Obesity and Nutrition Management in the Context of GLP-1: Proceedings from the Stakeholders' Dialogue

2024

Obesity Medicine Association

eat right.org Academy of Nutrition and Dietetics

ATLAS CLARITY

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Background

On December 18, 2024, the Obesity Medicine Association, the Academy of Nutrition and Dietetics (the Academy), and ATLAS CLARITY LLC convened a national virtual Stakeholders' Dialogue, "Obesity and Nutrition Management in the Context of GLP-1" (the Dialogue).[1,2] This two-hour event brought together 26 diverse stakeholders—people living with obesity, payers, clinicians, advocates, policymakers, and researchers[3]—to address the critical role of nutrition support in the context of comprehensive obesity care for people living with obesity taking novel anti-obesity medications, particularly glucagon-like peptide-1 (GLP-1) medications.

The Dialogue focused on identifying actionable solutions to integrate nutrition interventions into comprehensive obesity care management. These solutions can help address many issues, including the risk of lean body mass[4] associated with GLP-1 use, a key factor contributing to sarcopenia, frailty, and functional decline. Given the evolving landscape of obesity management and the increasing use of GLP-1, the dialogue sought to foster collaboration and develop actionable solutions that would lead to better integration of nutrition interventions into comprehensive patient care.

The outcomes of the Dialogue will inform a Blueprint that the co-hosts will publish in 2025, outlining strategies to strengthen access to nutrition interventions and addressing fundamental challenges in obesity management. This Blueprint will provide actionable steps across all relevant stakeholder groups to tackle fundamental challenges in the short, medium, and long term.

The Stakeholders' Dialogue

Prior to the Dialogue, ATLAS CLARITY sent participants pre-read background materials that provided key context for the discussion. These included:

- A list of key terms and their definitions (Appendix B),

[1] Support for "Stakeholder's Dialogue: Obesity and Nutrition Management in Context of GLP-1" was provided by Abbott.
[2] For the purposes of the Dialogue, the term "GLP-1" was used as a starting point to discuss modern anti-obesity medications, defined as medications that modify biological processes that affect appetite and significantly improve outcomes, such as type 2 diabetes, hypertension, and dyslipidemia. While the Dialogue was prompted by the advent of GLP-1, the discussion was sufficiently broad to address all forms of anti-obesity medications.
[3] A list of attendee titles and affiliations is available in Appendix A.
[4] Lean body mass (LBM) represents non-adipose tissue mass, excluding any additional mass from sudden changes in water content. See De Rosa S, Umbrello M, Pelosi P, Battaglini D. Update on Lean Body Mass Diagnostic Assessment in Critical Illness. *Diagnostics*. 2023; 13(5):888. https://doi.org/10.3390/diagnostics13050888

- A position statement from the Obesity Medicine Association on "Comprehensive Care for Patients with Obesity"[5]
- A journal article from the Academy of Nutrition and Dietetics on "Incretin-Based Therapies and Lifestyle Interventions: The Evolving Role of Registered Dietitian Nutritionists in Obesity Care"[6]
- A Health Affairs journal article, authored by Dialogue participants and co-hosts, titled "To Promote Health and Health Equity, Include Quality Nutrition Care as Part of Anti-Obesity Medication Therapy"[7]

The co-hosts asked participants to review these materials in advance of the Dialogue to ensure a shared understanding of the subject matter.

Stakeholders' Dialogue Framework

The Dialogue built upon the foundation established by the pre-reads and provided a forum for interactive discussion and collaborative problem-solving. The two-hour virtual event, conducted via Zoom, commenced with opening remarks from Kristi Mitchell, CEO of ATLAS CLARITY, followed by welcome messages from Teresa Fraker, Executive Director of the Obesity Medicine Association, and Deepa Handu, Senior Scientific Director of the Academy. Next, subject matter experts gave a brief overview of the current state of comprehensive obesity care management, nutrition interventions, and related policies.

Comprehensive Obesity Care Management Presentation

Dr. Lydia Alexander gave a presentation on comprehensive obesity care management. She emphasized obesity's status as a chronic, progressive, relapsing, and treatable disease, noting the commonality of weight regain without surgical intervention. Her presentation also highlighted the transformative potential of GLP-1 in healthcare, offering clinicians a new and effective treatment option.

[5] Fitch, A., Alexander, L., Brown, C. F., & Bays, H. E. (2023). Comprehensive care for patients with obesity: an Obesity Medicine Association position statement. https://doi.org/10.1016/j.obpill.2023.100070
[6] Gigliotti, L., Warshaw, H., Evert, A., Dawkins, C., Schwartz, J., Susie, C., ... & Rozga, M. (2024). Incretin-Based Therapies and Lifestyle Interventions: The Evolving Role of Registered Dietitian Nutritionists in Obesity Care. *Journal of the Academy of Nutrition and Dietetics*. https://doi.org/10.1016/j.jand.2024.10.023
[7] Blancato, B., Dawson, M. A., Mitchell, K., & Blankenship, J. (2024). To Promote Health And Health Equity, Include Quality Nutrition Care As Part Of Anti-Obesity Medication Therapy. *Health Affairs Forefront*. https://www.healthaffairs.org/do/10.1377/forefront.20240507.317642/full/

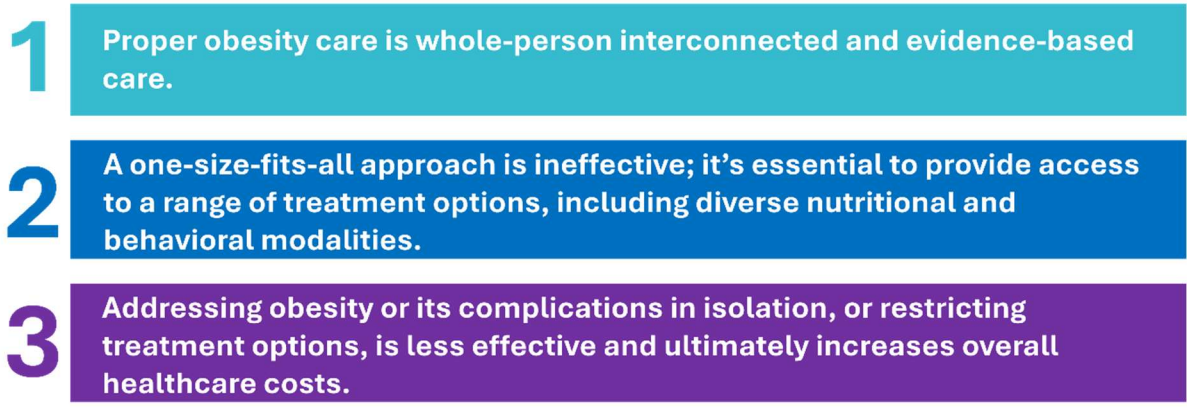
Dr. Alexander noted that with the rise of GLP-1 medications, both challenges and opportunities exist for medical professionals and clinics, as Figure 1: GLP-1 Challenges and Opportunities for Medical Providers and Clinics denotes.

Figure 1. GLP-1 Challenges and Opportunities for Medical Providers and Clinics

Acronyms: GLP-1: Glucagon-Like Peptide-1; ROI: Return on Investment

While Dr. Alexander identified GLP-1 medications as highly effective at helping induce weight loss, she emphasized the critical importance of comprehensive obesity care. Dr. Alexnader defined comprehensive care as evidence-based nutrition therapy, physical activity, behavioral modification, and medical intervention to support lasting health and well-being. Within that framework, she described three principles that promote effective obesity care, which are denoted in Figure 2: Key Principles for Effective Obesity Care.

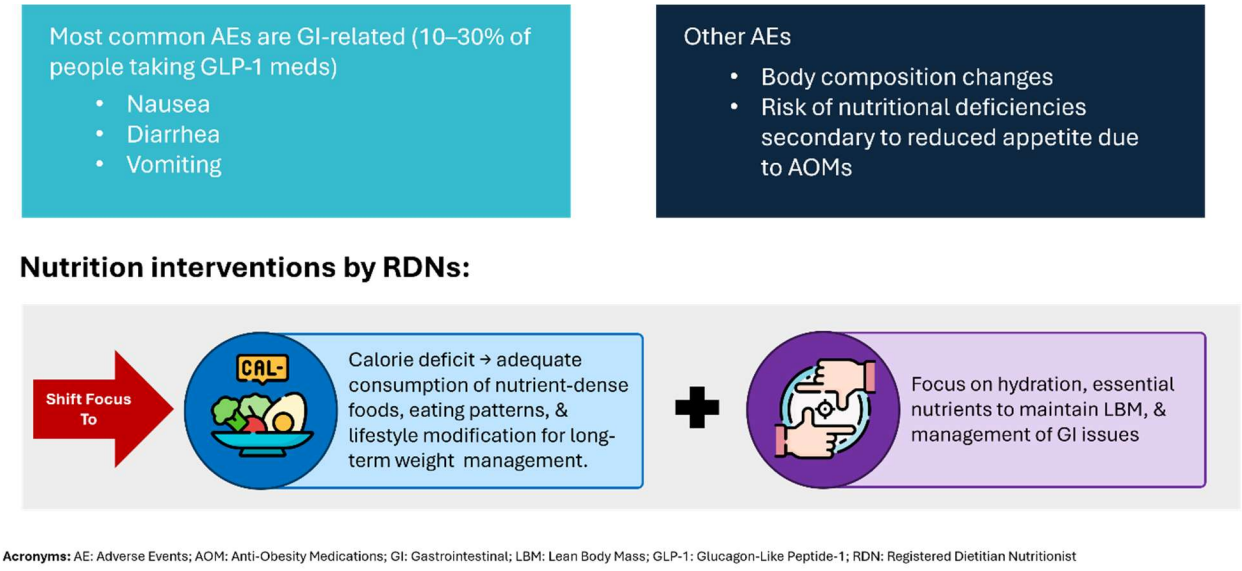
Figure 2. Key Principles for Effective Obesity Care



Nutrition Interventions Presentation

Dr. Deepa Handu presented on nutrition interventions, providing a definition of these interventions and citing examples such as coaching, problem-solving, and goal setting. Furthermore, Dr. Handu's presentation emphasized the importance of pairing GLP-1 therapy with nutrition interventions administered by registered dietitian nutritionists to achieve optimal outcomes. Her presentation highlighted adverse events associated with GLP-1 medications, as well as how nutrition interventions provided by registered dietitian nutritionists could help manage GLP-1 related issues, including lean body mass loss and adverse events such as gastrointestinal issues, as shown in Figure 3: GLP-1 Adverse Events and Management.

Figure 3: GLP-1 Adverse Events and Management



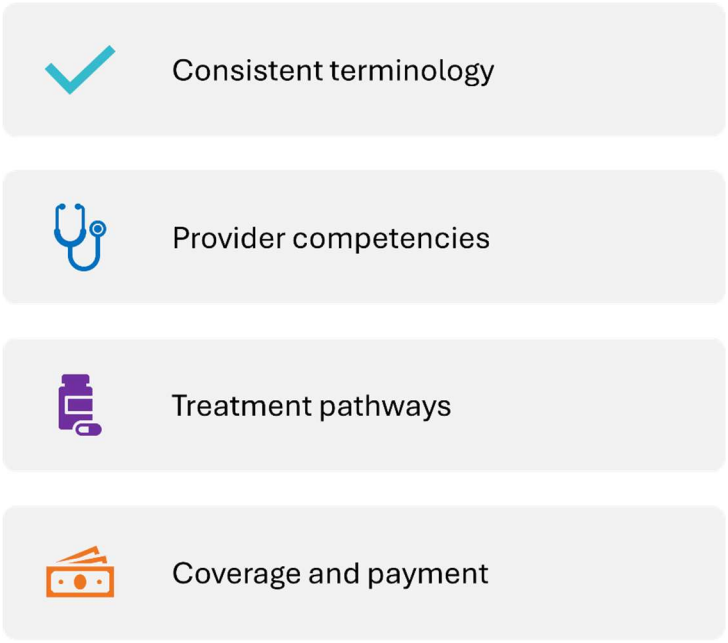
Acronyms: AE: Adverse Events; AOM: Anti-Obesity Medications; GI: Gastrointestinal; LBM: Lean Body Mass; GLP-1: Glucagon-Like Peptide-1; RDN: Registered Dietitian Nutritionist

Dr. Handu and co-host Christina Badaracco, RN, MPH, noted that dietitians could help address adverse events, which are common in GLP-1 users and often lead to GLP-1 discontinuation and can help promote healthy eating and lifestyle patterns.

Nutrition-Related Policy Presentation

Finally, Jeanne Blankenship, MS, RDN gave a presentation on nutrition-related policies. She identified four key opportunities that can impact nutrition policy, as shown in Figure 4: Key Opportunities to Impact Nutrition Policy denotes.

Figure 4: 4 Key Opportunities to Impact Nutrition Policy



Ms. Blankenship explained the reasoning behind each of the opportunities to impact nutrition policy:

- **Consistent terminology:** Creating consistent terminology is crucial for clear communication among payers, providers, and the public regarding nutrition interventions, dietitian roles, and GLP-1.
- **Provider Competencies:** Enhancing provider training will help address the variable nutrition competency of providers, with a focus on clinical skills, intervention knowledge, and complex case management.
- **Treatment pathways:** Establishing a multidisciplinary, patient-centered standard of care is essential for optimal care delivery and payment.
- **Coverage and payment:** Extending payment/reimbursement for nutrition services is vital. Registered dietitian nutritionists must deliver nutrition care that is coupled with access to GLP-1 or other anti-obesity medication.

Facilitated Participant Discussion

Following the opening remarks, the Co-hosts divided participants into two discussion groups: Group A consisted primarily of clinicians, people living with obesity, and

advocates, while Group B consisted primarily of payers, policy experts, and researchers.[8] This two-group structure enabled deeper exploration of individual topics within each group and maximized participant engagement. Designated scribes documented the discussions within each group.

A moderator led each breakout group: Christina Badaracco, RN, MPH led Group A, and Kristi Mitchell led Group B. The moderators were given five question domains, each with specific questions and suggested probes (Appendix C). Figure 5: Domains illustrates the domains.

Figure 5: Domains

Given that the Dialogue pre-reads focused on defining existing barriers for each question area, the discussion groups were designed to problem-solve by proposing solutions and evaluating their implementation feasibility.

Reconvening and Next Steps

Following the discussion groups, the moderators for the two groups presented recurring themes, key insights, and potential areas for action. Also, participants had the opportunity to submit any additional thoughts not shared during the Dialogue to a designated scribe. The ATLAS CLARITY team then analyzed the collected notes thematically to generate a

[8] It is important to note that many participants fit into more than one stakeholder category (e.g., several clinicians were also researchers; some policy experts were also patients, etc.).

condensed list of approximately ten solutions that could address identified barriers. The Co-hosts subsequently asked participants to rank these solutions based on their feasibility and impact. Their rankings will serve as the basis for the Blueprint.

Key Themes from the Dialogue

Participants gave detailed and insightful solutions to the critical barriers currently faced by people living with obesity who take anti-obesity medications. Thematically, these barriers were:

- **Developing a comprehensive, multi-disciplinary standard of care**: Creating a standard that will integrate the expertise of various specialists, including dietitians, psychologists, and physical therapists, to ensure holistic patient care.
- **Strengthening the multidisciplinary care team**: Expanding access to dietitians, mental health providers, and peer support groups, as well as improving communication and collaboration within the care team.
- **Implementing targeted education and awareness campaigns**: Creating campaigns that will aim to educate the public, healthcare providers, grant reviewers, and policymakers about obesity as a chronic disease, the importance of comprehensive care, and the appropriate use of GLP-1 medications.
- **Advocating for policy changes**: Supporting the passage of a revised federal Treat and Reduce Obesity Act, securing Medicare coverage for GLP-1 medications, and expanding access to telehealth services.
- **Addressing health equity concerns**: Ensuring equitable access to affordable medications, minimizing coverage gaps, and addressing the specific needs of underserved populations.

Appendix D has detailed meeting notes.

Next Steps

Participants have reviewed and ranked the proposed solutions that were discussed during the Dialogue. The Obesity Medicine Association, the Academy, and ATLAS CLARITY are using these rankings to develop the Blueprint, outlining actionable steps for stakeholders across sectors to effectively address the challenges in the short, medium, and long-term to develop blueprint, which will be published by April 30, 2025.

Appendices

Appendix A: Attendee Titles and Affiliations

The following table lists the individuals who attended the Stakeholders' Dialogue: Obesity and Nutrition Management in the Context of GLP-1 Medications Meeting on December 18, 2024. The Obesity Medicine Association, the Academy of Nutrition and Dietetics, and ATLAS CLARITY served as co-hosts.

Invitees:

Name with Credentials	Title	Organization
Amy Hess-Fischl, MS, RDN, LDN, BC-ADM, CDCES	CDCES	University of Chicago
Anne Coltman, MSHA, RDN, FAND, FACHE	Senior Director of Quality, Standards, and Interoperability	Commission on Dietetic Registration
Bob Blancato	National Coordinator	Defeat Malnutrition Today
Catherine Ferguson, MA	Vice President	American Diabetes Association
Corri Wolf, PhD	Assistant Dean and Department Chair	New York Institute of Technology
Christy Gallagher, MPAff	Coordinator	Obesity Care Advocacy Network
Diane Enos, EdD, MPH, RDN, CAE, FAND	Chief Executive Officer	American Society for Metabolic and Bariatric Surgery
Dominique Williams, MD, MPH, FOMA, Dipl ABOM	Medical Director	Abbott
Elizabeth Ciemins, PhD, MPH, MA	SVP Research	American Medical Group Association
Jake Galdo, PharmD, MBA	Chief Executive Officer	Seguridad; CPESN Health Equity
James Zervios, BA	COO	Obesity Action Coalition
Jen Muse, MS, RD, CDN	Sr. Program Manager	American Heart Association
John Jakicic, PhD, MS	Professor	University of Kansas Medical Center
Laura Borth, MS, RD	Policy Director	Defeat Malnutrition Today
Liz Paul, MA	Advocate and Member of the Obesity Action Coalition	Obesity Action Coalition
Martha Belury, PhD, RD	Department Chair and Professor, Ohio State	OSU, Department of Food Science and Technology

	University, Department of Food Science and Technology	
Martha Dawson, MSN, RN, FAAN, FACHE	Past President/CEO	National Black Nurses Association
Mitzi Wasik, PharmD, FCCP, FAMCP	Executive Director, AMCP Foundation; Senior Vice President, Practice Strategy and Innovation	Academy of Managed Care Pharmacy
Patty Nece, JD	Immediate Past Board Chair	Past Board Chair, Obesity Action Coalition
Renee Rogers, PhD, FACSM	Senior Scientist	University of Kansas Medical Center
Tracy Zvenyach, PhD	Director, Policy Strategy & Alliances	Obesity Action Coalition

Hosts:

Name with Credentials	Title	Organization
Alison Steiber, PhD, RDN	Chief Mission, Impact Strategy Officer	Academy of Nutrition and Dietetics
Kristi Mitchell, MPH	Principal & Founder	ATLAS CLARITY
Teresa Fraker, FACHE, RN, CPHQ, CBN, FASMBS-IH	Executive Director	Obesity Medicine Association

Presenters:

Name with Credentials	Title	Organization
Deepa Handu, PhD, RDN	Sr. Scientific Director, Evidence Analysis Center	Academy of Nutrition and Dietetics
Jeanne Blankenship, MS, RDN	President and CEO	The Nutrition and Health Policy Collaborative
Lydia Alexander, MD, DABOM, DACLM, MFOMA	President and Chief Medical Officer	Obesity Medicine Association; Enara Health

Moderators:

Name with Credentials	Title	Organization
Christina Badaracco, MPH, RDN, LDN	Nutrition Expert and Thought Leader	ATLAS CLARITY
Kristi Mitchell, MPH	Principal & Founder	ATLAS CLARITY

Scribes:

Name with Credentials	Title	Organization
Jeff Berko, MPH	Senior Research Manager	ATLAS CLARITY
Penelope Solis, JD	Senior Research Manager	ATLAS CLARITY

Appendix B: Key Terms and their Definitions

To ensure clarity and consistency in terminology, the co-hosts gave the following key terms and their definitions to participants in the Stakeholders' Dialogue: Obesity and Nutrition Management in the Context of GLP-1 Meeting.

Term	Definition
Incretin-based therapies	A class of obesity management medications that includes glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and glucose-dependent insulinotropic polypeptide (GIP)
Anti-obesity Medications	Medications that modify biological processes that affect appetite and significantly improve outcomes, such as type 2 diabetes, hypertension, and dyslipidemia. Anti-obesity medications are effective adjunctive therapy to lifestyle changes for improved weight loss and health outcomes.
Medical Nutrition Therapy	A nutrition-based treatment provided by a registered dietitian nutritionist. Medical Nutrition Therapy includes nutrition diagnosis as well as therapeutic and counseling services to manage obesity.
Nutrition intervention	Purposefully planned and implemented actions intended to positively change or improve a nutrition related problem.
Comprehensive obesity management	A holistic approach to treating and managing obesity that includes a combination of nutrition therapy, physical activity, behavioral modification, and medical interventions (e.g., medications, bariatric procedures, and complication management). These actions are all aimed at achieving sustainable weight loss and addressing associated health risks, with a focus on long-term health management.
Healthcare access	The "timely use of personal health services to achieve the best possible health outcomes."
Clinical practice guidelines	Recommendations (not legally binding) on how to diagnose and treat a medical condition, designed to help ensure that patients receive appropriate treatment and care. Often based on a systematic review of the literature.
Patient-centered care	Care in which "an individual's specific health needs and desired health outcomes are the driving force behind all health care decisions and quality measurements. Patients are partners with their health care providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective. …[Often] involves shared decision making between patients, families, and providers to design and manage a customized and comprehensive care plan."
Intensive Behavioral Therapy	Intensive behavioral therapy for obesity consists of (1) screening for obesity using BMI; (2) dietary assessment; and (3) intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

Appendix C: Questions and Probes from Discussion Groups

This appendix provides the questions that guided the discussion sessions during the Stakeholders' Dialogue: Obesity and Nutrition Management in the Context of GLP-1 Meeting on December 18, 2024.

Participants were divided into two discussion groups:

- **Discussion Group A:** clinicians, people living with obesity, and advocates (Facilitated by Christina Badaracco, MPH, RDN, LDN)
- **Discussion Group B:** researchers, payers, and policymakers (Facilitated by: Kristi Mitchell, MPH)

The moderator leveraged a different set of questions for each breakout group.

I. Discussion Group A Questions

The questions were divided into five domains: (A) Standard of Care, (B) Education and Awareness, (C) Reimbursement and Policy, (D) Health Equity, and (E) Evidence Generation. Each domain's explanation and questions are identified below.

A. Standard of Care

High quality, evidence based clinical practice guidelines offer a way of bridging the gap between current science, best practice, policy and patient choice. We know that several professional societies have published guidelines for the management of overweight and obesity in adults. The Obesity Medicine Association has published a position statement and a set of clinical algorithms for optimal obesity care management. Is there currently a multi-stakeholder guideline published to date that includes guidance for the comprehensive management of obesity? Probe: What are the barriers to making this happen? Which organizations should be involved in developing this guideline?

To what extent is implementation of the comprehensive obesity care model being evaluated?

When we think about comprehensive obesity care management, what is the value of evaluating the impact of routine implementation of this model?

<u>Assessment</u>

What are the most valuable indicators for measuring body composition for people prescribed anti-obesity medications? To what extent are people aware of these indicators, and actively tracking and monitoring the indicators?

What are the most valuable indicators for measuring lean body mass in people prescribed anti-obesity medications?

What clinical indicators of lean body mass should be tracked?

1) Computed tomography scan, magnetic resonance imaging, dual energy x-ray absorptiometry
2) Bioelectrical impedance analysis, ultrasound, body mass index, skinfold thickness, body roundness index
3) Home monitoring (body impedance analysis, body roundness index) not just during office visits?

Nutrition intervention

How are side-effects (e.g., diarrhea, nausea, etc.) associated with GLP-1medications addressed in the comprehensive obesity care model?

Given side effects, how is a nutrition intervention determined?

What nutrition intervention(s) are considered part of comprehensive obesity care management?

Care Team/Setting

As we think about implementing comprehensive obesity care, who should be included as part of the care team and what are their roles? Probe: What is the role of the pharmacist?

Is the current workforce sufficient to support comprehensive obesity care management? If not, what do we need to do to build it?

What systems/processes are needed to better facilitate care coordination among care team members across the comprehensive obesity care model?

[Asked of Dialogue participants who said that they were currently using a GLP-1 medication] To what extent do you feel your needs and preferences are being met when coordinating your care during your weight loss journey?

B. Education and Awareness

People living with obesity

As we think about implementing comprehensive obesity management, there is an opportunity to think about educational and training needs for key stakeholders. To what extent are they getting this information now and by whom?

Moving forward, when in the obesity care management process, should people living with obesity be educated about loss of lean body mass and protein deficiency?

What can providers do to mitigate or prevent loss of lean body mass?

Providers

What content could be added to clinicians and providers outside of obesity medicine specialists and dietitians, (e.g., primary care physicians, nurses, and pharmacists) training to enhance knowledge and awareness of comprehensive obesity care, consequences of rapid weight loss, and opportunities for nutrition interventions? What are the challenges to doing so?

How do we keep all providers up to date as the field (medications, research, and policy) changes?

C. Reimbursement and Policy

Currently, Medicare only covers medical nutrition therapy for individuals with obesity who also have diabetes or renal disease and national coverage of intensive behavioral therapy for obesity is limited, what national policies should be implemented to ensure comprehensive obesity care management?

Specifically, what additional policies are needed to ensure that nutrition interventions are covered for people living with obesity prescribed GLP-1 medications?

Are there any lessons to be learned from bariatric surgery for comprehensive obesity management? Are there any lessons to be learned from earlier anti-obesity medications (e.g., orlistat, etc.)?

Behavioral/psychosocial services: how does that get paid for?

D. Health Equity

What are the disparities in people living with obesity receiving comprehensive obesity care management? What can be done to address those barriers? What policies need to be in place to reduce health inequities across populations? (e.g., race/ethnicity, rural/urban, income)

What additional barriers do people living with obesity face in receiving comprehensive obesity care management? What needs to be done to address those additional barriers?

Telehealth

Studies have shown that telemedicine interventions can successfully help people living with obesity lose weight. Telemedicine interventions provide a safe, remote alternative and may expand treatment access to hard-to-reach populations.

What policies should be put in place to ensure that telehealth can continue to be used to support nutrition interventions related to GLP-1 administration among people living with obesity?

Probe: For consumers accessing GLP-1 medications through online telehealth companies like HIMS/HERS, Ro, what safeguards can be put in place to ensure that comprehensive obesity care management, including nutrition education and counseling, is fulfilled?

Probe: How can these safeguards be communicated to people living with obesity, and inform their choice?

How can these organizations be held accountable for ensuring a high level of quality of care?

E. Evidence Generation

What additional evidence (to build more robust guidelines, or evaluate role of care team members) needs to be generated to be included in these guidelines? Probe:

a. Body composition: how valuable and impactful is it? What are the costs and benefits? What are the short- and long-term effects of GLP-1 on lean body mass? Nutrition status more broadly? Mental health?

b. What are the long-term effects of GLP-1 medications with and without comprehensive obesity care management?

c. What is the impact of GLP-1 medications on nutrient intake? How strong is the evidence? What additional evidence is needed?

d. How long can and should a person stay on GLP-1 medications? Is there an optimal dose? Can GLP-1 medication be stopped if there are other supports in place?

II. Discussion Group B Questions

The questions were divided into four domains: (A) Standard of Care, (B) Education and Awareness, (C) Reimbursement and Policy, and (D) Health Equity. Each domain's explanation and questions are identified below.

A. Standard of Care

We know that several professional societies have published guidelines for the management of overweight and obesity in adults. The Obesity Medicine Association has published a position statement and a set of clinical algorithms for optimal obesity care management. We also know that clinical practice guidelines set the foundation for coverage and reimbursement policies. In the absence of such a document for obesity care management, how would nutrition interventions that track and measure lean body mass be considered?

What data do payers need to make decisions that support comprehensive obesity care model? Policymakers?

Body composition scanning: how valuable and impactful is it? What are the costs and benefits? What are the short- and long-term effects of GLP-1 medications on lean body mass?

Care Team/ Setting

As we think about implementing comprehensive obesity care, who should be included as part of the care team and what are their roles? Probe: What is the role of the pharmacist?

Outside dietitians and obesity specialists, what role can others on the care team play in patient education and nutrition counseling? Probe: role of pharmacists? physiologists? nurses? community health workers?

What policies can we implement to facilitate stronger care coordination for obesity management?

B. Education and Awareness

To what extent does overall knowledge and awareness of comprehensive obesity management need to be enhanced, given this expanded focus on GLP-1 medications as a treatment option?

Probe: What do policymakers need to know? What do payers need to know? What do consumers need to know?

C. Reimbursement and Policy

NATIONAL POLICY

Jeanne mentioned two specific national policies that have been discussed and some that have been introduced but not passed - Medical Nutrition Therapy and the Treat to Reduce Obesity Act. Seems like there is some additional work that needs to be done, but not for lack of trying by many folks on the call.

Medical Nutrition Therapy

Currently, Medicare only covers medical nutrition therapy for individuals with obesity who also have diabetes or renal disease. If medical nutrition therapy were to pass, what are the barriers to reimbursement for nutrition interventions implemented for comprehensive obesity care management? How do we address those barriers?

What do we need to do to increase access to medical nutrition therapy? (e.g., payment for medical nutrition therapy address provider shortages, etc.)?

To what extent does medical nutrition therapy need to be individually tailored? Is it feasible to develop a "standard" for medical nutrition therapy that can be applied widely?

Data Needs: What is the return on investment on implementing medical nutrition therapy?

Treat and Reduce Obesity Act

To date the national coverage determination for intensive behavioral therapy for obesity is overly restrictive to the types of health professionals and settings of care, significantly limiting and even undermining patient access to comprehensive services. We know that the Treat and Reduce Obesity Act has been under consideration for years. To tackle this issue, what is it going to take to get it over the finish line? Moreover, how will its passage support coverage and reimbursement for necessary nutrition interventions that are embedded in comprehensive obesity management?

STATE POLICY

What about obesity management and intensive behavioral therapy reimbursement at the state level? Probe: are there lessons to be learned from current policy that applies to today with GLP-1 medications and nutrition interventions?

POLICY WRAPUP

What other policies should be implemented to ensure reimbursement for comprehensive obesity care management?

Probe: Are there lessons that can be learned from reimbursement for bariatric surgery?

PRIVATE PAYERS

To date there still is a wide range of coverage for anti-obesity medications like GLP-1 medications, that said nearly 50% of health plans cover/reimburse. What role, if any, do health plans play in embracing comprehensive obesity care management and appropriate nutrition interventions in the advent of GLP-1 medications?

Nutrition Intervention

Specifically focusing on nutrition interventions- What is currently reimbursed? What will it take to reimburse for body composition testing, dual x-ray absorptiometry, computed tomography scans, bioelectrical impedance analysis, body roundness index, etc.

What type of data are needed by payers to support future reimbursement and coverage of nutrition interventions?

Obesity Care Model Collaborative.

The American Medical Group Association Foundation implemented a 3-year initiative to develop and implement a framework for obesity care. Through the Obesity care model Collaborative, the American Medical Group Association brought medical groups and health systems together to share strategies and best practices

Quality and Value of Care

What role could quality measures play in advancing comprehensive obesity care management?

Probe: How can we expand or improve upon current quality measures in this?

What organization(s) would take the lead in developing such measures? Is this something that Centers for Medicare and Medicaid Services would adopt?

Quality Initiative/ Payment Model

Let us say that we have an agreed upon comprehensive obesity care model, quality measures/outcomes measures of interest, and interest from the broader community. Would this set the stage for a Center for Medicare and Medicaid Innovation demonstration? Or national quality initiative?

EMPLOYERS

What data do employers need in programs that focus on comprehensive obesity management?

D. Health Equity

What additional barriers do people living with obesity face in receiving comprehensive obesity care management? What needs to be done to address those additional barriers?

What policies and/or programs do we need to put in place at the federal, state, or local levels to reduce health inequities across populations?

Telehealth

Studies have shown that telemedicine interventions can successfully help people with obesity lose weight. Telemedicine interventions provide a safe, remote alternative and may expand treatment access to hard-to-reach populations.

What policies should be put in place to ensure that telehealth can continue to be used to support nutrition interventions related to GLP-1 medication administration among pe living with obesity?

Probe: For people who access GLP-1 medications through online telehealth companies like HIMS/HERS, Ro what safeguards can be put in place to ensure that comprehensive obesity care management, including nutrition education and counseling is fulfilled?

How can these organizations be held accountable for ensuring a high level of quality of care?

Appendix D: Scribe Notes*

*Please note that this is not a transcript of the two breakout groups but rather a summary of the notes taken by each scribe.

Standard of Care – Group A

1) Published Guidelines for Bariatric Surgery
   a) The American Society for Metabolic & Bariatric Surgery has adopted evidence-based guidelines that address anti-obesity medications, intensive behavioral therapy, and bariatric surgery – adopted by The Centers for Medicare and Medicaid Services and many insurance providers, and conducted a Delphi study (https://doi.org/10.1111/cob.12722).
      i) Bariatric Surgery Guidelines and Recommendations - American Society for Metabolic and Bariatric Surgery
   b) The American Diabetes Association has standards of care, which practitioners use; comprehensive obesity standards of care coming out soon.
      i) 8. Obesity and Weight Management for the Prevention and Treatment of Type 2 Diabetes: Standards of Care in Diabetes–2024 | Diabetes Care | American Diabetes Association
      ii) The American Diabetes Association will be coming out with new guidelines in the new year.
   c) The United States Preventive Services Task Force has recommendations for screening, and how that might influence prevention, but less about standards of care.
      (1) States implement the United States Preventive Services Task Force guidelines to varying degrees. Medicare and Medicaid are supposed to cover those rated A or B, but implementation is lacking.
      (2) Recommendation: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions | United States Preventive Services Taskforce
   d) American Heart Association/American College of Cardiology/The Obesity Society
      i) 2013 American Heart Association/American College of Cardiology/The Obesity Society guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society - PubMed
   e) American Association of Clinical Endocrinology
      i) American Association Of Clinical Endocrinologists And American College Of Endocrinology Comprehensive Clinical Practice Guidelines For Medical Care Of Patients With Obesity - Pubmed
   f) Up-to-Date has many links to guidelines.
   g) Guidelines vary depending on context and group; it is unclear how authoritative these guidelines are.
2) Organizations that should be represented in guidelines but are not:
   a) American Psychological Association.

b) Physical activity/exercise is a necessary part of comprehensive care.
    i) There is a lot of misunderstanding of what exercise can do in the context of obesity, particularly in the area of body composition.
c) North American Obesity Treatment specialty organizations.

3) To what extent is comprehensive obesity care model being implemented, and implemented well?
    a) Implementation of access to medication is different from what care is provided, and what is covered by Medicare/Medicaid.
    b) Implementation varies at policy/coverage level vs. individual care level.
    c) State and federal activity is very fragmented; surgery has more access and coverage, whereas nutrition, lifestyle support modification, and obesity medications coverage is particularly dismal; states will "check the box" claiming that one nutrition visit per year counts as access, when it clearly does not provide comprehensive care.
4) Assessment of body composition
    a) Practitioners need to use validated measures, based on clinical evidence and guidelines. Drugs were approved for certain clinical markers based on research studies, and we need to use the clinical indicators that were used in the research studies.
        i) Body Mass Index, waist circumference, and body weight are the primary markers based on currently available evidence, even if they are imperfect measures
        ii) Secondary or tertiary indicators may include blood pressure or others
    b) Key question: what do you want to measure, and why? Every measure has limitations. We can measure cardiometabolic health, but we have to measure many other things (e.g., sarcopenia, function, etc.) in comprehensive obesity care. Can not be just body composition in isolation – need more holistic measures.
5) Nutrition Interventions
    a) At American Society for Metabolic & Bariatric Surgery intensive behavioral therapy is a requirement for bariatric surgery (part of a quality improvement program by the American College of Surgeons called the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program); but surgeons are absorbing cost for intensive behavioral therapy because coverage is not there. Billing for providing intensive behavioral therapy is hit-or-miss. Prior to surgery, you have to show people living with obesity have seen dietitian, psychologist, etc. before they can move forward with surgery, which can take ~1year, which is a huge bias and barrier for treatment and care.
        i) Often, people living with obesity get a script, it is not covered and they ca not afford it, switch to a compound, have delays, leads to worse care because they had no management. Surgeons are providing medication because they know it is part of comprehensive care, but we need to get coverage. Surgery is often delayed by lack of access to I intensive behavioral therapy.

ii) Data need: what percent of people living with obesity are getting a prescription, who is going direct for service, who is getting a compound, who is seeing a provider, etc. (What is happening in practice vs. what should be happening).
iii) Need to examine where people are getting GLP-1 medications from: script, compounding, online, etc. Access is influencing care.

Standard of Care – Group B

6) Need to justify the investment in nutrition interventions through data (cost-effectiveness). There is a gap in funding for cost-effectiveness data, but there are efforts to create empirical models that could show how much savings could be realized. Developing cost models is essential to provide payers with data-driven evidence of how nutrition interventions can decrease overall healthcare costs.
7) Total cost of care is also a consideration for data generated to validate nutrition interventions.
8) Payers do not want just simple math that shows nutrition interventions reduce diabetes, but rather need to look at cost of care overall (not just clinical effectiveness – which we have a lot of data on, also need cost-effectiveness)
9) Limited funding for nutrition is a barrier (e.g., National Institute of Health preclinical and clinical trials do not focus on nutrition interventions). Less than 5% earmarked- need to have political pressure. There is a chicken-and-the-egg problem.
    a) All work should be evidence-based, but there is just not enough evidence to act upon. Impact on guidelines or standards is that do not have evidence because need someone to fund the research. Who should be the funder if not National Institute of Health (e.g., health plans)?
10) Data sets for nutrition interventions are not coded so it is hard to look at them. The American Medical Group Association said it wants to include nutrition interventions but it is hard to identify nutrition data in patient journey research that is currently ongoing.
    a) Funding depends on funder – pharma companies are more likely to fund limited medication studies, but we need a full view of the patient journey.
11) Obesity measures may need to be in place so can see what is being done in the real world. This could include the diagnosis of obesity or also treatment (e.g., medication for people living with obesity).
12) Real world evidence generation in disease states like obesity, are missing this and therefore it is difficult to quantify patient impact, drive meaningful coverage criteria, etc.
13) Total cost of care is also a consideration for data generated to validate nutrition interventions.
    a) To make an impact on body composition, need comprehensive care teams, specific to the treatment line (not just lifestyle). Need to specifically demonstrate protein adherence (as one example), not just the general importance of nutrition/dietitian.
14) To make change, need to have political pressure. Opportunities may emerge from elevating this topic in political discourse.
    a) Biological sex must be addressed in every National Institute of Health grant submission. Similarly, study participants' diet data should be part of every study to better understand how they respond to gene therapy or medication or whatever.
15) We need to <u>start</u> by changing attitudes and beliefs that obesity is a chronic disease, is driven by biology, not choice. This chips away at stigma.

Care Team/Setting – Group A

16) Who needs to be included in the care team, and what is their role?
    a) Need mental health provider (different from nutritionist in teasing out relationship with food, self-talk, internalized weight bias, etc.). Mental health is often not given enough attention.
    b) Dealing with mental health, regardless of your treatment, is incredibly important, particularly for sustained weight. Helps prevent self-blame and shame. You have to convince people living with obesity of the importance of mental health, addressing internalized weight-bias, self-stigma. Need help from outside to address self-induced mental health issues.
    c) A peer support group is incredibly helpful. Does things healthcare providers cannot.
    d) They started an interdisciplinary care team, with a primary care provider (made referral to team). Team = assessment made by dietitian, social worker, and endocrinology team. They made an ongoing care plan, targeted towards mental health care, medical nutrition therapy care, or whatever patient needed targeting most. Pharmacists also helped to adjust meds as needed. Full multidisciplinary team. People with obesity loved it!
17) Is the current workforce sufficient? If not, what needs to be done?
    a) Obesity care must be in healthcare/medical setting, not commercial setting. Seeing a physical activity specialist also needs to be a regular, continuous part of obesity care. Can not be a one and done type thing.
    b) Needs to start in education of healthcare providers – medical doctors, physician assistants, etc. Need to convince clinicians that mindset of it is not my job should turn into a mindset of it is everybody's job – this is a chronic disease and everybody needs to treat it.
    c) The workforce is sufficient, but the financial models around it are not. Some pharmacists lose money for every GLP-1 medication they dispense, so they cannot dispense them, let alone provide the necessary support (e.g., patient education) around them.

Care Team/Setting – Group B

18) Who should be on the team? Pharmacists, who else?
    a) A pharmacist plays a key role and may not be the person who has the nutrition conversation but plays the key role of educating people living with obesity on the drug and having the patients talk to the clinicians.
19) What is/should be required of people living with obesity once they are on a GLP-1 medication (e.g., meet with dietitian X times a year, see clinician X times a year)?
    a) Hard to require that there be certain interventions if do not have data to show that will make a difference. Example potential drawback: Insurance companies may

force people living with obesity to jump through these hoops and set up additional barriers before paying for what is necessary. Rather than make it mandatory, make it encouraged.

b) Clinicians need to be the ones to determine who needs a dietitian since there are not sufficient dietitians and people have unique needs.
c) Need to remember patient centered care to determine what is necessary. For example, if have nutrition deficiency may need to have an intervention.

20) Need to prevent the loss of lean body mass that occurs with rapid weight loss – we need to raise awareness or education on this Need to talk also about behavioral adherence and include counseling
    a) Need to come to a consensus on what matters most. Nutrition deficiency? Lean mass? Side effects? Those are the 3 biggest reasons people living with obesity stop taking meds. Need to look at those three things and how to overcome their issues.
21) Behavioral changes are difficult to achieve. Where does this fit in with respect to GLP-1 medications?
22) Need to decide how to address nutrition deficiency, side effects, and behavioral adherence and identifying key targets.
23) We still have no data on lean body mass which is a hot button issue.
    a) Maybe it is more about tissue quality rather than mass.
    b) Controlling lean mass loss may be impossible with severe caloric restriction.
    c) New medications are coming down the pipeline, but they will not improve quality of care nor solve every problem. Exercise means nothing without dietitians. We need everything to work together for comprehensive care; if the stars do not align, we are not going to make an impact for the patient.
24) Entire team needs to be educated and paid, for comprehensive care to work.
25) Diet counseling is disappearing because of the new medications.
    a) People believe medications can take care of everything and they do not need to make behavior changes.
26) Need to frame conversations as to what are the unintended consequences of medications, i.e. lean body mass loss, nutrition deficiency etc.
    a) The message cannot be medications vs. lifestyle, it must be medications address one problem, but what else is happening that medications are not addressing?
27) To address Treat and Reduce Obesity Act: Secure bipartisan support on future bill (who proposes bill and who co-sponsors bill) and look at new members of Congress on both house and senate side (new Chairman of Finance Committee). It is all about building and re-building new relationships. That is how you get things to move.

Education and Awareness – Group A

28) To what extent are people living with obesity getting necessary information, and where are they getting it from?

a) People living with obesity are not getting accurate information. Usually get education from social media and tik-tok. Partly due to medical schools not adequately training their students in obesity, weight bias, and nutrition.
    i) People living with obesity become desperate. Insurance will not pay for it; Medicaid will not pay for it. Many people living with obesity ask for a GLP-1 script, are given a script, and there is no education that accompanies it.

29) When (and how) in care journey should people living with obesity be educated about nutrition needs, lean body mass, nutrition deficiencies, etc.?
    a) Before ever being handed a script for GLP-1 by anybody. Should be told What it means to be on a GLP-1 medication, what it does. People living with obesity do not think about what it does for their nutrition needs, their body composition, their short- and long-term metabolism, side effects, ebb and flow of how it works. People have been sold they do not have to change how they eat, they just inject this drug. Prescription providers are giving people living with obesity a link, or a reading, but that does not work. That will continue until we change the payment model – need to reimburse providers to educate people living with obesity. Dietitian/Patient Education must be mandated part of every prescription.

30) What educational content do providers (primary care physicians, nurses, pharmacists, and other non-obesity specialists) need, that they are not currently getting?
    a) Two prong approach: Medical students and continuing ed for current practitioners: how to address obesity as a disease, and how to discuss obesity/weight in a trauma-informed way, how new class of medications work, how we need to prescribe them and manage them. We know they need management from nutrition standpoint and long-term management standpoint. Cannot just prescribe and walk away. Primary care physicians are the first line of defense.
    b) Looking into offering a credential. Some providers, including dietitians, do not always feel adequately educated/prepared/qualified. Barrier: credentialing comes with a cost, and will there be a return on investment for those who get the credential?
    c) Weight stigma and bias – happens inside and outside healthcare setting, all over world. Bias exists because we do not yet accept and believe it is a chronic, relapsing, progressive, treatable condition. Until we address that bias, it is very hard to make any other progress. We need a public service announcement that obesity is a chronic disease. Until that happens, stakeholders will not address it properly.
        i) Training needs to begin in medical school; students need to understand pathophysiology, so they are better informed about how it fits into sleep apnea, cardiovascular disease, etc.

Education and Awareness – Group B

31) Lost opportunities in appropriations process where research money is determined to influence key areas funded by National Institute of Health (including friends of National

Institute of Health that advocate for funding). Have an opportunity to advocate for federal funding for obesity research.
    a) Grant reviewers may need education.
32) Industry should have a strong role in supporting research including lifestyle interventions (like nutrition interventions) in addition to prescriptions of medications to people living with obesity.
    a) Seems like right now the National Institute of Health is only funded at 3% level
    b) Be more overt about how GLP-1 medications work best with nutrition interventions – industry needs to tell everybody that comprehensive nutrition interventions were a key part of the study.
33) Collecting pilot data is important whether funded by industry or others
34) Easy first step: Everyone should use person-first language and say people with obesity, which highlights that it is a disease, rather than obese people.
35) Confirmation process to identify sympathetic senators to raise this as an issue
    a) Obesity Care Advocacy Network Obesity Action Coalition submit questions and will prepare questions for the record
    b) Good food and safe medicines
36) To generate comprehensive care, it is important to come together with other organizations including all partners nutrition, exercise, et al.
37) Generate a social marketing campaign.

Reimbursement and Policy – Group A (not discussed in Group B)

38) What state/national policies need to be implemented to ensure comprehensive care?
    a) Get GLP-1 medication covered. We need to get Centers for Medicare and Medicaid Services to start covering this at a comprehensive level. Other insurance companies will fall in line once Centers for Medicare and Medicaid Services cover.
        i) Most surgeons will attempt to write 2 prior authorizations before giving up. If that does not get covered, they will switch to another option.
    b) Medicare considers it a cosmetic issue, which needs to change. That is malpractice. Stakeholders must be covering it as a chronic disease.
        i) Biden administration proposed coverage change in way Medicare and Medicaid address obesity medications. Trump administration will be in charge of moving it forward. We can submit comments now. We are trying to express as much individual and organizational support for bringing science to the fore as possible.
        ii) If the Treat and reduce obesity act does not pass, it needs to start from square one. It has been watered down, to only cover individuals coming onto Medicare who have been on GLP-1medications for 1 year.
39) Telehealth
    a) Telehealth guidelines were relaxed during COVID and will revert on Dec 31, 2024. That will be highly detrimental to comprehensive obesity care. Will be very consequential.

Health Equity – Group B (not discussed in Group A)

40) Cost is one of the biggest barriers to individuals in terms of who has access to medications.

41) Access through Medicaid program see different communities of color not having the same access to medications. People living with obesity could start on medications but then fall out of Medicaid – same issue with patients who are part of the Health Insurance Marketplace®.
42) Medications are too expensive for states to cover or employers to cover.
43) People are being driven to compounded medications.
    a) Pharmacoequity is an issue that needs to be addressed: https://static1.squarespace.com/static/60d09796bb807927ef6980c4/t/6744ef824bc6004c293621c9/1732571010671/APNOV24_Pharmacoequity.pdf
    b) Insufficient medication availability can lead to gaps in therapy, resulting in suboptimal patient care.
44) Need to be aware of compounded medications which are unregulated – dose levels that are not tested.
45) Access to nutrition interventions and telehealth are not on the top of anyone's mind – companies are making profit like never before, but people living with obesity likely do not talk to any healthcare provider about nutrition.

Appendix E: Acknowledgements

The **Stakeholders' Dialogue: Obesity and Nutrition Management in the Context of GLP-1 Medications Meeting** was made possible through the collaborative efforts of three co-hosts:

- **The Obesity Medicine Association** is the largest organization of physicians, nurse practitioners, physician assistants, and other health care providers dedicated to improving the lives of patients affected by obesity.
- **The Academy of Nutrition and Dietetics,** the world's largest organization of food and nutrition professionals, is committed to improving the nation's health and advancing the profession of dietetics through research, education, and advocacy.
- **ATLAS CLARITY,** a San Francisco-based advisory services firm dedicated to improving patients' health and well-being, focusing on closing health disparities.

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