Brief Cutting Edge Report
CLINICAL TRIALS AND INVESTIGATIONS

Obesity

A Proposed Standard of Obesity Care for All Providers and Payers

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Objective: The aim of this work is to develop a practical, tangible, measurable, and simple standard of care for the treatment of adult obesity that provides guidance for both clinical providers and community settings.
Methods: Three roundtables with relevant stakeholder groups were convened by the STOP Obesity Alliance at The George Washington University to develop the proposed standard of care.
Results: The proposed standard of care for adult obesity treatment proposes practices for the spectrum of clinical, community, and digitally based entities and for clinical providers. Coverage and payment policy standards are also provided.
Conclusions: These standards are intended to augment published guidelines developed for obesity care providers and can also be viewed as the first step to define an optimal benefit package.

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Introduction

The goal of this project was to develop a list of actionable statements that reflect a minimum standard of care for the treatment of adult obesity, positioned as an inclusive model of care that applies to both primary and community-based care. The proposed standard acknowledges that effective and evidence-based obesity care occurs in a variety of settings, including the community and within the health care delivery system.

The proposed standard of care is intended to augment published guidelines developed for obesity specialists, including The Obesity Society/American Heart Association/American College of Cardiology working group's guidelines (1) for treatment. The proposed standard of care is governed by certain fundamental core principles, including shared decision-making, when to use adjunctive therapies, and when to move patients to higher intensity treatments. Assurance that patients have access to appropriate levels of care is essential, regardless of the point of entry.

Large variations exist in benefit design and coverage for obesity treatments across payers (2). These variations may reflect, in part, the absence of a consensus on what constitutes optimal obesity care. The proposed standard of care provides a template for health professionals to adapt and translate into actionable protocols for implementation within various practice settings. The proposed standard of care can also be viewed as the first step to define an optimal benefit package.

Methods

To develop the proposed standard of care, the STOP Obesity Alliance convened a series of three roundtables with relevant stakeholder groups, including health professionals who care for patients with obesity, community- and nonclinic-based providers, payers, and patient advocates. A complete list of attendees can be found in Supporting Information Table S1. A steering committee was developed to outline the goals of the project and to provide a smaller group to help oversee the project. Roundtable meetings focused on what the standard of care for adult obesity should be and the regulatory or legislative and institutional policies necessary to implement the standard of care. The roundtable participants also discussed whether quality of life measures and cost–benefit analyses should be included in developing a standard of care.

The final proposed standard of care recommendations represent consensus decisions from the roundtable participants and relevant stakeholder organizations, including STOP Obesity Alliance members. However, participation in the roundtable and review process does not indicate an endorsement of the final document by the participating organizations.

Results

A proposed standard of care for adult obesity treatment

Clinical practice guidelines articulate the essential elements for the treatment of adult obesity. However, current guidelines fail to specify

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who should provide care, where care should be delivered, and what care should be provided by whom. These specifications are essential to guide payer coverage. Large variations exist in benefit design and coverage for adult obesity treatments across payers. Building on existing momentum from the renewed commitment of plans to pay for evidence-based obesity care services and to augment the published standards developed for obesity specialists, a diverse set of stakeholders were recruited to inform this document.

Our goal is to develop a practical, tangible, measurable, and simple standard of care for the treatment of adult obesity. Because evidence-based obesity care occurs within community and health care settings, we focus on an inclusive model of care that provides guidance regarding the treatment of obesity for both clinical providers and community settings.

Core principles of care

The following core principles underlie the proposed standard of care recommendations:

1. Obesity should be treated as a chronic disease.
2. Care should be evidence based, pragmatic, and deliverable.
3. Patients deserve access to appropriate levels of care, regardless of their point of entry to the health care system.
4. Providers should be sensitive to bias and language and make accommodations for patient care (i.e. adequate furniture, equipment, and an environment that accommodates a patient's needs (3).)
5. Providers should be trained to initiate the conversation about weight and weight change with patients to assess willingness to address their obesity.
6. Shared decision-making and bidirectional communication between individuals and providers are essential. Providers need to be aware of and refer to the full range of appropriate treatment services for obesity.
7. Evidence-based competencies that are discipline specific should be met by each type of provider (4).
8. Social determinants of health should be considered when developing a treatment plan, taking into consideration patients' home, work, and community environments; interpersonal relationships and family dynamics; stressors; and cultural preferences.

Proposed standards for adult obesity treatment

The recommendations that follow are intended to provide health professionals, payers, community organizations, policy makers, and those affected by obesity with guidance on foundational components of evidence-based obesity care. These standards should not be applied in isolation. They represent practices that positively impact the health of people affected by obesity. The practices are categorized by those that apply to "all providers" and those that apply specifically to "clinical providers."

Proposed standards for all providers

The following practices apply to all providers. For purposes of this standard of care, our definition of "all providers" is the full spectrum of clinical, community, and digitally based entities that support the health of persons with obesity.

1. All providers, patients and clients, community organizations, and policy makers should recognize and respond to obesity as a lifelong chronic disease and apply a chronic care model to its management.
2. All providers should recognize the multidisciplinary skill set needed to participate effectively in an interprofessional care team, including prescribers, physical therapists, dietitians, kinesiologists, psychologists, and others.
3. All providers should address obesity through shared decision-making processes. Providers need to take into consideration the circumstances, needs, and preferences of the individual in developing an obesity-management plan.
4. All providers should use patient/client-centered communication and employ strategies to minimize discrimination toward individuals with obesity.
5. In addition to reduction in body weight, all providers should emphasize changes in behaviors and health outcomes as measures of success.
6. Patients and clients should be monitored for weight regain. All providers should recommend measures to prevent weight regain.
7. Providers should not utilize, recommend, or refer patients or clients to obesity treatments for which the potential risks and costs outweigh the expected health benefits for a given patient, especially treatments that are unproven and/or potentially harmful.

Proposed standards for clinical providers

The following practices apply specifically to providers who deliver clinical services, such as prescribers, for whom a more detailed knowledge of obesity and its pathophysiology is required.

1. Clinical providers should be competent to address the role of social determinants of obesity and its outcomes.
2. Clinical providers should consider an individual's genetic background and ethnicity when considering the risk associated with BMI and/or waist circumference.
3. Clinical providers should assess patients for obesity-associated comorbidities.
4. Clinical providers should educate patients or clients about the relationship between excess body fat and health risks.
5. Clinical providers should employ evidence-based counseling techniques (e.g., cognitive behavioral therapy, motivational interviewing, the five As [ask, assess, advise, agree, and assist]) to facilitate behavioral change.
6. Clinical providers should jointly decide with patients or clients on obesity care options that include weight management counseling on diet, physical activity, behavior modification, pharmacotherapy, and/or bariatric surgery. For patients who have not achieved sufficient weight loss or health benefits with self-help approaches, referral to evidence-based intensive behavioral counseling or delivery of a structured program of comprehensive lifestyle intervention (12-14 visits in the first 6 months and continued therapy for at least 1 year) is indicated. Clinical providers, when appropriate, should provide services and/or resources to meet the psychosocial needs of patients who may have weight management challenges.
7. In consultation with the patient or client, clinical providers should refer patients or clients to an evidence-based program or recommend an evidence-based dietary strategy, considering individual preference and the potential health benefit of diet composition.
8. Clinical providers should recommend appropriate levels of physical activity and/or refer patients or clients to programs that include physical activity counseling as part of an obesity care effort.
9. Clinical providers should minimize the use of medications that may cause weight gain and preferentially consider those that are

weight neutral or associated with weight loss for patients or clients with overweight and obesity.

10. When appropriate, clinical providers should discuss and/or prescribe obesity medications. Medications approved by the US Food and Drug Administration for weight management should be included in health care system formularies and used according to product label indications. Medications should be prescribed in conjunction with the lifestyle intervention.
11. When appropriate, clinical providers should discuss and/or refer to bariatric surgery patients or clients who meet surgical criteria.
12. Clinical providers should be knowledgeable about long-term nutritional and medical needs of patients or clients who have bariatric surgery and should provide care consistent with established guidelines.

Coverage and payment policy standards

These standards are intended to be implementable and acceptable to payers. We recommend that payers cover and reimburse evidence-based programs and interventions from randomized trials that (1) produce a 5% or greater weight loss for a clinical intervention, (2) produce a 3% weight loss for a community-based intervention, (3) prevent the onset or reduce the severity of obesity-associated comorbidities, and/or (4) support weight maintenance that is sustained over 6 months.

In addition, providers delivering obesity care interventions can be from a variety of disciplines as long as outcomes can be achieved in an evidence-based program or with an evidence-based treatment.

Conclusion

The group considered but did not reach consensus on including quality of life measures when assessing success in obesity treatment. Potential quality of life measurements include: Centers for Disease Control and Prevention Healthy Days Measure; Duke Health Profile; Impact of Weight on Quality of Life; Medical Outcomes Study Short Form 36; Obesity and Weight-Loss Quality of Life; Obesity-Related Disability Test; Obesity-Related Problems Scale (7) or (17); Obesity Related Well-Being Questionnaire; Patient Health Questionnaire; Promis-10 Global

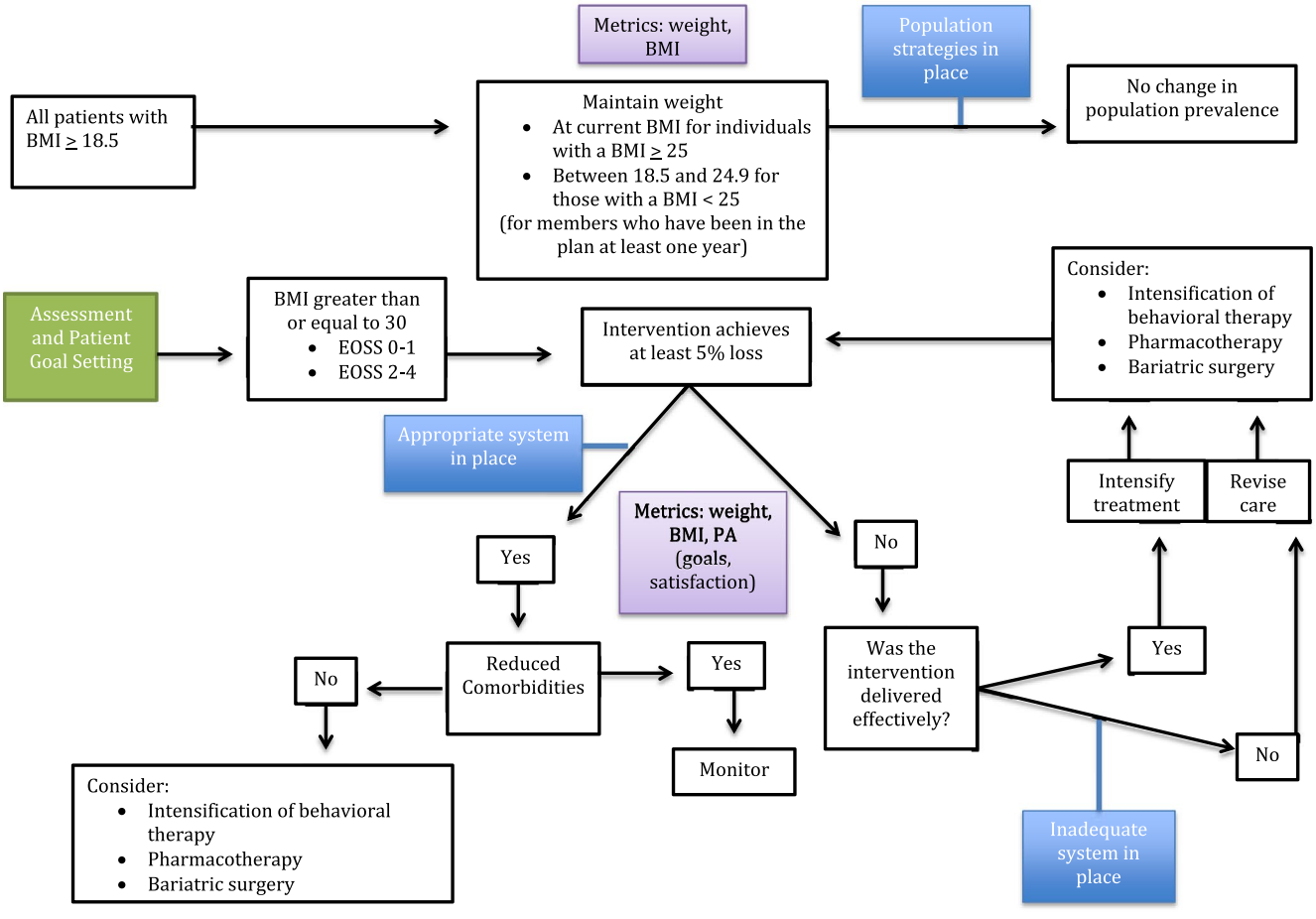

Figure 1 Algorithm: a means for assessing health plan success in obesity management. PA, physical activity; EOSS, Edmonton Obesity Staging System (5). [Colour figure can be viewed at wileyonlinelibrary.com]

Health Short Form; Social Isolation Index; and Weight-Related Sign and Symptom Measure. Comparison of these measures for their short-term and long-term utility would potentially identify the measure(s) most acceptable for routine clinical use. The group also discussed the need for health plans to assess their success in obesity management. Figure 1 provides an algorithm for such measurements. In addition, the group agreed on the need to develop an optimal benefit design for obesity care. The STOP Obesity Alliance has begun the process of drafting and seeking input from experts and stakeholders on what would constitute an ideal obesity care benefit.**O**

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