

STOP Obesity Alliance Recommendations for Nonprofit Hospitals Addressing Obesity as a Part of Their Community Health Needs Assessment and Implementation Strategy

Over 2,900 nonprofit hospitals currently operate in the United States, serving their communities in a variety of ways such as by providing medical assistance to the uninsured and health education and programming to the community at large. Provision of such “community benefits” is required of nonprofit hospitals to maintain their tax-exempt status, and hospitals must document these activities with the Internal Revenue Service (IRS) each year. Until recently, the activities the IRS would consider as a “community benefit” have not been well-defined, and such activities have typically not been documented in ways that would allow optimal collaboration with community leaders or address the most critical of community health needs. The Affordable Care Act’s requirement that nonprofit hospitals undertake regular community health needs assessments (CHNAs) and devise an implementation strategy to provide “community benefits” to address identified needs will better align nonprofit hospital investments with community needs and create new opportunities for community-hospital partnerships.

With obesity affecting more than one-third of adults and 17 percent of children in the United States, it is likely that obesity itself, as well as the environmental determinants of obesity, may be detected as a significant community health need through the CHNAs and included in the implementation strategies of many nonprofit hospitals. The STOP Obesity Alliance is available as a resource for nonprofit hospitals that choose to address obesity through community benefit programming.

The STOP Obesity Alliance is a diverse group of consumer, provider, government, labor, business, health insurers and quality-of-care organizations united to drive innovative and practical strategies that combat obesity and foster change in society’s perceptions of, and approaches to, preventing and treating obesity in the context of the real-world environment in which we live. The Alliance’s work focuses on areas with the potential for making the highest impact for individuals affected by obesity, and is grounded in three core principles and five related policy recommendations:

Core Principles:

- *Reducing Overweight and Obesity Is About Improved Health, Not Appearance*
- *The Work to End Obesity Cannot End With Personal Responsibility*
- *Prevention and Intervention Go Hand in Hand*

Recommendations:

- *Redefine Success*
- *Encourage Innovation and Multi-factorial Interventions to Strengthen the System of Care for Overweight and Obesity*
- *Address and Reduce Stigma as a Barrier to Improving Health Outcomes*
- *Broaden, Intensify and Coordinate the Research Agenda for Obesity*
- *Encourage Physical Activity for Improved Health*

STOP's core principles and policy recommendations (described in detail below) may help nonprofit hospitals and community leaders who are working together to complete their CHNA and develop an implementation strategy to address the weight-related health needs identified in their communities.

There are many ways that nonprofit hospitals can use these core principles and recommendations to tailor evidence-based community interventions around obesity. Broadly speaking, hospitals are permitted to count "community benefit" activities under two overarching categories: community health improvement and community building. Under the health improvement category, activities can include programming ranging from clinical programs to health-related educational initiatives. For example, confusion over what a successful weight-loss program is may lead some hospitals to the false conclusion that clinically meaningful weight loss cannot be delivered in a clinical or community setting. Research shows that programs that help patients lose 5-10 percent of their body weight can lead to significant health improvements and community programs that foster such moderate weight loss can prove to be beneficial for community members across the weight spectrum.

Moreover, as weight is a highly stigmatized condition, hospitals should consider incorporating activities that will reduce obesity stigma both within the community as a whole and also within their provider setting. For example, we know that many physicians lack obesity-related training which may contribute to difficulties in the patient-provider relationship and in the clinical management of what is a serious medical condition. Nonprofit hospitals may consider implementing education and training programs to help physicians and other healthcare staff to better work with patients affected by obesity.

In addition to providing "health improvement" support, nonprofit hospitals may also choose to make "community building" investments, such as the development of evidence-based community health-related infrastructure. Support for the building of infrastructure such as recreation centers, parks, and bike lanes encourages and provides opportunities for physical activity, an essential component for maintaining one's fitness and health.

While there are many obesity-related services that hospitals can provide, there is still a critical need for more systematic and comprehensive research on the efficacy, cost-effectiveness, and identification of "best practices" for community-based obesity-related services. Nonprofit hospitals can benefit not only themselves, but the larger community, by documenting and disseminating information about their community services and outcomes. The CHNA and Implementation Strategy process will be a valuable tool for public health, community leaders, and health care providers in addressing the obesity epidemic moving forward.

In addition to this set of overarching principles and recommendations which might help guide initial program design and implementation, the Alliance will conduct an expert roundtable within the next few months to further explore issues around obesity program design and implementation as it pertains to the CHNA reporting requirement and Implementation Strategy. From this roundtable, we hope to provide hospitals with examples of best practices in community-based obesity programming and research in community building options targeted at healthy weight.

We hope that the STOP Obesity Alliance Principles and Recommendations and our ongoing work in this area will be helpful to nonprofit hospitals as they consider ways to build new

partnerships and develop programming to address obesity in their communities. Please visit our website www.stopobesityalliance.org for updates and resources on this important endeavor. If your organization would like to get involved with STOP's efforts, please email the staff at obesity@gwu.edu.

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ALLIANCE CORE PRINCIPLES

Reducing Overweight and Obesity Is About Improved Health, Not Appearance

The goal of improving health outcomes serves as the basis for addressing overweight and obesity. Overweight and obesity is linked to over 20 chronic diseases, including type 2 diabetes, certain types of cancer, hypertension and coronary heart disease. Most individuals affected by overweight or obesity, and many of their health care professionals, have unrealistic weight-loss goals that are focused on cosmetic changes, rather than long-term health. These goals may be to achieve a societal norm or to reach a normal BMI in a short period of time. Promoting sustained health improvements over cosmetic results will help focus the dialogue on obesity toward healthy mental and physical outcomes.

The Work to End Obesity Cannot End With Personal Responsibility

The STOP Obesity Alliance is dedicated to negating the myth that overcoming obesity is solely a matter of personal responsibility and moving toward an understanding that overcoming obesity requires environments where people have opportunities to make good, healthful choices. Many factors contribute to obesity and overcoming them extends beyond individual will. Racial and ethnic minorities and underserved communities experience health disparities in health status and outcomes that lead to higher rates of chronic diseases, including obesity, and increased costs of care. The Alliance sees roles for employers, schools and educators, health care professionals, community leaders, families and the government in creating an environment that will help overcome and prevent overweight and obesity.

Prevention and Intervention Go Hand in Hand

In a time of limited resources, there are those who see the solution to overweight and obesity as an either/or proposition: prevention or intervention. STOP Obesity Alliance members have approached the issue differently, grounding Alliance research and recommendations in the understanding that prevention and intervention strategies are both essential in effectively addressing obesity. Alliance members see a continuum to achieving and maintaining healthy weight. Health literate and culturally relevant approaches, methods, and tools for prevention and intervention must be applied as appropriate not only to achieve a healthier weight but also to sustain a healthy weight over time.

ALLIANCE RECOMMENDATIONS

Recommendation One: Redefine Success

Explore the use of a five to ten percent sustained reduction of current weight as the appropriate measure of success for the purpose of determining whether treatment interventions and innovations are effective.

Currently, success in sustained weight loss is evaluated based upon different definitions of success by patients, providers, and researchers. However, a growing body of evidence suggests that losing between five to ten percent of current weight leads to major improvements in key health areas, including diabetes, lipid blood levels, and even mortality. The National Heart, Lung, and Blood Institute, part of the National Institutes of Health, examined a wide array of randomized controlled studies and recommended a ten percent reduction in weight to achieve lower blood pressure, lower LDL-cholesterol and triglycerides, increased HDL-cholesterol and lower blood glucose levels and decreased incidence of type 2 diabetes.

For the purposes of mitigating the health and productivity impact of overweight and obesity, a consensus definition of the amount of sustained weight loss necessary to improve health would help us evaluate the efficacy of overweight and obesity interventions and inform reimbursement policies and health benefit design by public and private third party payers and employers accordingly.

Most individuals affected by overweight or obesity and many of their health care providers have unrealistic weight-loss goals; few succeed in achieving those goals. These unrealistic goals may be to achieve a societal norm that is mostly cosmetic. Promoting the health improvements that result from a five to ten percent sustained weight loss could help focus the dialogue on obesity toward healthy outcomes.

The Stop Obesity Alliance Recommends:

- Promoting the use of a sustained loss of five to ten percent of current weight as a key measure to judge the effectiveness of weight reduction interventions.

Recommendation Two: Encourage Innovation and Multifactorial Interventions to Strengthen the System of Care for Overweight and Obesity

Aggressively explore multifactorial interventions that can achieve a five to ten percent sustained weight loss for those whose condition has not been successfully addressed solely by nutrition and physical activity and for whom bariatric surgery is not an option. Motivate payers, insurers and employers to encourage innovation around these treatments and disease management.

Few research studies and clinical programs have described effective interventions for patients affected by lower levels of overweight or obesity, before obesity becomes severe and co-morbidities develop. At a BMI of 40 (or a BMI of 35 with co-morbidities), bariatric surgery may become an effective option for treatment for some individuals.

The paucity of effective treatments is compounded by the dominant focus of obesity research on single interventions. Furthermore, these interventions are often carried out in a homogenous group of patients, often without including details on individual characteristics that could guide “real-world” application and help clinicians to tailor treatments for different individuals. Studies often report a range of results from minimal to large, without information indicating for whom treatments were most or least successful.

Consequently, there is an urgent need to develop, test, and evaluate interventions that include multiple components (surgery + behavioral treatment + diet, for instance, or personal trainer + diet + drugs, diet and exercise plan) among diverse populations affected by lower levels of overweight and obesity, *before* co-morbidities develop. Eventually, this effort may lead to the creation of screening tools that could help match an individual patient’s characteristics and needs with appropriate interventions.

While individuals affected by overweight or obesity seek help and advice in many non-medical settings, primary care providers, and in some cases specialists who are acting in a primary care capacity, see many people affected by overweight or obesity, whether for weight management, treatment of co-morbidities, or both. As such, it is important that these providers are positioned to provide effective screening and treatment to people across the weight spectrum, from lower to more severe levels of overweight and obesity. Various research studies on primary care physician practice patterns have shown, however, that these providers often do not provide such services due to a number of factors including time, knowledge of treatment modalities, and potential discomfort with broaching the topic with patients.¹

To achieve these goals, the STOP Obesity Alliance recommends:

- Encouraging innovation around treatments, intervention and disease management with support from employers, insurers, and other payers.
- Supporting efforts by professional organizations to train health professionals in order to develop and disseminate best practices for obesity treatment that incorporate tailoring treatments for individuals to achieve maximal results.
- Identifying and disseminating successful or promising practices for interventions.
- Encouraging governmental and non-governmental entities to focus on translating the research on obesity management into recommendations for best practices in the care of individuals affected by obesity and overweight.

Recommendation Three: Address and Reduce Stigma as a Barrier to Improving Health Outcomes

¹ See, for example: Bardia, A.; Holtan, S.; Slezak, J.M.; Thompson, W.G. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clin Proc* August 2007;82(8):927-932.

Cultivate a positive environment by promoting awareness and open discussion among health professionals, opinion leaders, role models (e.g., parents, teachers, coaches) and the public of the harmful impact of stigmatizing people affected by overweight and obesity and promote interventions that provide support for sustained weight loss and go beyond recognizing the role of personal responsibility.

There is no evidence that stigmatizing individuals affected by overweight and obesity motivates them to lose weight. In fact, stigmatization may postpone and even prevent these individuals from getting treatments that could improve their health. Similarly, providers without effective treatments to offer may avoid discussions about obesity out of fear of offending their patients. Stigma and fear of offending people with overweight and obesity can silence patients and providers and keep them from addressing obesity directly and constructively. Personal responsibility for behavior change is critical to successful sustained weight loss. But, until recently, the discussion of personal responsibility has been the beginning and the end of the obesity debate. To effectively address this epidemic, we must also deal with broader societal barriers to reducing obesity.

Individual perceptions of the causes and prospects for reducing obesity among patients, providers and payers may influence decisions about obesity treatment, particularly in a time of health care cost containment. Cultivating a positive environment will allow for open and honest discussions about stigma and increased understanding about the environmental and individual causes of obesity are likely to reduce the stigma of being obese, thus reducing this barrier to successful treatments.

The STOP Obesity Alliance recommends:

- Incorporating educational messages about the environmental and individual causes of obesity.
- Including awareness messages in obesity public initiatives conducted by both government and private entities.
- Supporting efforts to include stigma awareness and training for health professionals.
- Facilitating inclusion of people who are affected by obesity or overweight in the development and dissemination of awareness messages and efforts.
- Encouraging the inclusion of measures of access to health care services by ensuring medical technology is accessible and comfortable for people who are affected by overweight or obesity (e.g., MRIs, beds, wheelchairs, mammography facilities).
- Engaging in ongoing research on the impact of stigma as it relates to: the pursuit of successful weight management tools; the willingness of individuals affected by overweight and obesity to seek help; the relationship between weight and socio-economic status; and the willingness of public and private decision makers to invest in individual treatment.
- Finding language for health care providers to approach the topic of weight loss in a way that leads to an effective and open discussion with patients.

Recommendation Four: Broaden, Intensify and Coordinate the Research Agenda for Obesity

Encourage an interdisciplinary research environment that addresses the obesity epidemic as a result of a complex interplay of biological, genetic, behavioral, cultural, environmental, social, policy and economic factors.

Throughout the current research landscape, most contributing factors of overweight and obesity are examined separately, with little research or agreement on how aspects of one domain influence another. There is a need for an enhanced collaborative effort among both governmental and non-governmental entities to study all of the important factors contributing to the obesity epidemic and how they interact with each other. The research agenda should examine both the factors and impact of obesity as it relates to health services, socio-economics, the health care system, benefit design, environmental factors/costs, and other broad issues that may affect the epidemic.

Policy makers need reliable information to assess the relative value of addressing the obesity epidemic directly. What are the impacts on productivity, military preparedness, employment patterns and international competitiveness? Addressing how overweight and obesity affects these areas, and encouraging research that addresses a broad spectrum of root causes and contributors to overweight and obesity will become increasingly important as this epidemic progresses.

The STOP Obesity Alliance recommends the formation of a broadened research agenda that includes the following four areas:

- *Clinical Research*
 - Clinical research that measures the impact of incremental weight loss—e.g., five to ten percent—on health improvements across the spectrum of, and tailored to, the severity of overweight and obesity.
 - Clinical research that measures the impact of interventions on non-weight health outcomes (such as exercise to improve fitness and quality of life) for improved health of people who are overweight or obese.
 - Explore re-defining what constitutes “evidence” for obesity interventions - overweight and obesity result from a combination of factors interacting with each other; successful interventions are also likely to be multi-component, with no single intervention ensuring widespread success. Yet, the standard for evidence-based medicine, the randomized controlled trial, is ideally suited to assess the effect of a single cause or intervention. It is time to reconsider how to rigorously evaluate interventions that do not fit the single cause-and-effect standard to incorporate both environmental and individual factors important for ameliorating obesity.²

² Jain A. Treating obesity in individuals and populations. *British Medical Journal* 331:7529 (December 2005), 1387-1390.

- *Actionable Research*
 - Develop and disseminate best practices to translate successful or promising interventions to real-world practice including clinical, school, worksite and community-based settings. For example, practice-oriented translational research approaches can be used to identify and overcome barriers to the dissemination, adoption and sustainability on:
 - Effective implementation of evidence-based practices;
 - Establishment of effective and economical modes of care; and
 - Effective and economical health promotion strategies.³
 - Develop rigorous methods that answer questions such as, “Do treatments work in the real world of everyday practice?” or “For whom do interventions work best?” For example, use of a “practice-based evidence for clinical practice improvement” can fill gaps in information needed by clinical and health policy decision makers and facilitate better understanding of what occurs when interventions developed in controlled environments with small samples of people are applied in the field with thousands of people with diverse backgrounds and needs.⁴
- *Health Services and Policy Research*
 - Apply health services research to address the immediate needs of payers, providers, individuals, employers, and other stakeholders who are on the front lines of the obesity epidemic. For example, research is needed to better understand how treatment for obesity and its comorbidities is affected by access to care issues related to third-party health insurance coverage design in both the public and private sectors.
 - Additional cost-benefit analysis on interventions related to overweight and obesity for both public and private sectors.
- *Quality Measurement and Improvement Research*
 - Support efforts by NCQA to develop measures on the evaluation and treatment of obesity in primary care settings.
 - Support efforts by NQF to create a nationally-endorsed framework for quality measurement and public reporting for the prevention and treatment of obesity across the continuum of care.

Recommendation Five: Encourage Physical Activity for Improved Health

³ “Translational Research Overview.” University of Connecticut Health Center, The Ethel Donaghue Center for Translating Research Into Practice and Policy. Available at: http://trippcenter.uhc.edu/Translation_Research/research.htm. Accessed November 8, 2007.

⁴ Horn, S.D., and Gassaway, J. (2007). Practice-based evidence study design for comparative effectiveness research. *Medical Care*. 45(10) Suppl 2. S50-S57.

Encouraging interventions and creating environments that support physical activity will improve health, independent of weight or weight loss, resulting in a healthier population.

Physical activity has significant and widespread benefits, regardless of one's weight.

In particular, increasing evidence demonstrates that physical activity leading to improvements in cardiorespiratory fitness ("fitness") is an important contributor to health and disease prevention, independent of weight or weight loss.ⁱ⁻¹¹

Many studies show that having excess weight and poor fitness is associated with the highest risk of premature death and disease. In contrast, people with high fitness levels, even if affected by overweight or obesity, have lower rates of chronic disease and premature death, compared with those who have poor fitness levels. Thus, interventions and environments (such as the workplace, community, home, parks and public recreation areas, etc.) and systems aimed at promoting and increasing physical activity to improve fitness can have wide-ranging benefits.

In clinical terms, cardiorespiratory fitness refers to the health and function of the heart, lungs, and blood vessels, and is an objective and reproducible method of assessing improvements in physical activity. Engaging in regular physical activity and reducing periods of inactivity can increase one's fitness level and health outcomes, independent of weight loss.

The STOP Obesity Alliance Recommends:

- Encouraging interventions and creating environments and systems that support active living as well as moderate-vigorous physical activity to improve health, independent of weight or weight loss.

¹Sui X, LaMonte MJ, Laditka JN, et al. Cardiorespiratory fitness and adiposity as mortality predictors in older adults. *JAMA*. 2007; 298(21):2507-2516.

²Wei M, Kampert JB, Barlow CE, et al. Relationship between low cardiorespiratory fitness and mortality in normal-weight, overweight, and obese men. *JAMA*. 1999; 282(16):1547-1553.

³Lee CD, Blair SN, Jackson AS. Cardiorespiratory fitness, body composition, and all-cause and cardiovascular disease mortality in men. *Am J Clin Nutr*. 1999; 69(3):373-380.

⁴Barlow CE, Kohl HW, Gibbons LW, Blair SN. Physical fitness, mortality and obesity. *Int J Obes Relat Metab Disord*. 1995; 19:S41-S44.

⁵Church TS, Cheng YJ, Earnest CP, et al. Exercise capacity and body composition as predictors of mortality among men with diabetes. *Diabetes Care*. 2004; 27(1):83-88.

⁶Stevens J, Cai J, Evenson KR, et al. Fitness and fatness as predictors of mortality from all causes and from cardiovascular disease in men and women in the lipid research clinics study. *Am J Epidemiol*. 2002; 156:832-41.

⁷Evenson KR, Stevens J, Cai J, et al. The effect of cardiorespiratory fitness and obesity on cancer mortality in women and men. *Med Sci Sports Exerc*. 2003; 35:270-7.

⁸Stevens J, Evenson KR, Thomas O, et al. Associations of fitness and fatness with mortality in Russian and American men in the lipids research clinics study. *Int J Obes Relat Metab Disord*. 2004; 28:1463-70.

⁹Rankinen T, Church TS, Rice T, et al. Cardiorespiratory fitness, BMI, and risk of hypertension: the HYPGENE study. *Med Sci Sports Exerc*. 2007; 39:1687-92.

¹⁰Hu G, Barengo NC, Tuomilehto J, et al. Relationship of physical activity and body mass index to the risk of hypertension: a prospective study in Finland. *Hypertension*. 2004; 43:25-30.

¹¹Wessel TR, Arant CB, Olson MB, et al. Relationship of physical fitness vs body mass index with coronary artery disease and cardiovascular events in women. *JAMA*. 2004; 292:1179–87.