Congressional Briefing: Ensuring Patient Access to Effective Treatments For Obesity

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Welcome

Lesli Foster
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Washington, DC
Opening Remarks

Beth Battaglino, RN-C
President & CEO
HealthyWomen
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Special thanks to Novo Nordisk for its financial support of this briefing
Opening Remarks: Legislative Solutions

US Rep. Brad Wenstrup, DPM (R-OH)
Sponsor, Treat & Reduce Obesity Act

State Senator Steven Bradford (D-CA)
Sponsor, Obesity Treatment Parity Act
US Rep. Brad Wenstrup, DPM (R-OH)
Understanding Obesity as a Chronic Disease

Angela Fitch MD, FACP, FOMA, Dipl. ABOM

President, Obesity Medicine Association
Chief Medical Officer, knownwell
Assistant Professor, Harvard Medical School
Obesity Is a Multifactorial Disorder

Genetics

Environment

Development

Behavior
The Science of Obesity

Obesity is a disease characterized by:

- Excess accumulation of fat in adipocytes (fat cells)
- Fewer new adipocytes being made than normal
- Expansion of organ volume
- Higher inflammation
- Dysregulation of metabolic process
- A body mass index (BMI) of 30.0 or higher
Obesity Is a Chronic Disease

“Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both … They are also leading drivers of the nation’s $4.1 trillion in annual health care costs.”

Key Point: Obesity meets the criteria set in this definition and is also linked to an array of other chronic conditions.
Obesity Is a Chronic Disease

... of Epidemic Proportions in the United States

4 out of 10 American Adults Live with Obesity

Prevalence of Obesity Based on Self-Reported Weight & Height, RFSS 2020-2022

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Obesity Treatment Is a Part of the Toolkit: 
**Anti-Obesity Medications (AOMs)**

AOMs work in different ways, including:

- Reducing fat absorption
- Reducing appetite & cravings
- Increasing feelings of fullness after consumption of food
- Working with your body’s hormones to keep adipocytes (fat cells) smaller

**Key Point:** Six AOMs have been approved by the U.S. Food and Drug Administration (FDA) for long-term use.
Clinical Data on Efficacy of AOMs

SELECT TRIAL

- **Study Design**: Multicenter, double blind, randomized control trial – patients assigned to semaglutide (AOM) or placebo, >17,000 participants: ~72% with BMI ≥ 30 and no diabetes history

- **Primary Study Endpoint**: Death associated with cardiovascular causes

- **Key Result**: Semaglutide reduces risk of cardiovascular death in people living with obesity or overweight without diabetes history by ~20% compared to placebo (hazard ratio, 0.80; 95% CI: 0.72 to 0.90; P<0.001)

**Key Point**: AOMs are safe, effective and should be part of the toolkit used to treat obesity
Long-Term Chronic Disease Management Is Key


10-year weight history of patient after surgery and long-term medication for maintenance

Overall mean baseline body weight = 107.3 kg

Change in body weight, %

Time after start of lead-in period, wk

Obesity, Co-Morbidities and Social Determinants of Health

Travis Batts, MD, FACC
Association of Black Cardiologists
Disclaimer

The views expressed in this discussion are solely my own. Any views, statements or inferences do not represent the United States Air Force, Department of Defense or any agency (state, local or federal) with which I am employed or affiliated.
What Is Cardiometabolic Syndrome?

**Cardiovascular Outcomes**
- Increased cardiovascular risk factor burden
- Increased coronary artery disease
- Increased heart failure (HFrEF > HfPEF)
- Increased atrial fibrillation
- Increased sudden death
- Increased venous thromboembolism

Substantial variability in end-organ consequences related to MetS underscores a need to identify subtypes of MetS on the basis of pathophysiology that can be targeted for specific evidence-based management strategies. ASCVD = atherosclerotic cardiovascular disease; MetS = metabolic syndrome.
CENTRAL ILLUSTRATION  Key Factors Involved in Visceral Obesity and Related Cardiometabolic Risk

Energy in:
- Poor nutritional quality
- Highly processed food
- High added sugar content

Energy out:
- Sedentary behavior
- Lack of physical activity

- Genetic susceptibility
- Stress
- Smoking

FIGURE 7  Steps in the Clinical Management of Obesities

- Long-Term Weight Loss
  - Visceral obesity
  - Nonpharmacological approaches
    - Caloric restriction
    - Lifestyle habits
  - Pharmacotherapy
  - Intra-gastric technologies and/or approaches
  - Pharmacological/technological approaches

- Treatment Intensity
  - Assessment of fat distribution and atherosclerotic dyslipidemia
  - Intensive cardiovascular risk factor modification
  - Cardiac diagnostics and targeted therapy (LVH, echo, MRI, cath)

- Surgical approaches
  - Gastric bypass
  - Biliopancreatic diversion with/without switch
  - Gastric banding, Sleeve gastrectomy
  - Severe obesity
Factors Contributing to Disparities

- U.S. Racial/Ethnic Disparities
  - Black
  - Latinx
  - Asian and Pacific Islander

- Limited access to resources
- Biopsychosocial allostatic load
- Early life adversity
- Low rates of antihyperglycemic medication use
- Patient-provider discordance
- Linguistic and communication barriers
- Inequitable distribution and quality of resources
- Discriminatory policies and practices
- Aggregated population-level data and analyses

- Clinical Practice and Outcome Factors
  - Experienced racism and discrimination
  - Acculturation
  - High risk lifestyle behaviors
  - Unmet social needs

- Systems/Structural/Environmental Factors
  - Racism at all levels
  - Unhealthy built environments

- T2D, Obesity
  - CVD
  - Poor A1c control
  - Post-bariatric surgery complications
FIGURE 2 The Present-Day Impact of Historical Discrimination and Racism on Obesity and Diabetes

↓ Trust in medical establishment

Health care provider bias toward minority patients

Structural and institutional racism

Language and communication barriers

Health Care Context
Poor access to care, ↓ quality of care, ↓ participatory decision-making in patient-provider relationships, ↓ health literacy

Physical Context
↓ neighborhood stability, cleanliness, sidewalks, open space, parks
↓ access to healthy food
↓ affordable housing

Stress, Obesity, Insulin Resistance, Blood Glucose

DISPARATE HEALTH OUTCOMES
Diabetes, Obesity, Heart Disease

investigation in public works, businesses, and school systems in minority neighborhoods; and discrimination in housing loans and high-quality jobs contribute negatively to social determinants of health, influencing metabolic disease outcomes. Adapted with permission from Golden et al (10).
Factors Contributing to Health Equity

- T2D, Obesity
- Homeostatic, biopsychosocial milieu
- Supportive childhood environment
- Access to resources
- U.S. Racial/Ethnic Disparities
- Black, Latinx, Asian and Pacific Islander
- Community Health Worker/Promotores Programs
  - Individual/Population Factors
  - Experienced inclusion and diversity
  - Met social needs
  - Acculturation*
- Clinical Practice and Outcome Factors
  - Patient-provider concordance
  - Lifestyle behavior modification
- Systems/Structural/Environmental Factors
  - Anti-racism actions at all levels

- A1c control
- Anti-hyperglycemic medication use
- Post-bariatric surgery improvements
- Certified interpretation and health literacy awareness
- Healthy built environments
- Equitable availability and quality of resources
- Use of disaggregated populations data in research
- Culturally and linguistically appropriate policies and practices

The State of Obesity: BETTER POLICIES FOR A HEALTHIER AMERICA 2019

With Special Feature on Racial and Ethnic Disparities in Obesity and Advancing Health Equity
Proposed Equity-Oriented Obesity Prevention Action Framework to assist in selecting or evaluating combinations of interventions that incorporate considerations related to social disadvantages and social determinants of health

Food retail and provision
Schools and worksites
Built environment
Parks and recreation
Transport

Promotion of unhealthy products
Higher costs of healthy foods
Threats to personal safety
Discrimination
Social exclusion

INCREASE HEALTHY OPTIONS

REDUCE DETERRENTS TO HEALTHY BEHAVIORS

IMPROVE SOCIAL AND ECONOMIC RESOURCES

BUILD COMMUNITY CAPACITY

Anti-hunger programs
Economic Development
Legal services
Education and job training
Housing subsidies; tax credits

Empowered communities
Strategic partnerships
Entrepreneurship
Behavior change knowledge and skills
Promotion of healthy behaviors

Source: National Academies of Sciences, Engineering, and Medicine

Partnering For a Healthier America

DNPAO partners with national, state, and local groups to advance the following programs and initiatives:

Early Childhood Education (ECE)
We partner with states to incorporate obesity prevention standards and practices into their ECE systems. We also support a selected group of ECE providers to make facility-wide improvements using a learning collaborative. These activities support breastfeeding, healthy eating, and physical activity.

Childhood Obesity Research Demonstration (CORD)
We focus on improving community-clinical collaborations to help prevent and manage childhood obesity in families with low incomes. We test a model that increases obesity screening and counseling services for eligible children in selected communities and refers them to local family healthy weight programs.

Childhood Obesity Data Initiative (CODI)
We work with the Task Force for Global Health to understand how well childhood obesity prevention and treatment strategies work by linking researchers, program analysts, and specialists.

High Obesity Program (HOP)
We fund 15 state grant universities in states with county obesity rates greater than 40%. Grantees work with local cooperative extensions to help increase the availability of healthy foods and safe, convenient places to be active.

Racial and Ethnic Approaches to Community Health (REACH)
We fund and support local groups in developing culturally-tailored community programs to assure good nutrition and physical activity are attainable for all people. The program empowers community organizations to identify their unique needs, assets, and opportunities to reduce chronic diseases and risk behaviors.

State Physical Activity and Nutrition (SPAN)
We fund and support state health departments in using evidence-based approaches to help people achieve good health. Together, we explore and implement strategies to increase access to healthy foods and promote safe places to be physically active.

Together, We Are Making a Difference!

- Obesity declined among toddlers in WIC aged 2 to 5 years from 15.9% in 2010 to 13.9% in 2016.
- Since 2010, 40 states have strengthened child care licensing regulations by incorporating high-impact obesity prevention standards.
- Since 2010, 5,346 schools obtained and offered salad bars to almost 3 million children to increase healthy fruit and vegetable options.
- The percentage of US adults meeting the aerobic physical activity guideline significantly increased from 44% in 2008 to 54% in 2018.

Help us keep America healthy and strong. Learn more at: cdc.gov/nccphp/dnpao

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Multi-Pronged Approach to Addressing Obesity

- No two patients are the same in pathophysiology or background – every person living with obesity needs a plan suited to their unique circumstances to achieve a better quality of life, inclusive, but not limited to maintaining a healthy weight.

- Access to all the tools in the toolkit, including treatments to manage obesity, is limited for too many patients. This must change if progress is to be made on obesity in the US.
The Perspective of a Patient Advocate

Michele Tedder, MSN, RN
Senior Program Manager at the Black Women’s Health Imperative (BWHI)
The Perspective of a Patient Advocate

Where I started:
- Internalized biases
- External biases
- Concurrent, chronic conditions:
  - Type 2 diabetes
  - High cholesterol
  - Joint issues
  - Sleep apnea
The Perspective of a Patient Advocate

Access to the right kind of care matters:

• Work with physicians you can trust
• Learn about different treatments and tools to help you meet your goals
• Don’t focus on any one specific number or on blaming yourself
• Weight management:
  • Not a "one and done" task
  • Ill-suited to a "one-size-fits-all" approach
• Individualized treatment plans should be accessible to all
My Journey

People living with obesity must have access to ALL options in the continuum of care.
Panel Discussion
Questions?
Please type questions in the Q&A box
Takeaways

• Obesity is a multifactorial, chronic disease impacting 40% of American adults.
• Obesity is linked to many other chronic conditions.
• Social determinants of health can complicate the ability to alter lifestyle.
• All people living with obesity need access to behavioral, nutrition and mental health counseling for obesity, as well as access to FDA-approved anti-obesity medications and bariatric surgery when appropriate.
• AOMs are promising, scientifically proven, effective treatment options that can assist people living with obesity in their weight management journey.
• Insurance coverage for all parts of the toolkit is key to achieving success!
• Comprehensive care — and insurance coverage for all parts of this care — are the keys to success in addressing obesity

KEY: Co-sponsor and pass the Treat and Reduce Obesity Act (H.R. 4818, S. 2407), and support complementary state legislation like the California Obesity Treatment Parity Act (SB 839).
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