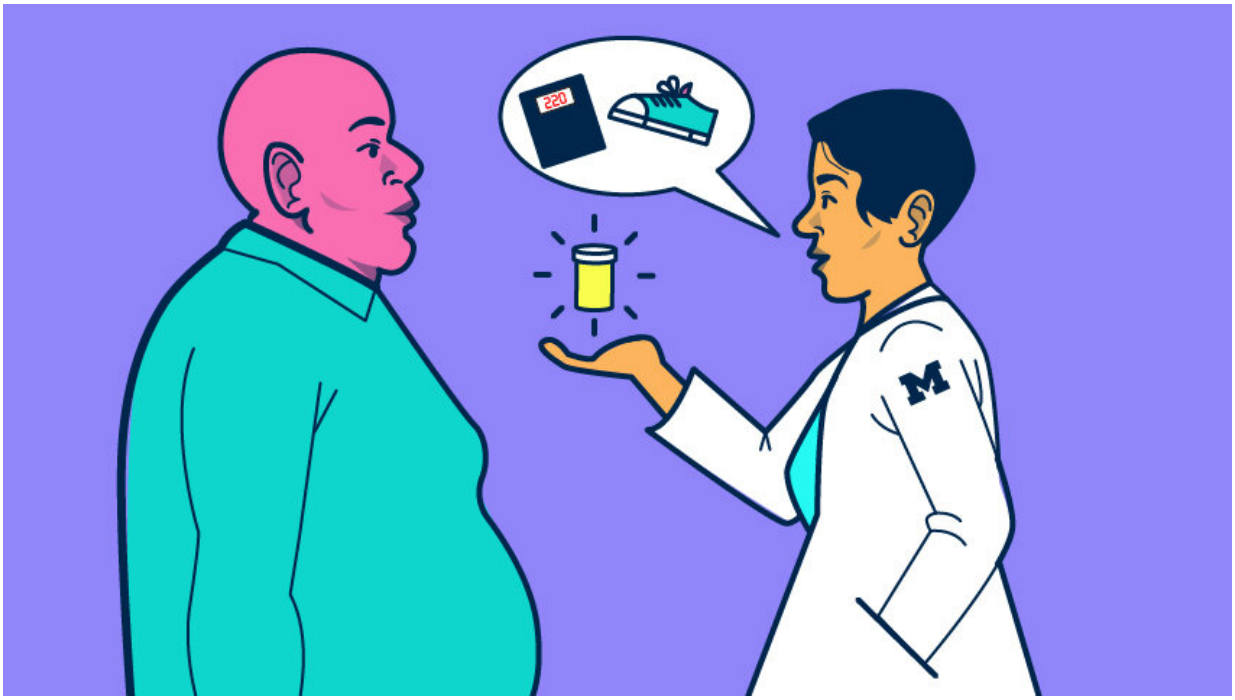
What will it take to transform obesity care for all?

May 31 2022



Primary care clinicians can prescribe obesity medications as well as lifestyle change to people with obesity. Credit: University of Michigan

When a person with diabetes, high blood pressure, or osteoarthritis goes to their primary care clinic, they expect treatment that's grounded in modern medical evidence.

That might mean nutrition and exercise recommendations, prescriptions

for medications, regular measurement of their progress and referrals for visits to specialists or even surgery.

But if they have obesity, they may not get the same level of evidence-based care for that chronic condition, recent studies have shown.

Why not? Like obesity itself, the answer is complicated, say Michigan Medicine primary care physicians with advanced training in obesity medicine.

The reasons include health insurance rules that exclude obesity medications and behavioral therapy, lack of training among primary care clinicians on best practices for treating obesity such as prescribing newer medications, and societal stigma against people with obesity.

And unlike those other chronic health conditions, few outside forces have driven primary care clinics to focus on providing high-quality, personalized obesity care for all.

That means it will take a multi-pronged effort to ensure that the tens of millions of Americans with obesity get better care, say Lauren Oshman, M.D., M.PH. and Dina Hafez Griauzde, M.D., M.Sc. of Michigan Medicine, the University of Michigan's academic medical center. Both are trained in obesity medicine and members of the U-M Institute for Healthcare Policy and Innovation.

Through a recently published framework for obesity care in primary care, and other efforts, they and others are helping lead efforts to ensure that more people with obesity can reduce their risk of developing, or suffering complications from, obesity-related conditions. These may include diabetes, high blood pressure and osteoarthritis.

Gaining a healthier control of weight could not only change and extend

these patients' lives and improve their well-being, but also save the nation tens of billions of dollars in health care costs, according to research published in *INQUIRY: The Journal of Health Care Organization, Provision, and Financing* in 2021.

"Obesity is a chronic disease and has been classified as one since 2013," says Griauzde, an assistant professor in the Division of General Medicine. "We need to remove the perception that obesity is willfully caused by unhealthy lifestyle choices, which has been a misperception historically held by the medical profession and is still a pervasive misunderstanding held by many today."

"We know now that obesity is a chronic disease caused by metabolic and hormonal changes, with influences from genetics, stress and community-level factors. And that means it is sometimes best treated by medications and surgery in addition to lifestyle change," says Oshman, an associate professor in the Department of Family Medicine. "Just as people with diabetes can manage their condition with lifestyle change but some need medication, the same is true for obesity. Treating obesity as a chronic disease in primary care, with a similarly graded, personalized approach, makes sense."

The insurance conundrum

One big hurdle: the lack of insurance coverage for a range of FDA-approved medications that treat obesity. Studies have shown they can help a person with obesity lose up to 15% of their body weight, much more than the 5% that diet and exercise might achieve with concerted, sustained effort.

But without insurance coverage, these medicines remain out of reach for many, especially people living with lower incomes, Oshman and Griauzde note.

That's why the two physicians teamed up to provide evidence about the costs and potential impacts of the drugs to the board that oversees Michigan's Medicaid prescription drug coverage.

That information helped lead to the approval of coverage of such drugs this spring for Michiganders with Medicaid insurance who have obesity (defined as a body mass index over 30 kg/m^2). The medication coverage also includes people with overweight (BMI between 27 and 30 kg/m^2) who also have a weight-related risk factor such as hypertension, coronary artery disease, type 2 diabetes, elevated cholesterol, or sleep apnea.

A growing number of states—but still fewer than half—have adopted similar provisions for their Medicaid populations. The Veterans Health Administration also covers the drugs for veterans in its clinics.

But Medicare still does not cover these drugs for people over 65 with obesity, because of a provision in the Part D prescription drug program that excludes coverage of weight control medications. A bill introduced in Congress last year seeks to change that.

And most prescription drug programs offered by employers do not cover the full cost of obesity drugs. That leaves patients paying hundreds or even thousands of dollars a month if they want to try an FDA-approved obesity medication—which they may need to take for years to keep weight off.

To reduce confusion, the team created a quick-reference guide for Michigan physicians that providers insurer-specific coverage information, coverage restrictions, and patient costs.

Even as insurance plans' coverage of obesity medications varies widely, many plans cover another obesity treatment: bariatric surgery.

It's more effective at reducing weight than medications or lifestyle change, but is also costly and carries risks, and getting insurance approval can involve multiple steps.

Those risks have declined in recent years in Michigan, thanks to a statewide effort to improve the quality of bariatric surgical care funded by the state's largest insurer, Blue Cross Blue Shield of Michigan. That effort, called the Michigan Bariatric Surgery Consortium, also works to help primary care providers understand who can benefit most from weight loss surgery. But once a patient has surgery, their insurance may not cover the medications that 1 in 4 of them may need to maintain that high level of weight loss.

Redesigning primary care to delivery effective obesity treatment

Another big hurdle standing in the way of effective obesity care is the lack of a primary care- based system for obesity care.

Primary care clinicians are expected to treat patients with obesity, but often lack the knowledge and time to do so effectively. Fortunately, a small and growing number of physicians are now certified in obesity medicine through the American Board of Obesity Medicine (ABOM) and can provide personalized and effective obesity treatment to individual patients.

That's why Griauzde and colleagues recently published a roadmap for a new way to integrate ABOM-certified physicians into primary care settings and break down clinical silos while individualizing care and supporting patients in their efforts to lose weight.

That roadmap serves as the framework for the new Weight Navigation Program at Michigan Medicine. This program is a joint clinical and research initiative led by endocrinologist Andrew Kraftson, M.D., who

serves as program director, family physician Amal Othman M.D., serving as medical director, and Griauzde as research director. Both Othman and Griauzde are ABOM Diplomates.

The Weight Navigation Program model embeds an ABOM-certified physician, called the Weight Navigator, in the primary care team to serve as an expert to other providers and patients with obesity.

The Weight Navigator meets with the patient for an extended consultation, developing a personalized obesity treatment plan using existing health system, community, and medication-based resources. These resources include intensive programs such as those offered by Michigan Medicine's Endocrinology and Cardiology divisions.

Another innovative aspect of the program is the use of a text messaging platform linked to patients' electronic health records, so patients can self-report their weight and progress to the Weight Navigation team and get extra help if they need it. A care manager tailors their outreach to patients to support them over time, address potential barriers, and facilitate changes to the treatment plan, if needed, to optimize patients' outcomes.

The program launched in late 2020 in one Family Medicine clinic and is now open to patients of all Family Medicine clinics across Michigan Medicine, with plans to expand to Internal Medicine clinics by the end of the year.

The team is studying the program's effects on patient outcomes and experiences. This data will help refine the program to provide better care for the entire population of people with obesity at Michigan Medicine and inform care delivery for other researchers and health systems facing similar obstacles.

"This program addresses known gaps in primary care for people with obesity and delivers personalized care that uses our health system's many resources, community resources and programs, and pharmacotherapy for weight management' says Griauzde.

At many health systems, Griauzde notes, "No one has looked at obesity care from a system level—everyone is siloed and seeing the patients they see and seeing who happens to show up for follow up." She hopes that by publishing on the new program they can help other systems adapt the approach as well.

Educating providers on obesity medication prescribing

It's hard for people with obesity to escape advertisements from pharmaceutical companies about obesity medications. Those ads aim to prompt discussions with their primary care clinician.

But that means clinicians need impartial information about the evidence behind the medications, the patients they're most appropriate for, and the potential out-of-pocket costs their patients might face if they try to fill a prescription for one.

Oshman recently gave a talk about the range of available medications and their pros and cons to clinicians who treat people with diabetes and prediabetes across Michigan, though the Michigan Collaborative for Type 2 Diabetes, another BCBSM-funded collaborative quality initiative.

Her talk, available for anyone to watch, uses de-identified patient case studies to examine treatment options in detail, and discuss insurance considerations. Her slides are available for download too.

The Obesity Medication Association and American Association of

Clinical Endocrinology also offer treatment reference tools for providers.

Griauzde notes that most of the medications approved for obesity are already prescribed by physicians for other reasons, including intensive blood sugar control in people with diabetes, depression, headache and tobacco cessation.

Depending on the patient's needs, most can be taken long-term to help achieve and maintain weight loss—just as medications to lower blood sugar, blood pressure and cholesterol are. But they should always be taken in conjunction with nutrition and activity program.

If a patient doesn't receive effective obesity care from their primary care provider, they may turn to commercial services of uncertain quality—and not tell their primary care provider they've done so. That could lead to risky clashes between medications.

On the other hand, many providers may still remember, or have heard of, the risks associated with a combination of medications used for obesity in the 1980s and 1990s, known colloquially as "fen/phen." If anything, she says, that experience has put more focus on safety of the current generation of obesity medications and ensuring the safety of the ones now in the pipeline.

The more recent experience of the pandemic shows the importance of addressing obesity in an evidence-based way, Oshman and Griauzde say. Obesity emerged as a major risk factor for developing severe COVID-19 or dying of it, and the higher rates of obesity in communities of color and low-income populations helped contribute to the higher COVID-19 death toll among members of these groups.

Often, treating obesity with medication can reduce the impact of

inflammation and hormonal impacts on patients' other conditions—and they may even be able to stop taking the medicines they've been on for other reasons. Griauzde notes that for primary care providers who engage in practicing obesity medicine, "it's bringing the joy back to primary care, because we can give people a chance to live a life with fewer medications overall, and a reversal of health consequences."

The Weight Navigation Program and the evaluation of its effects on patient outcomes are funded by the Elizabeth Weiser Caswell Diabetes Institute, the Michigan Center for Diabetes and Translational Research Pilot, and the National Institutes of Health (DK092926, DK123416).

"Developing weight navigation program to support personalized and effective obesity management in primary care settings: protocol for a quality improvement program with an embedded single-arm pilot study" was published in *Primary Health Care Research & Development.*

More information: Dina H. Griauzde et al, Developing weight navigation program to support personalized and effective obesity management in primary care settings: protocol for a quality improvement program with an embedded single-arm pilot study, *Primary Health Care Research & Development* (2022). DOI: 10.1017/S1463423621000906

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Provided by University of Michigan