Replacing Bias with Evidence in Obesity Policy & Practice

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Disclosures

• Consulting Fees
  – 3D Communications
  – Eisai
  – Enteromedics
  – HealthLogix
  – Novo Nordisk
  – Sentara Healthcare
  – St Luke’s University Health Network
  – The Obesity Society
• Research funded by the Obesity Action Coalition

Presentation Objectives

• Explain how bias undermines evidence based policy and practice in obesity
• Describe a more evidence-based approach to obesity policy and practice
• Describe major policy goals of the Obesity Care Advocacy Network
Replacing Bias with Evidence

What is bias in obesity?

What Is Bias?

Bias is an inclination or outlook to present or hold a partial perspective, often accompanied by a refusal to consider the possible merits of alternative points of view. Biases are learned implicitly within cultural contexts. People may develop biases toward or against an individual, an ethnic group, a nation, a religion, a social class, a political party, theoretical paradigms and ideologies within academic domains, or a species.

– Adapted from Psychology: Contemporary Perspectives

Paul Okami

Two Kinds of Bias Are Pervasive in Obesity

• Weight bias directed at people with obesity
• Intellectual bias favoring personal convictions
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How does bias affect obesity care?

The Impact of Bias Starts with Research & Scientific Literature

• Observational studies
• Short-term endpoints
• Surrogate endpoints
• Publication bias
• Repetitive studies build a bias of familiarity

“Many conjectures commonly advanced as recommendations to reduce weight gain or promote weight loss – ‘eat breakfast every day,’ ‘eat more fruits and vegetables,’ ‘eat more meals with family members,’ ‘reduce fast food availability’ ‘eliminate vending machines from schools,’ etc. – could be tested and we should challenge ourselves to do so more often”

Casazza and Allison: Stagnation in the clinical, community and public health domain of obesity

Myths and Presumptions Presented as Facts

Myths
• Small energy changes add up to big weight loss
• Realistic goals yield better weight outcomes
• Slow weight loss is best
• Readiness to change matters
• PE prevents childhood obesity
• Breastfeeding prevents obesity
• Sex burns 100-300 calories

Presumptions
• Breakfast prevents weight gain
• Exercise and eating habits learned shape weight for life
• More fruits & veggies will
• Snacking causes obesity
• Sidewalks and parks prevent obesity

Source: Casazza et al, 2013.01, NEJM
No Matter How Strong Links Do Not Equal Cause and Effect

Obesity Is Caused by More than Diet and Physical Activity
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Bias against people with obesity

What Is Weight Bias?

• Negative attitudes toward individuals with obesity
• Stereotypes leading to:
  – Stigma
  – Rejection
  – Prejudice
  – Discrimination
• Verbal, physical, relational, online
• Subtle and overt

Weight Bias Invades Every Corner of Life

Substantial Evidence of Bias in:
  – Media
  – Employment
  – Education
  – Healthcare
  – Interpersonal Relationships
  – Youth
Health Professionals Harbor Bias Against Patients with Obesity

- Non-compliant
- Lazy
- Lack self-control
- Awkward
- Weak-willed
- Sloppy
- Unsuccessful
- Unintelligent
- Dishonest

Ferrante et al., 2009; Campbell et al., 2000; Magilves et al., 2002; Forder, 2005; Durlak & Duva, 2009; Pratt & Moore, 2006; Rosenthal et al., 2010.

Historical Bias About Obesity

The best place to start is by simply telling the patient the truth. "Sir or Madam, it's not OK to be obese. Obesity is bad. You are overweight because you eat too much. You also need to exercise more. Your obesity cannot be blamed on the fast food or carbonated beverage industry or on anyone or anything else. You weigh too much because you eat too much. Your health and your weight are your responsibility."

Robert Doroghazi, MD
AJM, Mar 2015

Encountering Bias Discourages Patients from Seeking Care

- Delaying appointments
- Avoiding routine preventive care
- Seeking care in emergency departments
- More frequent doctor shopping
Bias Compromises Quality of Care

- Less empathetic care
- Less preventive care
- Patients feel berated and disrespected
- Obesity blamed for every symptom

“You could walk in with an ax sticking out of your head and they would tell you your head hurt because you are fat.”

Weight Bias Makes the Obesity Worse

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How does bias affect obesity policy?
Untreated Obesity Harms Nearly Every Organ System

- Pulmonary
- Nonalcoholic fatty liver
- Gall bladder disease
- Gynecologic
- Osteoarthritic
- Dermatologic
- Gout

- Intracranial hypertension
- Stroke
- Cataracts
- Cardiovascular
- Diabetes
- Pancreatitis
- Cancer
- Phlebitis

Our Sick Care System Treats the Results of Obesity

- Heart disease
  - Dyslipidemia
  - Hypertension
  - Coronary Artery Disease
  - $444 billion
- Diabetes
  - Heart attacks
  - Strokes
  - Kidney failure
  - Amputations
  - $245 billion
- Cancer, liver disease, and more

Treating Obesity? Not So Much

Primary Care Physician Practices

- Routinely Assessing BMI and Following Up
  - 28%
- Not
  - 74%

Source: Klabunde et al, 2014, Am J Health Promotion
Health Plans Have Long Discouraged People from Seeking Obesity Care

- Routine policy exclusions for obesity "Regardless of any potential health benefit"
- Lifetime procedure caps
- High out of pocket costs
- Problematic reimbursement rates and procedures
- Requirements for pre-authorization

General Population

"Do you have health insurance that would pay the cost of [ ] if you needed it?"

- Hospital
- Doctor
- BP Meds
- Dietitian
- Obesity Meds
- Medical Weight
- Bariatric Surgery

Note: Remaining respondents were unsure of coverage.

Wellness Programs

- Substantial financial incentives allowed
- Based upon biometric outcomes
- Including BMI
- Reportedly being adopted by employers with increasing frequency
**Employed Respondents**

"Does your employer have a wellness program with incentives or penalties based on your weight or BMI?"

- **Yes**
- **No/Not Sure**

**Employed Respondents With BMI-Based Wellness Programs**

"Do you have health insurance that would pay the cost of [ ] if you needed it?"

- **Diet**
- **Exercise**
- **Obesity Meds**
- **Medical Wt Mgmt**
- **Bariatric Surg**

Note: Remaining respondents were unsure of coverage.

**Study Findings**

- Consumers most often report not having health insurance that will cover obesity treatment
- Even when employers target BMI in wellness programs
  - As they increasingly do
  - Consumers often say their health insurance excludes obesity treatment
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Moving Toward Better Access to Care

Change Over Time in Barriers to Obesity Care

Milestones in Regarding Obesity as a Disease

Evolving Reimbursement for Obesity Care: Counseling

Prior to 2012: Considered Feeble: most payers bill for services rendered primarily to treat obesity

As of 2012: Medicare and most private payers cover obesity treatment. Many also covering counseling given by DCPs

Going forward in 2015: Affordable Care Act (ACA) mandates coverage of obesity treatments and counseling by PCPs

Prior to 2012: Private payers covered medical costs only when BMI > 40

Currently: Medicare and most private payers provide coverage for annual obesity screening, obesity counseling and medical management of obesity if BMI ≥ 30

*Some payers limit coverage to BMI ≥ 35 with a comorbidity doctor. Presented by Michael S. Kaplan, 2015
CMS Expanding Coverage of Diabetes Prevention & Obesity Care

Bariatric Surgery Coverage in Employer Health Plans Steadily Improving

Improvement in Obesity Med Coverage Largely Anecdotal

- Transparency lacking
- 2014: OPM warns against excluding obesity meds from federal employee plans
- 2015: NCOIL calls for coverage of the “full range of obesity treatments”
- Formularies with 74 million covered lives now include obesity meds
  - Aetna and Express Scripts began covering obesity meds in 2012
  - Saxenda was added to the CVS Caremark 2016 formulary

Access to Obesity Care

The Impact of Access to Obesity Care

Metabolic Surgery Outcomes
Bringing Calls for Better Access

Type 2 Diabetes Remission Rates

Gastric Band

Gastric Bypass

Source: Courcoulas et al., 2015.07.01, JAMA Surg.

Cost Benefit Analysis
Increasingly Favors Surgery

• UK NICE Guidelines
  – Expedited assessment in BMI>35 with recent-onset type 2 diabetes
  – Also assess for BMI 30-35
• California Technology Assessment Forum
  – Unanimous decision favoring surgery for BMI 30-35 with type 2 diabetes
Cost Benefits Driving Better Access for Behavioral Care

- Growing movement to expand programs following the Diabetes Prevention Program
- CMS actuaries found $2650 cost savings per Medicare member over 15 months

Access to Care Is Most Problematic in the Middle

Health Economics Literature on Obesity Drugs Is More Limited

- Cawley et al, 2014
  - Savings in Medical Expenditures Associated with Reductions in Body Mass Index
  - Savings in annual medical costs from a 5% weight reduction
  - $2,127 for a starting BMI of 40
  - $1728 a starting BMI of 35
  - $60 for those with a starting BMI of 30
  - Costs for individuals with diabetes are greater
  - At high levels of BMI, thousands of dollars per year

- Ara et al, 2012
  - Clinical effectiveness and cost-effectiveness of using drugs in treating obese patients
  - Cost-effective when using a threshold of £20,000 per QALY
  - Analysis reflects older obesity drugs only

- Finkelstein et al, 2015
  - Cost-Effectiveness Analysis of Qsymia for Weight Loss
  - Cost-effectiveness highly dependent upon sustained use & benefit
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Shifting public views of obesity

“Obesity Is a Personal Problem of Bad Choices”

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Competing Obesity Narratives

- **Moral Failure**
  "Obesity is such a big problem because too many people don’t take personal responsibility for eating right and exercising. It’s disgusting."

- **Addiction**
  "Obesity is such a big problem because too many people get hooked on junk food and sugary drinks. They’ve become addicted and can’t help themselves."

- **Environment**
  "Obesity is such a big problem because the food industry sells so much unhealthy food while modern lifestyles make adequate exercise impossible."

- **Disease**
  "Obesity is such a big problem because too many people get blamed for this disease instead of getting the medical help they need."

Adapted from Thibodeau et al. 2015.09
Conclusion from Obesity Narratives

• Signs of increasing acceptance for:
  – Medical narrative
  – Environment narrative

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Advocating for a better approach
The mission of the Network - Unite and align key obesity stakeholders and the greater obesity community around key obesity-related education, policy, and legislative efforts in order to elevate obesity on the national agenda.

The primary goals of the Network are to:
- Prevent obesity disease progression
- Improve access to evidence-based treatments for obesity
- Improve standards of quality care in obesity management
- Eliminate weight bias and stigma

Screening & Prevention
- Evidence-based obesity care for prevention of chronic disease
- USPSTF
- CMS IBT
- IBT pilots

Access to Obesity Care
- Senate Chronic Care Workgroup (ongoing)
- Treat and Reduce Obesity Act (ongoing)
- Medicaid Healthy Families
- State employee health benefits
- FEHB/OPM
- DOL – letter to state insurance commissioners
- OPM

Quality Standards
- Obesity quality measure workgroup (ongoing)
- Roundtable (Jan 19, 2016)
- Workshop
- CMS Quality Measure Development Plan (March 1, 2016)
- CMS/AHIP Quality Measures Core Set (comment period)
- CMS Call for Measures (June)

Weight Bias & Stigma
- Obesity is a disease
- ACA Guidance: broad exclusions impermissible
- Cost benefits of intensive behavioral care
- CMS leading the way on broader access to DPP
- Steady improvements in formulary status for obesity drugs
- Rising patient advocacy

Conclusions and Reasons for Encouragement
- Rapidly growing understanding of obesity
- Health policy on obesity playing catch-up
- Bad coverage habits die hard
- But they are dying
  - OPM ruling banning cosmetic/lifestyle exclusions
  - ACA Guidance: broad exclusions impermissible
  - Recognition of value for surgery
  - Cost benefits of intensive behavioral care
  - CMS leading the way on broader access to DPP
  - Steady improvements in formulary status for obesity drugs
  - Rising patient advocacy
More Information

• More information: www.conscienhealth.org/news
• For these slides: http://conscienhealth.org/wp-content/uploads/2016/05/biasevidence.pdf