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Enhancing Obesity Management: Harnessing the Power of Clinical Care Pathways

This publication is sponsored by Eli Lilly and Company.

Obesity is a serious and highly prevalent chronic disease. It increases the risk or severity of hundreds of related comorbidities and complications. Obesity is associated with an increased risk of morbidity and mortality that is often driven by these related conditions, including metabolic disorders, cardiovascular diseases, and certain cancers.¹⁻⁴ Obesity affected approximately 41.9% of US adults from 2017 through March 2020, according to an analysis of data from a National Health and Nutrition Examination Survey (NHANES).^{5,6*} This serious, chronic disease disproportionately impacts non-Hispanic Black and Hispanic adults, those with a lower family income, and individuals who have not completed a college education.⁶

The economic toll of obesity also is staggering. Results of an analysis of health economic literature on obesity-related costs and data from the Medical Expenditure Panel Survey (MEPS) by the Milken Institute showed that obesity and overweight accounted for 47.1% of total direct and indirect costs of chronic diseases in 2016, or approximately \$1.7 trillion (2016 US\$).¹

DIAGNOSIS OF OBESITY

Though with some controversy, diagnosis of obesity currently involves measurement of body mass index (BMI).⁷ Increasingly, diagnostic assessment also includes observing or testing for the presence or risk of obesity-related diseases and considering an individual's characteristics (eg, sex and gender, age, ethnicity, waist circumference,

and body composition).^{3,8} A BMI of 25 kg/m² or greater is typically defined as overweight, whereas obesity is defined as a BMI of at least 30 kg/m².⁸ An obesity diagnosis may be further divided into classes—class I (BMI, 30-34.9 kg/m²), II (BMI, 35-39.9 kg/m²), and III (BMI, ≥40 kg/m²)—which are associated with a moderate, severe, and very severe risk of obesity-related diseases, respectively.³ In addition to BMI, waist circumference, waist to hip ratio, and body composition measurements can help in the diagnosis of patients who have overweight or obesity. Analysis of body composition can include bioelectrical impedance, air/water displacement plethysmography, and dual-energy x-ray absorptiometry scanning.^{3,9}

OBESITY MANAGEMENT

Each person with obesity is unique, and a range of factors contribute to obesity development and perpetuation; thus, treatments should be multifaceted, patient-centered, and individualized.¹⁰ Guidelines recommend that the primary goal of obesity management should be to improve patient health by preventing or treating weight-related complications through weight reduction as opposed to focusing solely on body weight reduction.³ These guidelines correspond with the 2020 Canadian clinical practice guidelines for treating obesity in adults.¹¹ There is general agreement that guidelines must be modernized and more broadly applied. Obesity Medicine Association guidelines state that the overall goals of obesity treatment should include improving

*Lower family income included a family income relative to at most 350% of the federal poverty level; below college degree included attainment of a high school diploma or some college or less than a high school diploma.⁶ Limitations of the study include the use of enhanced weighting adjustments to mitigate potential nonresponse bias; comparisons over time for subgroups between this and previous NHANES analyses should be interpreted with caution due to study methodology and unequal time period spacing in this analysis (2017-2018 and 2019-2020 cycles were combined; data collection was stopped in March 2020 due to barriers related to the COVID-19 pandemic).⁶

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THE AMERICAN JOURNAL OF MANAGED CARE

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patient health, quality of life, and body weight and composition via individualized treatment through an ongoing partnership between patients and health care providers (HCPs).¹⁰ A healthy dietary pattern and adequate physical activity are important components of effective weight management, and specific recommendations should consider patients' preferences and socioeconomic and cultural backgrounds. Although lifestyle interventions may be sufficient for some patients, others may also require pharmacotherapy and bariatric procedures to achieve and maintain meaningful weight reduction.¹⁰

The choice of whether to implement evidence-based lifestyle therapy alone or to combine it with pharmacologic intervention using an antiobesity medication (AOM) or metabolic and bariatric surgery depends upon the severity of each patient's obesity and related complications, treatment history, preferences, and risk-benefit ratio.^{3,8} If lifestyle modification is indicated, HCPs should collaborate with patients to identify health behavior goals and strategies to improve health and decrease the risk that obesity-related diseases progress.^{3,8} Pharmacologic intervention for obesity may be considered in patients with a BMI of 30 kg/m² or those with a BMI of 27 to 29.9 kg/m² and at least 1 weight-related comorbidity.³ According to American Society for Metabolic and Bariatric Surgery Guidelines, metabolic and bariatric surgery may be considered for patients with a BMI of at least 35 kg/m² regardless of the presence, absence, or severity of comorbidities.¹²

CARE EXPERIENCES OF PATIENTS WITH OBESITY

Evidence suggests low rates of discussion or utilization of obesity treatment modalities beyond lifestyle intervention among HCPs and patients. The results of a survey showed that counseling on lifestyle changes was almost universally offered (> 92%), whereas discussions on metabolic and bariatric surgery or AOMs with eligible patients

were much less common.^{13*} Only 24% and 33% of respondents discussed AOMs with patients who had a BMI of 30 to 39 kg/m² and at least 40 kg/m², respectively; metabolic and bariatric surgery was discussed with 76% of patients who had a BMI of at least 40 kg/m². More than 80% of surveyed HCPs did not offer AOMs to patients with obesity.¹³

Results of OBSERVE, an online survey study, revealed that of eligible patients who had never taken an AOM, 64.2% were unaware that these drugs were available.^{14†} According to the respondents, the most important factors associated with an increased likelihood of trying an AOM were a recommendation from an obesity specialist (72.2%) or primary HCP (69.1%) and insurance cost coverage (67.1%).¹⁴

ECONOMIC IMPACT OF OBESITY

Medical costs associated with obesity more than doubled between 2001 and 2016, accounting for total costs of \$260.6 billion in the United States in 2016. The results of a study of the 4 most populous states in the United States (ie, California, Texas, New York, and Florida) showed that annual medical care expenditures for adults with obesity were 2-fold higher than were those for people with a lower weight (\$5010 vs \$2504, respectively). People with a BMI of at least 40 kg/m² had 233.6% higher costs than did those who had healthy weight (\$5850 vs \$2504, respectively).¹⁵

UNMET NEEDS IN OBESITY MANAGEMENT

There is an unmet need for discussions about obesity and its treatment among HCPs and patients with obesity (**Figure 1**).¹⁶⁻¹⁹ Although BMI screening and obesity diagnosis are integral first steps in obesity care, only about half of adults with a BMI of at least 30 kg/m² have a documented diagnosis of obesity.^{3,16,20} Moreover, many HCPs do not discuss weight loss with their patients; these medical professionals

*The study evaluated self-reported treatment recommendations by providers and barriers to treatment in a multicenter academic health system. Among 111 respondents, 94% discussed BMI with their patients; only 43% and 56% recommended weight loss in more than 50% of clinic visits for patients with BMI 30 to 39 kg/m² and at least 40 kg/m², respectively. This study was limited by its small sample size and the nonvalidated questionnaire used for the survey.¹³

†Based on data from the OBSERVE study. A total of 917 US patients with a BMI of 27 to 29.9 kg/m² and at least 1 obesity-related comorbidity or patients with a BMI of at least 30 kg/m² were evaluated to understand the barriers to AOM use. Of the respondents, 19.9% were currently being treated or were previously treated with an AOM. The mean BMI of the respondents was 36.0 kg/m². The study was performed from May 2022 to June 2022.¹⁴

believe that they lack the necessary appointment time to discuss obesity care, and they may prioritize the treatment of other conditions, including those that are related to excess adiposity. HCPs can struggle with counseling patients on actionable lifestyle changes, and they may only be comfortable in discussing obesity when related comorbidities are present. Among 606 HCPs surveyed as part of the ACTION study (NCT03223493), 72% agreed that they had a responsibility to contribute to patient weight loss efforts, yet 33% of respondents lacked comfort in discussing weight management with their patients.^{16,*} Further, these HCPs rarely prescribed AOMs to patients with obesity.¹⁶ HCPs also have expressed that they have limited knowledge about referring patients for metabolic and bariatric surgery and, particularly, their related complications and follow-up.²¹

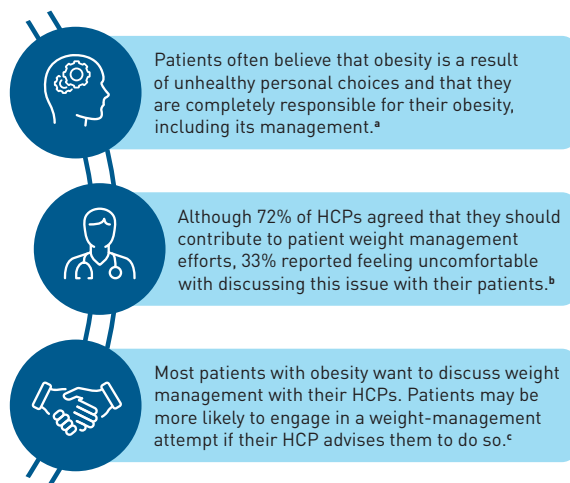
Low discussion rates may contribute to limited implementation of AOM therapy and metabolic and bariatric surgery in eligible patients with obesity. In an analysis of NHANES data from 2015 to 2018, MacEwan and colleagues found that 0.8% of eligible individuals (defined in the study as having a BMI ≥ 27 kg/m² and ≥ 1 related comorbidity or BMI ≥ 30 kg/m²) had used an AOM in the past 30 days.^{22,†} Another study of data from the Metabolic and Bariatric Surgery Accreditation and Quality and Improvement Project demonstrated that less than 0.6% of patients with a BMI of at least 40 kg/m² underwent metabolic and bariatric surgery from 2015 to 2018.²³

Weight bias and stigma are highly prevalent in health care settings, which can negatively impact patients' mental and physical health and can reduce the quality of health care. HCP bias towards patients with obesity manifests as not recommending available treatments and spending less time with patients who have obesity compared with those having lower weight.²⁴ Experiencing weight bias is associated with worse physiologic and psychological health in adults with overweight or obesity.²⁵ Therefore, it is important to develop health care system approaches that limit weight bias and stigma to potentially improve health and quality of care for patients with overweight and obesity.²⁶

COVERAGE AND COST SAVINGS OF OBESITY TREATMENTS

Coverage of guideline-recommended obesity treatments continues to expand. Under the Patient Protection and Affordable Care Act of 2010 (ACA), coverage of "intensive, multicomponent behavioral interventions (ie, behavior-based weight loss and weight loss maintenance interventions)" is required.^{27,28} Nutritional counseling coverage is mandated in most states; approximately half of states require coverage

Figure 1. Patient and Provider Perceptions Around Discussing Obesity¹⁶⁻¹⁹



HCP, health care provider.

^aResults of the OBSERVE and ACTION studies—surveys of adults with overweight or obesity^{14,17}

^bStatistics taken from the ACTION study¹⁶

^cResults of the ACTION study and conclusions from a Mayo Clinic analysis^{18,19}

for metabolic and bariatric surgery, and 2 states (ie, Virginia and New Mexico) mandate coverage of AOMs under the ACA as of 2021.²⁹ Changes such as those introduced in the Treat and Reduce Obesity Act of 2023 could expand Medicare Part D coverage to include use of AOMs for eligible patients.^{30,31} The US Office of Personnel Management (OPM), the largest employer in the United States, recently reiterated that obesity is a chronic disease that increases the risk of developing related diseases.^{32,33} The OPM also clarified that AOMs must be covered under the Federal Employees Health Benefits Program and that any exceptions must be explained.³³

Use of AOMs has been associated with total health care cost savings. According to results from a real-world analysis of data from the IBM MarketScan Commercial Claims and Encounters Database, after 2 years of follow-up, patients with obesity who were treated with AOMs experienced weight reduction and reduced total costs of

*This study was limited by self-reported data gleaned from the ACTION surveys, which may prove unreliable. Further, selection of respondents may have been skewed due to the survey response rate (10%-20%) and average length of time needed to complete the survey (> 37 minutes).¹⁶

†Based on a cross-sectional study of 2015-2018 NHANES data and 2016 MEPS data performed to estimate AOM use among patients eligible to receive AOMs in the United States. Patients (NHANES, n = 34; MEPS, n = 76) taking any AOM approved by the FDA were assessed. Results may be limited by the inclusion of only patients with specific comorbid conditions. Further, survey data are subject to recall bias and misreporting. For this study, the sample size was small and time frame was limited. Reasons for discontinuing use of AOMs were not examined.²²

Figure 2. Considerations When Planning and Implementing Obesity Management Programs^{37,38}



patient views and outcomes.³⁶ General practitioners and multidisciplinary support teams can play a crucial role in helping patients achieve sustainable weight loss.^{3,8,19,36,37}

In light of the need to broadly improve care for people with obesity and with contemporary knowledge and tools to support such improvement, the development and implementation of evidence-based clinical care pathways presents an opportunity for all providers to follow evidence-based, guideline-recommended care. A clinical pathway—also referred to as a care pathway, integrated care pathway, or management guidelines—provides clinicians with guidance on how to best approach and treat a patient with a specific disease state.³⁸

The algorithms included in the pathway contain evidence-based recommendations for screening, diagnosing, and monitoring patients; achieving treatment goals; and implementing interventions based on established clinical practice guidelines. Clinical care pathways may extend throughout the patient's disease course and across multidisciplinary teams.³⁸

Development of a standardized clinical pathway would help reduce treatment variation among providers within a health system and improve adherence to evidence-based

care.^{34,*} Across all 3 obesity classes, patients treated with AOMs saw non-AOM medication costs savings of \$1321 to \$1952 between year 1 and year 2 of treatment and total health care cost savings of \$1323 to \$2766.³⁴ The greatest total cost savings were seen among those patients with class 3 obesity.³⁴ Commercial plan sponsors weighing the addition of AOMs to their formulary may consider outcomes-based contracts and other options that ensure that the appropriate patient population receives treatment while mitigating some risk.³⁵

CLINICAL CARE PATHWAYS IN OBESITY

Hayward and colleagues showed that when HCPs conduct conversations about obesity in a supportive manner, they may achieve positive

guidelines. Standardized approaches also can be used to maintain information management for individual care; it then can be aggregated to inform health system population care and emphasize that, ultimately, care is individualized based on patient needs.³⁸

A US primary care, population-based delivery model may be a practical way to implement obesity management strategies. Suggested best practices for implementation include multidisciplinary collaboration across specialties, use of systems to monitor quality of care and identify barriers to implementing the program, training for leadership and staff, establishment of community partnerships, and effective use of available resources.³⁷ Such initiatives in obesity management provide an opportunity to improve real-world patient outcomes (Figure 2).^{37,38}

*Based on an analysis of claims data from 250 health plans in the United States involving 219,971 adults (age, 18-63 years) with commercial health care coverage and a BMI of at least 30 kg/m² or a BMI of 27 to 29.9 kg/m² and at least 1 comorbid condition. A total of 1405 patients were prescribed at least 1 AOM, whereas 218,566 patients were identified as AOM nonusers. Claims data used were from January 1, 2015, to December 31, 2019; costs were adjusted (2019 US\$). Differences in prescription medication costs (excluding AOM costs) after 2 years were -\$1321 (95% CI, -\$2261 to -\$381; *P* = .006) for patients with class 2 obesity and -\$1952 (95% CI, -\$2946 to -\$958; *P* < .001) for patients with class 3 obesity. Differences in total health care costs (excluding AOM costs) after 2 years were -\$1757 (95% CI, -\$3599 to \$86; *P* < .062) in patients with class 1 obesity, -\$1323 (95% CI, -\$4230 to \$1584; *P* = .372) for patients with class 2 obesity, and -\$2766 (95% CI, -\$4934 to -\$597; *P* = .012) for patients with class 3 obesity. Limitations included that only a commercially insured population was evaluated; the results may not be generalizable to noncommercially insured patients. Also, health care resources may be used more frequently by patients with obesity than by healthy patients, leading to more information on patients with obesity being captured in the database.³⁴

CONCLUSIONS

Obesity is a serious and chronic disease that negatively impacts health and quality of life and contributes to increased health care expenditures. Obesity care efforts are improving. However, challenges remain because of numerous health system and treatment execution barriers. Well-designed and rigorously implemented obesity clinical care pathways show promise as an area of focus for broadly improving care and care outcomes. Specifically, obesity clinical care pathways can reinforce use of evidence-based treatment guidelines leading to patient-centric care. Such pathways could improve quality of care and reduce bias and stigma, which must be addressed and overcome. Improving obesity care and the incidence and severity of related complications may help to improve health and quality of life and decrease health care costs. •

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Advancing Obesity Management Through Clinical Care Pathways: Insights and Best Practices From Key Opinion Leaders

KEY LEARNINGS

- Programs that involve a multidisciplinary therapeutic approach and individualized care are crucial to the treatment of an increasing number of patients with obesity and related comorbid conditions.
- Administrative buy-in is vital for successful obesity clinical care pathways. Cost reductions and improved patient outcomes strengthen the case for program implementation and garnering administrative support.
- Integration with population health management tools and dashboards enables health care teams to monitor weight data, referrals, and program engagement to facilitate personalized and effective care when implementing clinical care pathways.

The increasing population of people with obesity and related conditions has created an opportunity to develop programs that involve a multidisciplinary treatment approach and individualized care that depends on patient needs. Editors from *AJMC* spoke with key stakeholders from the University of Michigan in Ann Arbor; University of Colorado in Aurora; NP Obesity Treatment Clinic in Flagstaff, Arizona; and Massachusetts General Hospital Weight Center in Boston about the challenges and unmet needs of managing obesity, care pathways and practices used at their institutions, and approaches for developing obesity management programs. Highlights of this discussion include the importance of involving primary care physicians (PCPs), nurse practitioners (NPs), and physician associates to identify and treat patients with obesity and the urgent need for organized initiatives and improved access to electronic health record (EHR)-based decision support tools, PCP training, and weight-focused patient visits. Administrative buy-in, characterized by the support and commitment of organizational leaders, emerged as a pivotal factor in implementing and sustaining obesity treatment programs. Before development of systemic programs, obesity care pathways often were individually designed; however, there is increasing intent among health care professionals (HCPs) to create multidisciplinary approaches to understand, manage, and meet the needs of patients with this serious, chronic disease.

***AJMC*: Can you share what prompted your team to focus on obesity management?**

All stakeholders recognized a large unmet need in how HCPs at their institutions were managing patients with obesity. For example, **Angela Golden, DNP**, observed an opportunity for change in her own community in Flagstaff, Arizona. “Before I opened my practice, there were no providers who specifically focused on the treatment of obesity,” she explained. “Most of the providers who I knew in our community were aware of the hospital-based metabolic and bariatric surgery program only. Nutrition and activity programs were offered for those patients who were not candidates for surgery; however, there was no medical management of obesity in our community at all.”

Many stakeholders attributed these treatment gaps to a lack of awareness among PCPs of available resources. Even with available resources, physicians may not be sure how to use them, partially because of variations in program requirements and insurance coverage and a lack of time to discuss options with patients during routine clinical appointments. At the University of Michigan, obesity treatment options were available through subspecialty care programs, but **Andrew Timothy Kraftson, MD**, observed opportunities for improvement. “[At the University of Michigan], we are known for subspecialty care,” Kraftson said. “We have excellent programs in bariatric medicine—intensive weight management [that include very low-calorie diets using meal replacements], metabolic fitness, and more. However, these programs can be siloed, and we found that PCPs and patients were having trouble navigating the system. Some patients also did not meet the criteria for these programs or the programs did not align with patients’ preferences, and so care gaps existed in the system. Originally, the idea [to develop a pathway] was to develop a mechanism through which patients would be participants and providers would evaluate their journey with obesity and assist in the navigation of these particular specialty programs.” The key features of the Weight Navigation Program (WNP) include: 1) integration of American Board of Obesity Medicine (ABOM) diplomates into primary care teams to serve as expert consultants; 2) implementation of weight-focused visits with ABOM diplomates; 3) preference-sensitive use of available weight-loss treatment options (including health system, community, and pharmacotherapeutic resources); and 4) use of population health management tools to proactively identify and support individuals to achieve at least 5% weight loss.

Early on, the HCPs involved in developing obesity management programs at the University of Michigan realized the importance of involving PCPs. According to **Dina Hafez Griauzde, MD**, “[Effective weight management starts in the primary care setting]; PCPs are charged with identifying patients with obesity and ideally helping them develop an individualized preference-sensitive treatment plan.” Because of this, Kraftson explained, they developed a mini-sabbatical program through which PCPs who are ABOM diplomates

working in the context of the Weight Navigation Program (5 PCPs to date) can rotate among the different obesity-management specialty programs to gain firsthand knowledge about the programs offered. Diplomates also hold an obesity medicine certification program through the ABOM.

AJMC: What was the patient journey before the development of the obesity management programs?

Before the development of these organized initiatives, stakeholders shared that limited options were available for managing patients with obesity. According to Golden, “Anybody who would talk to patients about their weight would just tell them they needed to eat better and move more.” Other stakeholders provided similar responses. **Angela Fitch, MD, FACP, FOMA**, noted, “Providers were still telling patients to eat less and exercise more, because many did not know that only about 5% of patients would be successful with that intervention.” In the absence of organized initiatives, Fitch shared, lifestyle interventions were the primary recommendation for obesity management, and follow-up care or professional guidance was not provided. Patient body mass index (BMI) was measured during primary care visits, but that information was not used to improve the care of patients with obesity. “When I was working in primary care, we had no antiobesity treatment. There was a weight center for patient referral but no pathway and guidance on making those referrals,” said Fitch. “Because I was interested in obesity medicine, I researched it and started treating patients myself. Ensuring [that] patients with obesity were given the care they needed required finding a provider who was interested.”

AJMC: In your experience, what challenges do patients face in obtaining treatment for obesity, and what challenges do you face as providers?

All stakeholders agreed that limited access to treatment options and their associated costs hinder patients’ ability to obtain assistance with obesity management. According to Fitch, “The biggest change we need in the United States is to [ensure obesity is considered] a disease state with a standard benefit on insurance policies.” If the Treat and Reduce Obesity Act—which would cover antiobesity pharmacotherapy and counseling and dietitian visits—passes at the congressional level, then the Centers for Medicare & Medicaid Services (CMS) would cover [AOMs], and everyone else would have to follow.”¹¹

The stigma and bias faced by people with obesity was described by all stakeholders as another major barrier to care. Both HCPs and the general public often view obesity as a condition stemming from a lack of willpower or a mental health disease. Stakeholders emphasized that obesity is a serious, chronic, and treatable disease; to extend the reach of obesity management programs, they stressed, there must be shifts in the mindsets of HCPs and in the opinions of those who approve these programs. “The greatest barrier to the adoption of care pathways for obesity is acceptance of the disease itself,” said Fitch. “If the administration at an organization does not think obesity is a disease worthy of [attention], they’re not going to put resources towards it.” Golden similarly stated, “We have to increase education on obesity as a disease and not [a condition that is] the

[Effective weight management starts in the primary care setting]; PCPs are charged with identifying patients with obesity and ideally helping them develop an individualized preference-sensitive treatment plan.

—Dina Hafez Griauzde, MD

We have to increase education on obesity as a disease and not [a condition that is] the patient’s fault. Obesity has a pathophysiology that has to be treated, similar to [that of] other endocrine disorders.

—Angela Golden, DNP

patient’s fault. Obesity has a pathophysiology that has to be treated, similar to [that of] other endocrine disorders.”

Providers treating patients with obesity experience time constraints, just as they do when managing other diseases. Griauzde shared, “We are faced with the challenge of determining how to carve out time to devote to obesity medicine as well as how to grow an obesity-first model for managing many chronic conditions without compromising patients’ access to their PCP for routine care.” As a potential solution to the time challenge, Fitch suggested that lifestyle support could be provided in large group settings of around 25 people rather than in individual sessions, thereby increasing the scope of impact.

AJMC: What is the role and importance of administrative and staff buy-in for obesity treatment programs?

Administrative buy-in refers to the support and commitment of organizational leaders, such as hospital administrators or clinic managers, in implementing and sustaining obesity treatment programs. Administrative support can provide necessary resources—including staff, funding, and software development—to effectively implement and operate the program. This support also can demonstrate the organization’s commitment to addressing the problem of obesity and concerns around time constraints and resource allocation by providing additional resources and adjusting workflows. Interview stakeholders who work at larger institutions and clinics agreed that support from the administration is a crucial component to ensure the success of obesity management programs and the ability of programs to gain traction, achieve meaningful outcomes, and endure over the long-term.

Gaining administrative buy-in and support can be challenging. “It was not easy to get institutional support [for our program],” said Griauzde. “A concern at the institutional level was, ‘How is this [program] going to pay for itself?’ A reason that the Department of Family Medicine supported our program from the start was, in part, because they had transitioned to a capitated model of reimbursement.”

“ [The administration] saw that this is an investment that will pay dividends down the line. ”

—Andrew Timothy Kraftson, MD

“ We want to help providers perform their own patient care for weight management as they would for other diseases. ”

—Jodi Summers Holtrop, PhD, MCHES

Speaking on the program implemented at the University of Michigan, Kraftson shared that the team showed that it was at least cost-neutral, which helped to ensure administrative buy-in. “[The administration] saw that this is an investment that will pay dividends down the line,” he said. “If there’s some up-front cost for training or to cover the costs of board exam[ination]s, that would be money well spent. Carving out time for people to dedicate to obesity medicine is time well spent.”

At the University of Michigan Medical School, HCPs applied an economic mindset to ensure that the costs of obesity management programs are justifiable. Systems must have a business case for their persistence and survival in a managed care health system, and treating obesity is cost-effective. Dividends in the form of prevention are rapidly realized in terms of interventions for type 2 diabetes and osteoarthritis. This can also occur with obesity management. An organization may be convinced to support weight loss programs when presented with a business case focused on desired outcomes. Obesity medicine specialists frequently engage with administration, seeking clarity on their expectations and the specific focus of value-based reimbursement systems. Their goal is to ensure that their program aligns with the system’s needs and effectively meets the required criteria.

When securing administrative buy-in and support, it is important to recognize that administrators can also have inherent biases that may influence their decision-making. According to Fitch, “People bring their own biases to work with them, which means that health care administrators can have a bias and stigma [about obesity], and this can affect the potential for buy-in. You [may] need a program champion within your health system.”

Jodi Summers Holtrop, PhD, MCHES, discussed the importance of securing staff buy-in and ensuring that new strategies were implemented without removing control from individual providers. She emphasized the importance of preserving the “autonomy that PCPs have with their patients, because doctors have the patient’s comprehensive history.” She continued, “We want to help providers perform their own patient care for weight management as they would for other diseases.”

PATHWEIGH at the University of Colorado’s UCHHealth has a clinical team; within each practice, a clinical champion is designated to lead its implementation. This champion could be a physician, NP, or physician associate. They also aim to involve practice management in the initiative. Because office staff and medical assistants have an important impact on workflow, and deviation from their normal activities would affect the practice, buy-in from practice managers is needed to gain support and cooperation.

Leigh Perreault, MD, described the various stakeholders invested in weight management and ways that their support influences success. “Patients are stakeholders. Providers are stakeholders. Our medical system and insurers are clearly stakeholders,” she explained. “We also have a health economist working on [PATHWEIGH] to ensure that it is cost-effective. We have experts in Epic [Epic Systems] (our electronic health record system) who are building the patient- and provider-facing tools for us, and also the Health Data Compass Warehouse [that] retrieves data for us on use of the tools. We have the National Institutes of Health (NIH). We have our investigative team. We have trademarked our program through [the University of Colorado], so [this institution] is very interested in disseminating this outside of the university. We’ve been approached by multiple commercial entities trying to buy this or learn from it or replicate it. There has been a lot of stake put into this new process for weight management, and the support has been very beneficial.”

AJMC: Can you tell us about your clinical pathway program for patients with obesity?

Clinical care pathways play a crucial role in the effective and comprehensive management of obesity, addressing both the medical and psychosocial aspects of the disease. It has become imperative to develop structured approaches that guide HCPs in delivering standardized, evidence-based care. The systematic framework provided by clinical pathways streamlines the assessment, diagnosis, treatment, and follow-up processes for patients with obesity. Stakeholders shared information on the initiatives undertaken at their institutions. The strategies and approaches employed in these programs can be used to identify best practices, innovative solutions, and lessons learned that can inform further development of obesity management programs.

A structured obesity care pathway similar to those used for other chronic diseases should be established. According to Fitch, **options embedded in the care pathway also need to address the pillars of obesity treatment: nutrition, physical activity, behavior, stress management, and medications and surgery.** Program facilitators must use these services in an appropriate manner, acquire necessary knowledge, and have access to resources that enable service utilization. The care pathway should include not only obesity care-certified clinicians but also dietitians, pharmacists, and mental health providers. As part of the obesity care team, a pharmacist can effectively adjust medication dosages and monitor for potential adverse effects (AEs) through medication therapy management. Moreover, they can offer strategies to overcome AEs, leading to improved adherence and persistence. If patients lack coverage for nutrition counseling, they

may find local community centers to provide this service at no cost. The aim is to discover such resources and establish connections to incorporate these options into the care plan. Having a comprehensive care team enhances the likelihood of success, which may be supported through value-based care funding.

As the need for care pathways has been increasingly recognized, the stakeholders shared, numerous programs for obesity treatment have been implemented in the United States. These programs were often initiated by HCPs who observed worrying trends in the obesity rates of their patients, had an interest in combating the disease, and subsequently developed more formal initiatives. PATHWEIGH at UHealth is part of an ongoing study funded by the NIH to understand the implementation and effectiveness of a new process that facilitates weight management in primary care. The goal is to make it easier for clinical care providers to deliver evidence-based services that are already available.²

“PATHWEIGH strives to reclaim weight management into routine medical practice,” Perreault continued. “Patients are encouraged to schedule a weight-prioritized visit type if they would like medical assistance with their weight. They self-select this type of visit prior to their appointment or approach the front desk and say, ‘I would like a weight-prioritized visit type.’” *A weight-prioritized visit is a new visit type now available in Epic at UHealth.*” She added that there is a mutual responsibility between patients and clinicians when it comes to addressing obesity-related care. Patients should be aware that they can receive appropriate treatment for their weight, and clinicians should possess the knowledge and skills to provide such care. The billing is done using routine codes, without any additional costs.

PATHWEIGH is not a specific program; rather, it is a process by which patients can get ongoing care for their weight that lasts for extended periods of time, during which the treatment plan can evolve. Perreault perceives PATHWEIGH as a comprehensive toolbox encompassing various medical tools and approaches for addressing obesity-related issues. The implementation of new processes such as this relies on the understanding of context: each practice and community, as well as the healthy system itself, has its unique context, and patients bring their own context into the equation. A strong relationship fostered between the care provider and patient leads to informed decisions made collectively and collaboratively.

According to Fitch, institutions need “an underlying infrastructure to support the patient like any other chronic disease management pathway. A care pathway for obesity should be designed like a care pathway for diabetes in terms of [having] follow-up, consulting the dietitian, [and] having a nutritional plan, a physical activity plan, a behavioral plan, a stress management plan, and medication or surgery.” Fitch highlighted that 70% of the population is at an unhealthy weight, which she attributed to various factors, including those related to the environment. “If 70% of people have [an unhealthy weight], the environment is producing it. To change that as an individual person, you have to control that environment. You have to decide that you want to take some control over that environment, which is super hard to do—to live opposite of the world that you’ve been put in. It’s not impossible, but it usually takes a lot of support.”

Fitch reported that obesity can be overcome by applying a method she describes using the acronym SAME, which stands for structure, accountability, metabolic advantage, and environmental control.

Kraftson and Griauzde described the WNP at the University of Michigan, which began as a pilot initiative for providing guidance on obesity treatment. “Patients who meet the criteria to be referred to the Weight Navigation Program are required to have a BMI greater than 30 [kg/m²] and typically at least 1 weight-related health condition,” said Kraftson. “Based on a subsequent conversation with an obesity navigator [a physician who is an ABOM diplomate] and the patient’s medical criteria, the best fit [treatment plan] for the patient—medically, financially, and based on the patient’s preferences—is then offered to the patient. What began as a pilot [program] was later developed into an intervention pathway,” said Kraftson. A combination of obesity medical expertise, time carved out for obesity treatment, and population health tools (text messaging, patient dashboard) is employed to support proactive patient outreach and, if needed, adapt treatment plans to help patients reach their weight and health goals.

When making the determination to open a private practice, Golden stated, “I wanted to open a practice fully focused on providing evidence-based treatment for obesity within the chronic care model of insurance-based practice,” she said. Golden did not open a cash-based practice, because she wanted patients to be able to use their insurance to help pay for care of this chronic disease. To aid in this process, she stressed the importance of having a mentor who is well-versed in the billing and coding side of the business. “In starting up a practice like this, I couldn’t have done it without my mentor, Michael Kaplan, DO, [the founding partner of the Long Island Weight Loss Institute and the chief medical officer of the Center for Medical Weight Loss], who was willing to share his expertise with me.” Initially, most of her patients learned of her practice through referrals from NPs in the Flagstaff area. These referrals originated from HCPs working in departments of primary care, cardiology, and orthopedics, among others. According to Golden, “It wasn’t long before the majority of patients came to me from patient referrals. Today, more than 50% of my practice is from patient referrals.” In her practice, she meets with patients for 1-hour sessions to gather information. Based on food tracking, physical measurements, and laboratory parameters,

PATHWEIGH strives to reclaim weight management into routine medical practice. Patients are encouraged to schedule a weight-prioritized visit type if they would like medical assistance with their weight. They self-select this type of visit prior to their appointment or approach the front desk and say, ‘I would like a weight-prioritized visit type.’ A weight-prioritized visit is a new visit type now available in Epic at UHealth.

—Leigh Perreault, MD

Golden uses a shared decision-making form to help patients determine the best path forward in their obesity management.

By establishing clear guidelines and protocols, clinical care pathways help ensure consistency in care, optimize resource use, enhance patient-provider communication, and promote collaborative decision-making. Further, clinical care pathways facilitate the integration of multidisciplinary interventions, enabling a holistic approach that addresses the diverse needs of individuals with obesity.

AJMC: What is the role of EHRs in multidisciplinary obesity management programs?

Approaches for achieving weight management can change over time and require a long-term relationship between patients and providers. The PATHWEIGH process began when Perreault approached Epic, the EHR system used at UHealth of the University of Colorado; Epic has local champions for specific regions and clinics. HCPs worked with developers at Epic to generate an intake questionnaire to identify patients in whom the treatment of excess weight rather than that of obesity-related problems was being prioritized. Informally, Perreault and her colleagues tracked patients with obesity-prioritized visits and compared the results with those from another physician who did not prioritize weight. The team found that patients at UHealth who received obesity-prioritized visits had 3-fold greater weight loss success than did those who did not receive obesity-prioritized care. These results led to the formal development of the PATHWEIGH process.

Griauzde added that the WNP at the University of Michigan uses population health management tools that are integrated with the Epic EHR system to support patients outside of routine clinical settings. Patients in the WNP are invited to use a text messaging program for remote weight monitoring, and they can share their weight data at least once weekly with their WNP team. The weight data is sent to the EHR and pulled to a WNP dashboard. Based on weight change outcomes, the population health manager reaches out to patients (eg, with a supportive portal message for patients losing weight or a phone call for patients gaining weight to identify and address challenges). Griauzde noted, “The Weight Navigation Program aims to help patients achieve a minimum clinically significant threshold of at least 5% body weight loss.” Griauzde further described that in addition to viewing weight data, the WNP dashboard allows the health

care team to see where patients have been referred and whether the patients have engaged in programs.”

Rather than using an EHR, Golden believes, providing patients with documents that can be saved and referred to over time is important, as people typically remember only approximately 10% of what they hear. To provide the best possible patient care, she also highlighted the importance of collaboration with other HCPs. “NPs had a voice in the development of the original 2013 guidelines, which leveled the field tremendously. These were some of the most impressive collaborations I have ever been able to be a part of in any disease state.”

AJMC: How is patient progress monitored?

Griauzde explained that patients are monitored via various channels, including health records and direct contact. Patient data undergo regular review to evaluate progress. If there is evidence of weight gain or if a patient has actively participated in the program without achieving the target of 5% weight loss, proactive measures are taken by reaching out to these patients. This outreach involves using preestablished scripts and protocols that provide guidance to HCPs for decision-making and offer support tailored to the specific needs of these patients. The WNP uses text messaging as part of the EHR for remote weight monitoring captured in the dashboard. Patients enrolled in the text messaging program have the flexibility to choose a specific day and time to receive a text message prompting them to report their weight. “Many patients find this helpful in terms of accountability. Our program allows for tailored frequency of follow-up visits. If someone gets referred to bariatric surgery or to [the Department of] Endocrinology’s meal replacement program, the programs have set pathways for patients.” To ensure that patient progress is monitored, the dashboard is used to track individuals referred to other programs. HCPs then can take proactive measures to reengage patients who, according to objective determination, are not progressing.

Much of the success of the UHealth approach has been attributed to use of tools for monitoring patients through the Epic EHR system. Within the Epic system, there is a navigational menu designed for the toolbox. This feature provides physicians with a summary to help them assess a patient’s weight history and track any adjustments made to medication dosages. AgileMD (AgileMD, Inc), a third-party program embedded in Epic, is used as a 3-decision point algorithm. It provides education around weight management with diet, exercise, and other factors and helps list medications that are more or less likely to be helpful or harmful for patients based on their profile.

Fitch described that numerous approaches can be used by PCPs to engage patients in obesity management plans when medications cannot be prescribed. “Some patients have access to resources such as apps through their employer that promote a healthful lifestyle. If they don’t have access to these tools, [they should] refer patients to a dietitian, if possible. If not, [they should] schedule follow-up appointments to discuss a basic obesity action plan and [set] a nutrition goal.” A practical objective would be to incorporate 5 servings of vegetables or fruits into daily meals for a week. According to Fitch, improving nutrition quality primarily involves altering the

[Institutions need] an underlying infrastructure to support the patient like any other chronic disease management pathway. A care pathway for obesity should be designed like a care pathway for diabetes in terms of [having] follow-up, consulting the dietitian, [and] having a nutritional plan, a physical activity plan, a behavioral plan, a stress management plan, and medication or surgery.

—Angela Fitch, MD, FACP, FOMA

quality of the food environment and prioritizing consumption of fresh, whole foods over processed options. Setting goals such as increasing water intake, avoiding late-night eating, or engaging in physical activity also can be beneficial. A specific goal could be to aim for a daily count of 5000 steps.

Golden emphasized that patients can also be treated for obesity on an individual basis. After attending a 1-hour appointment with her to explain their specific situations, patients track their daily food intake, baseline activity, and step count. “After 2 weeks, patients return for a 45-minute visit to review their data, and we discuss how changing some of that data can be part of their treatment plan. At that point, we discuss whether medication, surgery, or both might be beneficial treatment options. We move forward based on the shared decision-making process.”

AJMC: What benefits or improvements have you seen with these programs?

The programs implemented by the stakeholders have shown various successes since they were first initiated. The WNP at the University of Michigan was awarded the Evan Newport HOPE Award. Kraftson described this as “an institutional award given to those who demonstrate exceptional commitment to patients in family-centric care. That’s something we’re proud of.” He added that patients who have received some form of follow-up care for obesity have achieved remarkable results. Using standard treatment methods, he reported, “We found that 13% of patients will lose 5% or more of their weight over 2 to 3 years. In the first year of the program, 40% of patients lost at least 5% of their weight.”

At UCHHealth, uptake of the program tools by affiliated clinics has increased rapidly. *“I’m very proud to say that [just recently], our final 19 clinics went live with the tools, so we now have all 66 of our clinics on board,” said Perreault. “It’s a huge day for our health care system, our team, and, hopefully, all the people who it will help.”*

The doctor provided more than any other doctor ever has resource-wise and went over my options. I really loved how thorough, empathetic, and understanding she was. I don’t know if I’ve ever had a doctor take that large of a chunk amount of time to sit down with me and just talk about my weight and treatment options.

—Patient at the University of Michigan

Several physicians have obtained their board certification in obesity medicine since PATHWEIGH was started. Finally, Holtrop pointed out, “More physicians have reported that they are implementing weight management programs within their practice. Patients also take advantage of the weight-specific visit type and tool sets and access our elearning [electronic learning tools].” The investigative team plans to release specific data regarding physician uptake in the future.

Patient satisfaction, a marker of program success, was also high, with a patient at the University of Michigan stating, “The doctor provided more than any other doctor ever has resource-wise and went over my options. I really loved how thorough, empathetic, and understanding she was. I don’t know if I’ve ever had a doctor take that large of a chunk amount of time to sit down with me and just talk about my weight and treatment options.” •

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