WIG Virtual Policy Briefing
April 28, 2021
"Obesity Epidemic: Lack of Access to Care and Treatment"

Featuring:
Louisiana State Representative Regina Barrow, WIG State Director
Melinda J. Watman, RN, BSN, MSN, CNM, MBA, Chair, *Massachusetts Coalition for Action,* Board Member, *Obesity Action Coalition*

Angela Fitch, MD, Associate Director, *Massachusetts General Hospital Weight Center,* Faculty, *Harvard Medical School*

Lucy Gettman: Welcome to Women In Government's virtual policy briefing "Obesity Epidemic: Lack of Access to Care and Treatment." We're excited to bring you this important discussion today.

Women In Government is a nonprofit, nonpartisan organization by and for women state legislators. I'm Lucy Gettman, Executive Director, soon to be Immediate Past Executive Director, which is why I'm so honored to introduce former Colorado State Senator Nancy Todd, also past Chair of the WIG Board of Directors. Senator Todd has joined Women In Government as Interim Executive Director. So, I'm thrilled to welcome you, Senator Todd, and I hand over the virtual microphone to you.

State Senator Nancy Todd: Thank you, Lucy. I'm really happy to be with you here and excited to take on this new role with Women In Government. I've been involved with Women In Government for the 16 years I served in the legislature, and I'm just delighted to be able to carry on the torch and make sure that the smooth transition from Lucy to our next Executive Director goes well. I welcome everyone, and for those of you that are new to WIG today, we are so glad that you could join us, and we hope that you'll continue to stay engaged with Women In Government. We've got a very, very busy year ahead for all of us.

Now, I would like to introduce our moderator for today's event, WIG State Director Louisiana Senator Regina Barrow. Please read her full and very impressive bio in the Chat Box. Senator Barrow, thank you for being here today. I am glad to see you once again, and I turn the floor over to you. Thank you.

Senator Regina Barrow: Thank you, thank you so much to the WIG team for having me today, and I look forward to this discussion. We have a couple of housekeeping items. Please take a moment to introduce yourself in the Chat Box and let us know who you are and where you're from. Today's speakers will be showing slides, and you may want to select "Speaker View" or "Side By Side" from your view options as you follow along with today's meeting. Finally, if you have any questions or comments during the session, please write them in the chat box at any time during the presentations and we will go through those with without Q and A portion at the end of the program. Also, please stay connected with Women In Government through social media and be sure to use the hashtag #ConnectingLegislativeLeaders.

Next, Women In Government would like to also ask and thank the business community and Business Council Members and Associate Members for their support of the organization and its mission. We cannot do this work without them, so, we are so appreciative to our sponsors.

I'm glad to be a part of today's discussion. Several legislators like myself recognize that obesity is a serious health condition that deserves attention so that our constituents can get the help they need. Today, we're going to talk more about obesity, not only from a policy perspective, but also from a social one. We will start the presentation from each of those presenters today and then finish with Q and A.

Please join me in welcoming our featured guest speakers for this session, Dr Angela Finch, Associate Director of Massachusetts General Hospital Weight Center and Melinda Watman, Chairwoman of Massachusetts Coalition of Action on Obesity and Board Member of Obesity Action Coalition. Please check out the Chat Box to read their qualifications and biographies.

Melinda, let's start with you, and I look forward to hearing your presentation as I turn it over to you.

Melinda Watman: Wonderful. Thank you so much. So, I want you to just close your eyes for a moment and imagine what the person I'm about to describe looks like, feels like, sort of your image of that person: successful, social, athletic, close family ties, well respected in the community, and just overall very impressive. In general, this is sort of what people pick – age, a few years give or take, their clothing, but this is the image that people have in mind. However, this person is actually the person I was describing. I have a very close association with this person because this person is me. I weigh 225 pounds, I have obesity, and I will always have obesity. I think of myself as being in remission, and what you have to remember is, in that previous slide, that was most of my life. So, the people who interacted with me looked at that person and did their judgments based on what I looked like, not based on the words I use to describe myself - all of which were true.

So, let's talk a little bit about that, about weight bias. What is weight bias? Well, you all can read what this is, but when you think about it in the big picture, I was subject to all of these things, as are most people with obesity, and what you end up is taking all of that in and internalizing it. So, in many ways you're your own worst enemy. You're the person who's got this extraordinarily strong amount of weight bias because all these things that have gone out around you. They're all happening pretty much all the time, so what I would encourage you to do is – you'll see at the bottom there the Harvard Implicit Study. I encourage you to take this test. It helps sort out some of your own internal biases.

I'm in the business, so to speak, and when I took it, I was amazed at the results. So, it's really quite a revealing test on our biases, and there's lots of them - there's weight, there's race, there's sexual orientation. So, Harvard has done a lot of tests that I think would be very interesting, but in particular we're talking about weight.

So, tagging on to what I was just saying about that test, the real issue is how does this play out for you? What do you think about people with obesity? Do you think of them as slobs, lazy, non-achieving? How do you feel when you interact with them, for instance you're on whatever public transportation you have – the T, the bus, and there's a seat next to you, an airplane – and there's a seat next to you and somebody with obesity sits down next to you what's your reaction? How do you feel? What do you do when you're with a group and somebody makes a disparaging comment about somebody who either passes by or sits down next to you with obesity?

This is a tough one because I sit on two sides of the fence, right? I was 225 pounds, and now I'm not. Well for people who don't know my story, because making fun of those with obesity is like a free for all and it's an accepted way of discriminating against people - I have been in situations where people have made very disparaging comments, and they think I'm one of them, so they don't even consider that there is anybody in this group who might have a different opinion. So, I've been put in a position of having to figure out "What do I say?" And I have a whole little group of things that I say, depending upon the situation. It does make people a little bit uncomfortable, but the truth is I think that's okay. I think people need to sort of have a bit of discomfort to understand what they're doing is very hurtful and potentially harmful.

So, I call this the evil twin syndrome, and that is that we all have thoughts that aren't so nice. We just do. We're human beings. And actually, that's okay in the sense that what we do with those evil twin thoughts, is what matters. So, do we act on them, or do we not? Do we do something that's completely out of step with the evil twin thought? Because we're so hard wiring that making someone change their mind - like "I hate celery, and nobody's going to convince me to like celery" - it's not going to happen.

So, I may say to you, over and over and over again, "You can't have these thoughts. You can't think like that. You can't. It's wrong." And you're going to say, "Nope that's the thoughts." But what do you do about them? So, what you do about them is not act on them. You act the way you should, which is not with disparaging comments, not with disgusting looks, not with sort of a physical - literally a visceral physical response. And sometimes, hopefully more times than not, with behavior repetition, my saying over and over again. "That doesn't work," but with a person over and over again doing quote "the right thing," then their mindset might change. So, you may see a shift, but mostly it's how you act.

You probably have heard me saying, "those with obesity," "I have obesity". Obesity is a disease, and Angela will talk about that more and because it's a disease, it should be spoken as a disease. If I say, "I have an obese patient" or "I have a friend who's obese," I've defined them. That is a defining statement. It's an adjective, and that's what that person is. If I say I have someone with obesity, it's a whole person with the disease, and if you think about it in terms of cancer, you would never say to someone or patient – a doctor or nurse that will never say this to the patient, "I have a cancerous patient."

It's "I have a patient with cancer," and it's that sort of language change - and it's called people first language - I think of the person, and then I put onto that what's going on with that person. And so, this is like a little thing that you can do when you hear someone say the word obese. You can say, "Hey, you know what I just learned…" and so I leave that for you to hopefully pass along.

This is just to show you, which is just really scary that the largest group of people who act - would act out on weight bias - are friends and family. For me it was hard to believe, and you see health care is right up there as well. So, I leave you with the thought that you do have the ability to make changes in your behavior and help make changes and other behaviors and they can be incrementally small to large, but it does matter to those with obesity. It really does matter. And with that, I will leave it to Angela Fitch.

Angela Fitch, MD: Thank you Melinda. So, we had Obesity Care Week just recently. World Obesity Day was March 4th. I encourage you to keep your eye on that for next year and ways to sort of promote getting the word out on obesity, because as Melinda said, there's a lot of bias and stigma. But you can see that 30% of annual health care costs are spent on obesity related conditions. That's $480 billion dollars in annual obesity related health care and 230 diseases and disorders that are contributed to by obesity.

Obesity is a disease of excess body fat. We define that today by body mass index, and you can see that we've now classified obesity – Class 1, Class 2, and Class 3 - as noting that that those with Class 3 obesity actually have more risk associated with that right? It's more severe of a disease, but, as noted at the top, this is a chronic treatable disease. It's a disease, as Melinda said. It's not people's fault. Yet, you can see where, if you look at this slide here, that while 65% of people with obesity think it's a disease, 82% of people with obesity consider weight loss to be completely their own responsibility - that somehow, they should try to fix it, not come to their doctor, not get help by other things, but that they should try to fix it. And that's that internalized bias and stigma next.

This is the state of obesity, which I'm sure you guys are well informed of. And you can see this graph getting redder and redder as the time goes on along the top. So, this is 2016, 2017. The red is indicative of greater than 35% of the population in that state having obesity, and you can see where this is getting worse and worse. This is a big burden on our healthcare system. So, in the United States, we have the highest percent of total healthcare expenditure at 14%. Two thirds (2/3) of diabetes costs are attributed to obesity, so if we treated obesity, we would get rid of two thirds of all of diabetes spending. We'd also get rid of a quarter of cardiovascular spending, and 9% of all cancer care can be attributed to obesity as well because cancer is directly associated with obesity also.

The pandemic has highlighted a lot of these issues and also making likely that things are getting worse. This was a survey by the American Psychological Association you may have seen some media around. If you look at the top, 29 pounds was the average weight gain reported by 42% of adults in our country related to the pandemic. So, this is a problem that's only getting worse on top of a problem that's getting worse. There was a JAMA study in the "Journal of American Medical Association" that actually looked at scale data. These were connected scales in patients that were part of a of a treatment program where the average weight gain was 1.5 pounds per month. If you extrapolate that over a year, right, you're talking about almost 20 pounds in a year's time - which is not good for people for anybody to gain 20 pounds.

The other issue that was highlighted with COVID is that the risk of death from COVID-19 – in the red box you can see there - if your age is less than 60 and your BMI was greater than 45, which is the number at the bottom or greater than 40 even, your risk of death - the risk ratio - was 17 times that of somebody without that BMI. So, you had 17 times more likelihood of dying of COVID-19 if you had a BMI greater than 40 during this pandemic. So, had we known that in the beginning - I mean hindsight is 20/20, but - if we had better access to treatment very early on and very rapidly, we could have probably said quite a few lives as it relates to those people that they got sick from COVID-19.

This is the issue with weight loss is that while people think, "You know, it's normal to lose weight. I should be able to lose weight." It's not normal. It's abnormal to lose weight. It's not the normal human process. So, when you lose weight on the left-hand side, your body fights back on the right-hand side by causing these release of hunger hormones, decrease in fullness hormones. This is your chemistry, not your character, that's driving your weight gain. So, we have to rethink about how we treat obesity, and that's my job as an Obesity Medicine Specialist. I talk about this to patients all the time. We need structure, we need accountability, we need a metabolic advantage, and we need an environmental change. The structure, the accountability, the environmental change - that's all the things that we're working on all the time, you know, in policy and getting treatment options out to patients. But the metabolic advantage is really only given by things like surgery and medications that treat the disease of obesity, and so that's what we'll focus on in a second here.

If you look at diabetes, for example, 10% of the United States has Type 2 diabetes. Of those people in the yellow there, most of those people are treated. Most of those people are treated with some sort of medication for their diabetes because it's a disease, and that's how we treat diseases. On the left-hand side, if you look at obesity as a comparison, 45% of people have obesity or treatable levels of weight struggles in our country. Yet only a very small percentage, less than 2% of people, actually receive treatment. This is this access issue that's multifactorial, compounded by the bias and stigma, and also some of the things we've set up in our healthcare system that make it hard to get access to this type of treatment.

The US Preventive Task Force in 2012 actually said that this should be a covered service, a preventative service, a grade B recommendation. The patient should be referred if they have a BMI greater than 30 and should be offered intensive, multicomponent behavioral interventions with a dietitian, with a psychologist, all these things you can see in the highlighted red circle. Yet still it's very challenging for patients to find access to this because we don't have this set up properly within our healthcare system.

This is the treatment pyramid that we look towards as we treat obesity, right? We see it as a disease, so on the left, as your health risks and your BMI increase, we need to increase our treatment intensity. It shouldn't be about "Oh I failed this, so now, I need this." If you have a BMI greater than 40 or you have a BMI greater than 35 with a comorbidity, then most likely, you need surgery. Surgery is what reliably produces a 30% to 40% weight loss, and that's what you're looking to achieve. Just like with, for example, breast cancer, if you have breast cancer and it's bad enough, you might need a mastectomy instead of a lumpectomy right? And we don't do that because we want to be having surgery. We do that because we know that that's the most effective treatment, and in this case, surgery is our most effective tool.

So here, if you look in the highlighted red box, you can see the different treatment options. On the left-hand side we have intensive behavioral therapy. On the next slide, we have surgery, and then we have our medication options that we have for treatment of obesity. If you see here, for greater than 15% weight loss, which is what most people want to achieve, right? If you're - if you're 250 pounds, you want to lose greater than 25 pounds usually. 25 pounds would be 10%, 15% would be more than that - about 40 pounds of weight loss. If you want to do that, your chances of doing that with Weight Watchers or

some sort of behavioral program there's only 12%. That - that is five times, if we add medication such as Semaglutide, which is coming soon in the next couple of months as an approved medication. That's three times the amount of people we get into that category with our current medications that we have here on the market today, these medications listed here. So, you can see where we can quadruple or even five times the amount of people getting into this weight loss success category with medication, as well as seven times that was surgery.

So, just to summarize things, the access to care, and again, you can have these slides to sort of highlight what these issues are with these accesses, these barriers that Melinda talked about - personal barriers, access barriers, insurance problems. In summary, these are some ways that we can improve access. I want to leave some time for questions, so I'll just leave you with this to think about, but the biggest issue is that most of the time anti-obesity medications and even surgery sometimes are not covered as a standard benefit by insurance. So, when we have a disease, and yet we don't have good coverage, including Medicare coverage, so the Treat and Reduce Obesity Act is our national act that would include these sorts of treatments, these behavioral lifestyle interventions, as well as medications on the Medicare formulary on CMS and then hopefully the rest of the insurance plans would follow.

Thank you so much. It's just that this is good news because this is a disease that's treatable as long as we provide people with the tools to be successful. Thank you so much.

Senator Regina Barrow: Thank you so much, Dr Angela Fitch and Ms. Melinda Watman. This has been some very great and very good information. I've noticed two questions in the chat box. Will you guys make these slides available to everyone after the presentation?

And the next question was dealing with the shape and size - for decades, we were told about the dangers of the apple shape obesity versus the pear shape obesity. Is that still reliable?

Angela Fitch, MD: That is still reliable. That talks about your waist circumference, really, and so the amount of adiposity or excess fat that you store in your abdomen is worse, if you will, than storing it, for example, in your buttocks or hips, which makes us more of a pear size. So, as women, in particular, a lot of times we do struggle more with weight in the buttocks and hips area, which, while it still can be a problem for people, you know, just carrying that weight around and joint pain and things like that, so it still could be an issue, but it's not as much about metabolic health issue as it relates to risk of diabetes and other sorts of conditions.

Senator Regina Barrow: Oh well, thank you so much for that response. You did mention and kind of touched a little bit on insurance coverage and the importance thereof. And so, in 2020, right before the pandemic actually hit, we were scheduled to go into session, and I had a bill filed to allow our state insurance plan to be able to cover obesity or bariatric surgery. Well, because of the pandemic, like everybody else, we closed down, and when we came back, we were asked to only bring bills that were COVID related, so I have brought that bill again this year, and we just heard it today in committee. It did pass out unanimously. There is a fiscal note attached to that bill, but we are believing that we can work through the process of having that be a pass, because in hearing the information, one of the things that

came out during testimony was how obesity unfortunately inadvertently affects women more than men, especially with our state health plan. They have recognized that more women are overweight than men. So, we are going to give an opportunity, providing that this bill makes it all the way through the process, that it will now offer that particular surgery for women.

Then, just on a personal note, you know as we were talking about COVID and the impact COVID has had on those individuals who are obese or with comorbidity, you know, unfortunately, y'all may not know, but unfortunately, I lost my husband to COVID in December, and he did have some of those comorbidities. And his actual cause of death was the attack COVID had on his pancreas. So, he did have some comorbidities that added to that. So ,this is so very important, and COVID really has highlighted the adverse effects of obesity.

Angela Fitch, MD: Yes, and I would encourage everybody - I mean that's great work that you did. I'm very, very sorry for your loss. I mean, I'm sorry for - you know, we've had so much loss right with this disease. And it's really been these two pandemics that have been overlapping, which is the pandemic of obesity and the pandemic of COVID because COVID, in particular, attacks the metabolic system and makes that metabolic system go kind of haywire. So, it's like - it's like a perfect storm of inflammation in the body all of a sudden, especially when people have that baseline inflammation from obesity. And so, there's a connection there, and we didn't know that, you know, until it happened. But people are talking about it now as a syndemic, which is when two pandemics come together to form a perfect storm of badness.

And as you mentioned, it's got racial disparities and other types of disparities too, so it's very - it's very challenging, and I really encourage people to do what you did and have bills that not only support bariatric surgery - because that's, like I said, the top treatment - but our pharmaceuticals are getting really good today.

You know we're getting some much better treatments today, and so, if we can get universal coverage of those, they shouldn't be a carve out. They're a carve out right now. Employers have to decide to cover anti-obesity pharmaceuticals. They're carved out just like infertility treatment, and they shouldn't be because it's a disease. Like we don't carve out cancer treatment. We don't say, "Oh, you know employer, if you want to cover cancer for your people, you've got to pay more for your plan." We don't say that because it's a disease, and we just treat it like that.

Senator Regina Barrow: I am so glad that you're really - that the both of you are really highlighting the fact that this is a disease, and that it should be treated that way. We have one last question before we end, and it comes from Sue Errington. Is cool sculpting simply cosmetic, or does it have health benefits too?

Angela Fitch, MD: It's pretty much cosmetic. So, we do use it for some people, like especially after they've lost a lot weight, because it might be helpful in troublesome areas, you know, to get rid of some troublesome areas cosmetically. But it doesn't really - the weight will come back on if you're not doing

something else at the same time to treat your obesity. If you just use cool sculpting alone, you know, the weight - the fat will come back on somewhere else.

Senator Regina Barrow: All right, well, it feels like we have finished for today. I want to thank you again, Melinda Watman, Dr. Angela Fitch. I'm glad we had the opportunity to talk openly without bringing needless shamed or negativity into this important conversation. Thank you to our audience for your time and your thoughts.

I'd like to remind everyone that this presentation and other resources will be available on the WIG website a few days post event. Now I'd like to turn the floor back over to WIG Interim Executive Director Ms. Nancy Todd for closing remarks.

Senator Nancy Todd: Thank you so much, Senator Barrow. And again, I offer my condolences for the loss of your husband, and again, congratulations on the work that you're doing in Louisiana in this area of obesity. It takes that personal information and experience sometimes to move things forward, and so I congratulate you on that. I thank you also, Melinda and Dr Fitch.

Now, for everyone on this call, I'd like to invite you to our upcoming programs. So, please join us on May 17th for an important bone health briefing with our partners at the National Osteoporosis Foundation. And please mark your calendars for our virtual Summer Summit Series that is going to be starting in late June, so check out www.womeningovernment.org for all upcoming event details and registration.

Stay safe, be well, and spread the education that you learned today. Thank you so much, and God bless you all!

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