treatment modality that reverses fibrosis."

He called bariatric surgery "very effective" overall, but added that "you really need to manage it through comprehensive care and follow these patients in the long term."

Efficacy of Existing Obesity Interventions



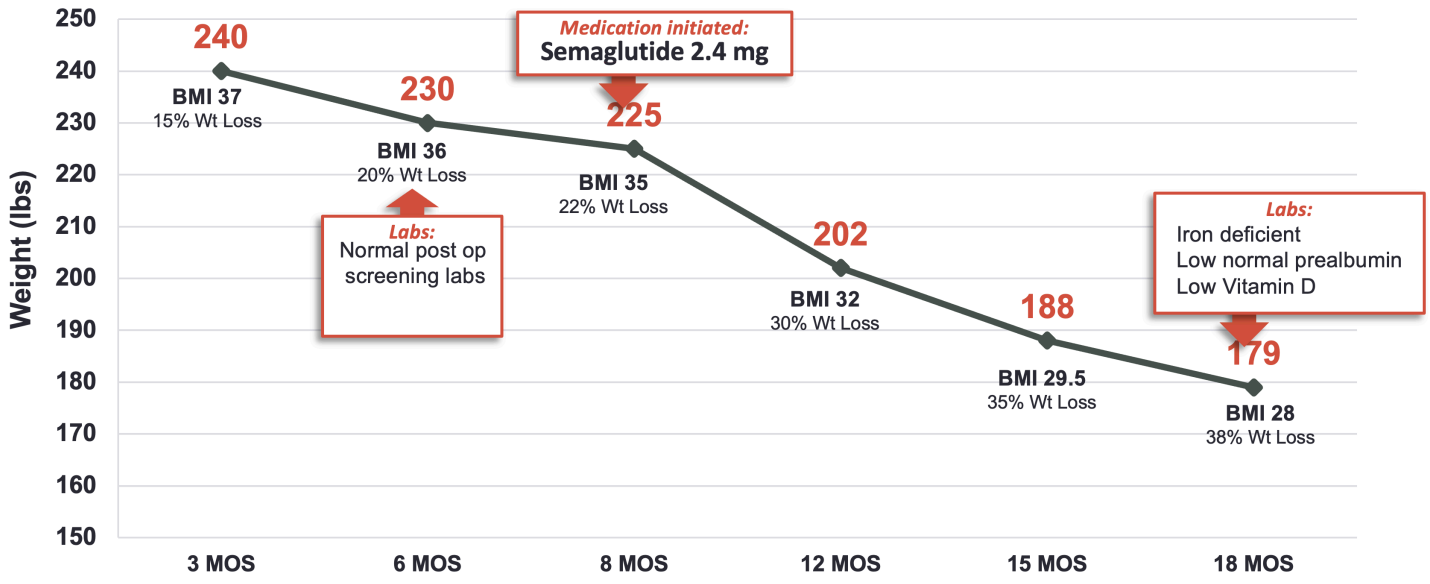
AoM, anti-obesity medications.
Bubble size represents mean % weight loss

Allison DB, et al. *Obesity*. 2012;20:330-342. [EQUIP]; Gadde KM, et al. *Lancet*. 2011;37:1341-1352. [CONQER]; Greenway FL, et al. *Lancet*. 2010;376:595-605. [COR-I]; Apovian CM, et al. *Obesity*. 2013;21:935-943 [COR-II]; Wadden TA, et al. *Obesity*. 2011;19(1):110-120. [COR-BMOD]; Pi-Sunyer X, et al. *N Engl J Med*. 2015;373(1):11-22. [SCALE]; Wadden TA, et al. *In J Obes*. 2013;37:1443-1451. [SCALE MAIN]; Enebo LB, et al. *Lancet*. 2021;397(10286):1736-1748. [Cag + Sema]; Wilding JPH, et al. *N Engl J Med*. 2021;384(11):989. [STEP 1]; Wadden TA, et al. *JAMA*. 2021;325(14):1403-1413. [STEP 3]; Rubino D, et al. *JAMA*. 2021;325(14):1414-1425. [STEP 4]; Ryan D. *Lancet Diabetes Endocrinol*. 2021;9(5):252-254. [STEP]; Sjöström L, et al.
N Engl J Med. 2007;357:741-52; Jastreboff AM, et al. *N Engl J Med*. 2022;387(3):205-216.

Still brought all of this research and guidance together with an encouraging patient example.

Mrs. Jones, a 38-year-old woman with a history of depression, migraine headaches, and premenstrual dysphoric disorder, had been following a low-fat meal plan, but did not get much physical activity. The healthcare team's intervention was multifaceted: shifting to a Mediterranean-type meal plan, increasing physical activity, screening and treating sleep apnea, and stopping prescriptions of paroxetine and diphenhydramine. Treatment also involved prescriptions of metformin, bupropion, and naltrexone, and enrolling in the bariatric surgery process. Because of this new plan, Mrs. Jones experienced a 38% weight loss.

Mrs. Jones: **Post-op** Weight Journey



Q&A

What about the possibility of small bowel obstruction with semaglutides?

"The class can and does cause decreased gastric emptying, and if someone has reflux, it can make the reflux worse," Still replied. While he said that he's not seen this in his practice, he noted that it's something to watch for, especially in patients with diabetes or patients who just can't tolerate the reflux symptoms. Thiamine deficiency has also been seen in higher rates in patients with obesity, although this has been reported both before[10] and after[11] bariatric surgery, with the latter involving partial gastrectomy, total gastrectomy, and Roux-en-Y gastric bypass.

How early should providers intervene, especially if a BMI marker isn't accompanied by comorbidities?

Shared decision-making with the patient regarding the timing to initiate medical management is key, Still said. "Once you start, the weekly GLP-1 or GIPs, it's a long-term commitment, just like any other chronic disease model."

Given the impacts related to hormone regulation, is there a role for intermittent fasting in obesity treatment?

While intermittent fasting can work by depleting glycogen in the liver and flipping the metabolic switch toward mobilization of fat, many people don't do it in a way that will generate the physiologic response, Still said. "You have to have a 12- to 14-hour fast in order to deplete the glycogen."

"There is no right diet," he emphasized when participants asked about the comparative merits of the Mediterranean diet and other options. "If the patient is going to adhere to it, that's the right one."

Do all of the new medications mean that providers should place less emphasis on dietary modification and behavior?

Patients should still increase physical activity and pursue good sleep hygiene, Still advised. As for nutrition, providers should spend the same amount of time and effort on it, but with an emphasis on diet quality.

The Patient Perspective: Navigating Obesity Care

Patricia (Patty) Nece, JD, *Counsel for Regulations and Legislation at U.S. Department of Labor (ret.); Past Chair of the Obesity Action Coalition*

Before she retired, Patty Nece was legal counsel for regulations and legislation at U.S. Department of Labor. She began the session by asking participants to picture a high-powered attorney. "They have a nice house, they drive a nice car, they have a big office—just think of what draws to your mind's eye," she prompted. Finally, she asked, "How many of you visualize someone overweight? How many of you visualized a person with obesity?" After just a few audience members raised their hands, Nece pointed out that 42% of American workers today have BMIs that fall within the obesity range.

Nece then related her complex and often challenging history engaging with the healthcare system, starting with a school nurse who singled her out during a classroom weigh-in. "In front of all my peers, I was told, 'You're fat, you need to lose weight.' And that was the message that I got my entire life: that your weight is all under your control," she said. "If you just pushed away from the table, had more willpower, ate less, exercised more, put that fork down, you could control your weight. If you take nothing else away from today, I hope you remember this: It's not that simple," Nece declared.

She shared how she tried diet after diet after diet and met with health providers who focused on the scale at the expense of other aspects of her health. Then she found herself in incredible pain—which her primary care physician dismissed as "obesity pain" without even conducting a physical exam. An orthopedist finally presented a more accurate diagnosis: severe degenerative scoliosis. During the years when doctor after doctor had dismissed Nece's concerns, her previously minor scoliosis had progressed into a 60-degree curvature of the spine. "My primary care physician missed that diagnosis because he wouldn't look past my weight," Nece said. "I wish I could say that's an isolated experience, but it is not. In fact, the number one complaint the Obesity Action Coalition receives is about bias in medicine."

After more diets and "well-meaning physicians who just didn't know how to help," Nece encountered Dr. Scott Kahan, director of the National Center for Weight and Wellness. "He took a 360-degree approach to weight management that involved medical treatment, medical care, nutritional care, movement, physical activity, and one thing that was incredibly important to me: psychological care." Nece shared how she had suffered from depression for years and hadn't realized it. "I had internalized all that weight bias I had experienced my entire life. I'd become my own worst bully."

Working with Dr. Kahan and his team, Nece lost a significant amount of weight without medication. When she began to regain it, she started a medication that was effective in maintaining weight loss. But that medication was later pulled from the market by the Food and Drug Administration due to the medication's risks and side effects. Then the pandemic happened. During this time, Nece regained much of the weight she had lost.

"But the cool thing about working with Scott is that I had no hesitation going back to him," she said. "Some patients—and I see this with bariatric surgery patients—feel like they've let their doctor down if they start regaining, and they're embarrassed by that. But Scott and his team had absolutely no judgment." Nece explained how Dr. Kahan guided her to a GLP-1 medication, which prevents glucose from entering the blood stream. But the side effects were too many.

Another option was tirzepatide, which activates both GLP-1 and GIP hormone receptors. She said that she's had "excellent results" with this medication so far. The one catch: Her insurance doesn't cover tirzepatide. This means she's paying for it out of pocket at a cost of roughly $1,000 per month. It's a cost she can afford in the short term, but she's hoping that the coverage situation changes soon for herself and other retired government employees.

The Treat and Reduce Obesity Act currently before Congress promises to expand access even more. "It would require CMS [the Centers for Medicare & Medicaid Services] and Medicare to cover anti-obesity medications and also expand behavioral options," Nece said, wrapping up her presentation with an appeal for advocacy. "I'm blessed and I'm lucky. But healthcare shouldn't come down to luck."

Breakout Session A:
Kidney Disease

Moderated by **Sandra J. Taler, MD**, *Consultant, Division of Nephrology/Hypertension, Professor of Medicine, College of Medicine, Mayo Clinic*

In October 2023, the American Heart Association released a Presidential Advisory[12] on the interplay among metabolic risk factors, chronic kidney disease, and the cardiovascular system, emphasizing a critical need for cardiovascular-kidney-metabolic (CKM) prevention and management. But pulling all of the pieces together is easier said than done in terms of connecting the dots, working across silos, and eliminating barriers related to workflows, education, access, coverage, and more. Taler led a discussion of where healthcare organizations are to date, where they need to go, and what's standing in the way.

Advancing CKM Diagnosis

Many healthcare organizations today are ahead of the game when it comes to one aspect of CKM diagnosis: screening for chronic kidney disease. One participant reported digitally monitoring for it, through a nurse practitioner in most cases, for nearly a decade. Another is implementing urine albumin-creatinine ratio (UACR) screening for all kidney disease patients on CMS/Medicare Advantage plans. "The game is on with chronic kidney disease and stratifying all patients."

But other means of detection might be underused. Participants mentioned that patients with normal A1C readings are not normally screened for chronic kidney disease. Nor are patients with heart failure, even as one participant noted that home screenings for hypertension often revealed chronic kidney disease as well. Another participant observed that health systems don't often measure for waist circumference, a metric for obesity that could be a flag for kidney disease and CKM, saying, "I wonder if you could start there?"

Advancing CKM Treatment and Prevention

New obesity medications offer promise for treating kidney disease, Taler noted. Care teams are currently using SGLT-2 inhibitors, which lower blood sugar, for patients with deteriorating kidney function.

Obesity surgery offers benefits for kidney disease as well. At many healthcare organizations, a patient BMI of 40 is the cutoff for kidney transplant surgery, as higher BMIs make surgery more difficult. "Doing a sleeve gastrectomy first gets patients to a kidney transplant quicker," Taler said.

Challenges and Considerations for Moving Forward

Participants discussed the many obstacles to CKM diagnosis, prevention, and treatment. As one example, lifestyle management programs for conditions like diabetes declined during the pandemic and haven't regained traction since. In addition, access to many treatments and medications can be limited, especially for groups like seniors.

Then there's the ever-growing array of procedures being added into care team and billing workflows. "We're already confused on hypertension guidelines, so without any obesity guidelines, there's more confusion," was one comment. "We would love to have patients on SGLT-2, but it's unclear what is covered," another participant remarked as the discussion segued into the not-insignificant aspect of administration—namely, that for insurance to count a procedure toward an organization's risk stratification, staff have to code it first.

One participant, whose organization also participated in AMGA's Obesity Care Model Collaborative,[13] talked about how they had been implementing patient-centered care. This includes "asking patients what their goal is and proceeding from there" and building community health centers in underserved areas to address social determinants of health along with the behavioral health aspects of CKM.

The session concluded with optimism for and consensus on the importance of diagnosing and treating these interconnected conditions. "If you get rid of diabetes, kidney disease can improve," one participant remarked. "And the earlier we start, the better."

Breakout Session B:
Diabetes

Moderated by **Brian C. Jameson, DO**, *Endocrinologist, Geisinger Health System*

Obesity and diabetes in the United States represent interconnected trends of increasing urgency.

In 2021 data from the American Diabetes Association, 38.4 million Americans—11.6% of the population—had this condition, with 8.7 million in this group remaining undiagnosed. Beyond these figures, 97.6 million American adults have prediabetes,[14] for which blood glucose levels are higher than normal but not yet high enough to be diagnosed as diabetes.[15]

In the area of type 2 diabetes, which accounts for 90%–95% of the diabetes cases in the United States,[16] obesity increases the risk of developing the condition by at least six times, regardless of genetic predisposition to the disease.[17]

In this session, participants discussed the potential of treating diabetes and obesity together. "We have different tools than we've had in the past and more insight into behavior change," Jameson said. "By helping individuals with comorbidities and promoting weight loss, we get patients moving in the right direction."

Among the positive outcomes, he cited an insulin-resistant patient who was able to lose weight through a variety of treatment options. She was then able to manage her disease with insulin. Jameson called continuous glucose monitoring (CGM) a "a game-changer." But participants said that getting at-risk patients access to CGM is often easier said than done.

While Medicare has been advancing its coverage of these devices for patients treated with insulin, commercial payer coverage has been more variable. In addition, therapeutic inertia may also impede progress on CGM utilization. Participants remarked that many providers make assumptions about whether or not patients can afford this technology or if they'll be able to operate it, rather than actually having conversations with the patients via shared decision-making.

One barrier to such conversations is time. When the average patient visit is only 10 minutes, how can providers build CGM into their workflow? Hesitancy with technology presented another challenge, especially as blood glucose monitoring equipment has evolved significantly in recent years.

Geisinger's Multidisciplinary Approach to Treatment

Geisinger is working with the full range of frontline care professionals, as well as patients themselves, to improve diabetes and obesity outcomes, Jameson said.

Patients with type 2 diabetes and a BMI above 30 kg/m^2 are flagged in the electronic medical record (EMR), signaling health educators or trained staff to initiate CGM. This program is in both primary care and endocrinology specialty clinics, and coverage is dependent upon insurance, with the most common indications being hypoglycemia, use of injectables, and insulin. Patients participate in setting their own goals and receive standardized education on the device, enhanced by Geisinger's printed and digital resources. Then every week, the health educator meets with the patient to talk about how things are going and track progress.

This workflow takes the burden of CGM education and administration away from busy physicians, Jameson said. And on the patient side, interacting with the technology gives people awareness into their actions and increases their confidence in their ability to control both their blood sugars and achieve a healthier weight.

Putting This Approach into Practice

Participants had many questions, starting with how to educate providers and care teams on obesity and diabetes' many details, such as treatment, coverage, and the conditions themselves.

Repurposing the resources patients receive was one suggestion. Incorporating just-in-time guidance into workflows and EMRs was another, with one participant noting that this can be particularly helpful for battling time constraints as well.

Discussion emphasized the importance of support throughout the care cycle. Recommendations included general education on how to navigate a complex healthcare ecosystem and one-on-one assistance with specific tasks, like the steps involved in uploading CGM readings into a self-service patient portal.

"It takes a village," one participant observed. Others noted the importance of "aha moments that change people's lives," remarking that "knowledge is power!"

Further conversation centered on the overall approach—and importance of prioritizing these conditions. "Start treating obesity as a disease. Stop ignoring it as a byproduct."

Breakout Session C:
Cardiovascular Disease

Moderated by **John Clark, MD, PhD**, *Associate Professor, UC San Diego Health*

The session began with participants sharing a wide range of challenges and goals related to obesity and cardiovascular disease management, from improving care planning to making an argument for building the ROI. Reducing delays in diagnosis was another priority. "Currently we focus so much on the top of the population health triangle," one participant remarked, referencing the high-resource patients with healthcare expenditures many times higher than those for the rest of the population,[18] that "we miss patients with one or two comorbidities."

Clark then shared his own path into obesity care. As a provider helping patients manage conditions like hypertension, he encountered many who wanted to manage their weight as well. This led to specialized study in obesity care—an area he said he had no exposure to during medical school or training. "The first time I learned about pharmacogenetics for obesity was when I was studying for my boards."

Multiple Components and Considerations

How can a care team raise its level of care for patients with obesity and cardiovascular disease?

"There's obesity care that is done well and obesity care that is not," Clark declared. The former requires a multidisciplinary team and comprehensive wraparound services, with an initial evaluation covering sleep and cooking habits, mental health, prior medicine use, and the range of comorbidities beyond cardiovascular disease. "It's important to take into account multiple variables that can impact health goals."

"This is not cookie-cutter treatment," he continued and illustrated with an example. Because they often lead to weight loss, protein shakes can seem like an obvious choice for obesity treatment. But this may not necessarily be the case. Clark noted a 70-year-old male patient whose binge eating disorder was made worse by these meal replacements.

"There's a difference between weight loss and obesity management," Clark said. "If we do diets but don't treat the obesity, we can do more harm than good." Instead, use tactics like motivational interviewing to determine which patients might benefit from which treatments—and who might not.

Navigating Access and Coverage

In an ideal world, care and reimbursement models would support collaboration between obesity and cardiovascular care. "We've got to advocate for this," Clark said.

In the meantime, it is important to be aware of coverage status, lags, and gaps for various stages in the treatment process. Registered dietitians, for example, can be helpful for an initial patient visit to set expectations and let the patient know this treatment is a journey. But this is not often covered by insurance, and there can be long waits—up to a year—for such services.

Meanwhile, Medicare covers certain bariatric surgery procedures for eligible patients: those with a BMI ≥35 and at least one comorbidity related to obesity (such as type 2 diabetes), and have previously been unsuccessful with medical treatment for obesity.[19] Clark called these procedures "grossly underutilized."

Next Steps for Moving Forward

Clark concluded the session with key takeaways and advice.

Tap existing resources, such as care model materials from AMGA Foundation's Obesity Care Model Collaborative. "It's helpful to have a library of shared tools informed by obesity specialists and standardized tools to make sure you're giving and reinforcing the same things."

Work with electronic health records to build patient care plans, but be careful using claims data alone to guide care—especially given the increased prescription of diabetes drugs for patients who have obesity but not diabetes.

Assign responsibility for obesity care to the primary care provider. On a care team with multiple people, who should be offering obesity services? Clark recommended starting with primary care. "Obesity is part of chronic care and should be part of the primary care physicians' responsibility," he said. "We need to train more patients to take ownership of obesity care."

Educate obesity providers on effective communication. "Most doctors aren't good at having these conversations in a patient-centered way," Clark noted. It's imperative for training to cover potential pitfalls and harms. When considering bariatric surgery and medications, for example, providers should be aware of contraindications related to heart health and document this fully in the notes.

Advocate for patients with obesity. Organizations should stay current and speak out about policies like the Treat and Reduce Obesity Act. "Get out the information and advocate," Clark said. Finally, consider health equity in any treatment you use. "How do we ensure our tools are working well and equitably? Is it really helpful for the patient who really needs it the most?"

Panel Discussion

Speakers:

- **John W. Kennedy, MD**, President, AMGA Foundation, Chief Medical Officer, AMGA
- **Christopher M. Steer, Esq.**, Founder & CEO, Steer, LLC
- **Sandra J. Taler, MD**, Consultant, Division of Nephrology/Hypertension, Professor of Medicine, College of Medicine, Mayo Clinic
- **Brian C. Jameson, DO**, Endocrinologist, Geisinger Health System
- **John Clark, MD, PhD**, Associate Professor, UC San Diego Health

What are the biggest challenges in managing obesity along with kidney disease, cardiovascular disease, or diabetes?

Responses ranged from specific areas, such as checking for albuminuria, to overarching concerns, such as ensuring access to care and connecting patients to wraparound services.

One participant noted that checking for albuminuria is approved for patients with diabetes, but isn't necessarily included for patients with other risk factors. "In this case, we're missing a lot of people with early kidney disease and albuminuria who should be treated differently."

Another challenge: Matching the right patients to the right treatments. One participant pointed out that some treatments for weight loss might actually be harmful to some patients being treated for obesity.

Increasing knowledge in areas such as these is critical. Education needs to extend to both providers and patients, and there's one critical point to emphasize: Patients need to be aware that they have a disease like obesity or diabetes, and providers must be aware that obesity is in fact a disease. Without such education, obesity risks sliding to the bottom of the list during a patient visit—and it wouldn't be the first time a common and serious chronic condition was overlooked in such a fashion. "Back in the early 1900s, hypertension wasn't considered a disease," one participant pointed out for historical context.

Where are the biggest opportunities for improving health outcomes?

Here as well, the conversation centered on education. Patients and providers alike need to know about the therapies that are now available—from diet and exercise to GLP-1 and GIP medication therapies and including bariatric surgery—and the interconnected ways patients can benefit.

Eligibility for a kidney transplant is one example. For a patient with a BMI over 40 considered to be at additional risk for the procedure,[20] bariatric surgery can decrease these barriers. In one study, all 15 patients who underwent bariatric surgery were eligible for a kidney transplant within six months of the procedure.[21] "This is way better than the almost-nothing rate for people who do not get the sleeve gastrectomy."

Throughout, physicians and members of the care team need "confidence to understand the work and how they fit into the picture." This knowledge needs to be tempered with compassion. "Patients still say they feel stigmatized by their providers."

Where should organizations focus to identify the right patients and drive new treatment paradigms?

"It comes back to the access discussion," was one take on the question. Specifically, how can organizations work with patients to break down barriers to treatments like new obesity medications? Often the obstacle—and the answer—lies in insurance coverage or social determinants of health.

What are the key components of an obesity care team?

At one organization, departments like kidney care refer patients to an obesity core group that works closely with endocrinology and a dedicated bariatric surgeon who is also a transplant specialist. Any patients pursuing bariatric surgery go through a process of dietary training and psychological counseling.

"I've seen heart failure specialists trying to create service lines or care paths with the obesity specialists or orthopedic surgeons, trying to get people to surgery just like nephrology for transplants," one participant shared. "It's many iterations of trying to partner together to try to identify good candidates for collaboration or shared management of care."

At another organization, "we bring in anybody we can, really." This includes pharmacists, community health nurses, primary care representatives, population health specialists, and diabetes educators, as well as hospitalists and hospital management and members from the quality team who work on care gap closures. "We've really tried to have one big team where we have overarching goals and strategies."

The trick, according to one participant, is "making sure all our primary care providers, advanced practitioners, people on the front lines, and clinics understand the new medicines and how they work and that they can get some education on the fly if they need a refresher. Then we just focus on trying to get as many touch points with the patient as possible."

What efforts are out there for putting the patient at the center of healthcare decisions?

One recurring suggestion was more of an overarching attitude than a stand-alone initiative: Be sensitive and open-minded in patient conversations.

Be thorough as well. One participant noted "all of the topics I may cover besides history of diabetes or chronic kidney disease," such as asking about a patient's daily routine, who does the cooking in the household, stress on a scale from 1 to 10, history of anxiety or ADHD. "It's really trying to look at the patient as a whole."

"If you just let the patient talk, they can guide you to what they want." From there, it's a matter of knowing about available resources and guiding patients to them.

It's critical to manage patient expectations at every step, especially regarding time frames, quick fixes, and realistic progress. In the words of one participant: "This is a journey. This is not like we're going to meet you for our first visit and solve everything."

How are you incorporating technology into care plans?

Participants mentioned tools from apps to patient portals. "I think COVID kind of pushed a lot of people in that direction because people got more used to remote care and dealing with each other that way." Another participant observed that "obesity care models are ideally suited to digital health and telehealth," citing monitoring products such as subscription-based apps and coaching platforms. CGM was called "a game changer" leading to important "aha moments," and home albuminuria monitoring "a really good tool to have."

But increased use of wearables, monitoring, and alerts also raises many questions. How do you make the technology reliable and safe? What's the ideal cadence of triggers and alerts for patient engagement, and how do you avoid overloading providers with notifications? Finally, how do you turn all the data into actionable knowledge?

What disruptions are you seeing in your organizations?

Pre-visit patient research, gathered from social media and online search engines and passed along by friends and family, has been making an impact, as has the introduction of new GLP-1 and GIP medications—with some noting "a seismic shift" in treatments. "Typically, 70% of the patients who came in were referred to bariatric surgery," one participant noted. "And now, in the last six months, that has completely flipped."

Metabolic and bariatric surgery has become "grossly underutilized" amid these trends, with participants pointing out that these are among the few obesity treatments that are actually covered by Medicare and that many patients still face access limitations for the new medications.

Final Thoughts and Moving Forward

"What haven't we talked about yet that needs to be highlighted?" Kennedy and Steer asked participants in the final session, eliciting observations and remarks on a wide range of topics, from coverage and reimbursement challenges to the merits of providing services to a healthcare organization's own employees.

"We talked in our group about adding obesity as a code for billing purposes, but that would bring it out and put it in the chart, make the patient aware we're saying they're obese."

"We easily use the terms morbidly obese and severely obese when we would never refer to a patient with diabetes as diabetic or hypertensive. And it really matters, especially when we are in the position of taking care of these patients."

"If we do diagnose somebody with obesity, we need to make sure that we're discussing their disease in a patient-centric way."

"Knowing the limitations of BMI as a marker. There can be somebody with a BMI of 27 who has dyslipidemia or non-alcoholic fatty liver disease. It's more about moving that conversation forward."

"Obesity is a disease. It's a health problem. And we're going to talk about it and treat it like we would cholesterol, blood pressure, diabetes. I think that helps the patient understand that they're not being labeled."

"Just to recognize that obesity is a disease process. It's a driver of other things, and it leads to other problems. It's not a side effect of other things."

"Sometimes leadership is focused on RVUs, and it's very risky to make investments when there's a chance that you may not see the returns quickly. But if they spend more up front, that can prevent a lot of the morbidity later."

"Costs are going to come down eventually for these drugs. But in the interim, we need to produce outcomes."

It's important to diagnose and treat interconnected conditions. "If you get rid of diabetes, the kidney disease can improve. And the earlier we start, the better."

Tap existing resources, such as care model materials from AMGA's Obesity Collaborative. "It's helpful to have a library of shared tools informed by obesity specialists and standardized tools to make sure you're giving and reinforcing the same things."

"Making sure all our primary care providers, advanced practitioners, people on the front lines, and clinics understand the new medicines and how they work and that they can get some education on the fly if they need a refresher. Then we just focus on trying to get as many touch points with the patient as possible."

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