AHIP
America's Health Insurance Plans

FACING THE CHALLENGE OF UNHEALTHY WEIGHT:

Recommendations for the Health Care Community

AHIP is the national association representing nearly 1300 members providing health benefits to more than 200 million Americans. Our member companies offer medical expense insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers, and public purchasers. Content and Design. AHIP—All Rights Reserved: © AHIP 2008.

Overview

The rapid increase in overweight and obese adults and children during the past three decades is one of the most significant health care challenges facing the United States, with health-related consequences and costs that affect everyone. Curbing, and ultimately reversing, this trend will require understanding, commitment, creativity and collaboration across all parts of society.

The prevalence of overweight and obesity is an especially difficult problem to address because of its many medical, social and cultural dimensions, and because of the limited evidence available on effective approaches to its prevention and treatment. But the need for action is urgent.

In 2007, AHIP assembled an Expert Panel on Obesity and Related Screening Measures to Improve Health (see Appendix A), consisting of health insurance plan chief medical officers and directors, clinicians, researchers, and policy and quality leaders from the public and private sectors.

Panel members discussed the state of the science surrounding obesity screening and treatment and the challenges raised by screening, including communication barriers, cultural and linguistic competency, and the need for appropriate and evidence-based guidance and follow-up.

Based on the work of the AHIP Expert Panel and other research and meetings sponsored by the AHIP Obesity Initiative, this report offers the following recommendations for the health care community:

- make routine body mass index (BMI) screening and interpretation a standard clinical practice for the care of adults and children;
- equip clinicians (physicians, physician assistants, nurses, dietitians, physical therapists, behavioral specialists, medical assistants and other medical professionals) with training and tools to communicate effectively with patients about BMI screening, overweight and obesity;
- connect BMI screening to evidence-based prevention and treatment options;
- build partnerships among health insurance plans, physicians and clinicians, employers and community groups, and disseminate promising practices;
- promote cultural competency and reduce racial, ethnic and cultural disparities; and
- measure and report progress in BMI screening through standardized measures such as the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®).

This report also examines some of the many innovative programs that health insurance plans and clinicians have developed, in collaboration with employers, schools, community groups and policymakers, to encourage BMI screening and to address the challenge of unhealthy weight among children and adults.

* AHIP's Obesity Initiative supports its member health insurance plans' obesity prevention and treatment efforts. The Initiative's ongoing series of forums, programs, grants, educational webinars, and roundtables bring health insurance plans and other stakeholders together to discuss the challenges of obesity, review the evidence, develop effective strategies, and share models that work. AHIP staff who contributed to the Expert Panel and this report include: Bob Rehm, vice president, public health and clinical strategies; Casey Korba, program manager, public health and prevention; and Kirstin Dawson, research associate, clinical affairs.

Support for the Initiative comes from the Centers for Disease Control and Prevention (CDC) and Pfizer Inc.

Facing the Challenge of Unhealthy Weight: Recommendations for the Health Care Community

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Defining Unhealthy Weight and Its Risks

Overweight and obesity affect the physical, emotional and social health of millions of Americans. The common measurement that is used to assess whether an individual's weight level is healthy or unhealthy is the "body mass index," or BMI, which is easily calculated with a mathematical formula that uses measurements of weight and height. There are important differences, however, in the ways BMI scores are used to define unhealthy weight for adults and children.

- The National Institutes of Health, the Centers for Disease Control and Prevention (CDC) and the World Health Organization classify adults with a BMI of 25 to 29.9 as overweight and adults with a BMI of 30 or more as obese.
- Since children have more natural body fat when they are young and there are normal differences in body fat between boys and girls, the risk of unhealthy weight for children is determined using a CDC-developed growth chart that places BMI scores in percentiles for a child's age and sex. The American Academy of Pediatrics classifies a child with a BMI that falls in the range from the 85th percentile, up to, but less than, the 95th percentile as overweight, and a child with a BMI in the 95th percentile or greater as obese.[1] (The CDC uses the terms "at risk of overweight" and "overweight" for these two percentile ranges.[2])

Two-thirds of U.S. adults are now overweight or obese

The prevalence of overweight and obesity among Americans, using BMI as the standard measure, is tracked by the National Health and Nutrition Examination Survey (NHANES), which is conducted for the CDC's National Center for Health Statistics.

Among adults aged 20-74, prevalence of overweight and obesity increased from 47.0 percent in the 1976-1980 survey period to 66.2 percent in the 2003-2004 survey period. In 2005-2006, 34.3 percent of U.S. adults, or more than 72 million Americans, were obese: 33.3 percent of men and 35.3 percent of women. The data show that the entire U.S. adult population has become heavier since 1980 and that the heaviest adults have become much more obese.

Being overweight or obese increases the risk of many diseases and health-related conditions,[3] including:

- type 2 diabetes;
- hypertension;
- high total cholesterol or high levels of triglycerides (dyslipidemia);
- coronary heart disease;
- stroke;
- gallbladder disease;
- some cancers (endometrial, breast, esophageal and colon);
- osteoarthritis;
- obstructive sleep apnea and other respiratory problems;
- depression, low self-esteem and other psychological reactions to body image; and
- stigma, discrimination, and teasing and bullying.

Two-thirds of U.S. adults are now overweight or obese

The good news is that modest weight loss can have beneficial health affects. A reduction of 5 to 7 percent of body weight is associated with lower incidence of diabetes, reduced blood pressure, and improved cholesterol and triglyceride levels.[4, 5]

Unhealthy weight is up sharply among children and teens

Almost one of every three children in the U.S. is considered overweight, with BMI scores that are at or above the 85th percentile for their age and sex, and there has been an alarming rise in obesity among even the youngest children over the past three decades. Between 1976-1980 and 2003-2004, the prevalence of children with BMI scores at or above the 95th percentile for age and sex increased from:

- 5.0 percent to 13.9 percent for children aged 2-5 years;
- 6.5 percent to 18.8 percent for those aged 6-11 years; and
- 5.0 percent to 17.4 percent for those aged 12-19 years.[6]

Overweight children are at increased risk of remaining overweight as they age, and becoming more severely overweight as adults. Even more troubling, some of the comorbidities associated with adult obesity are now appearing in late childhood, which has led to a dramatic reassessment of how physicians should manage risk factors for conditions such as cardiovascular disease.

In mid-2008, the American Academy of Pediatrics released updated guidelines[7] on cholesterol screening and treatment for children, which state that overweight children should receive cholesterol screening regardless of family history. While the primary recommendations for helping children manage unhealthy cholesterol levels are changes in diet with nutritional counseling and lifestyle changes such as increased physical activity, the updated AAP guidelines also recommend that cholesterol-lowering drugs be considered for children eight years of age and older. These new recommendations highlighted the severity of the many health risks associated with childhood obesity, but they also generated concerns that the widespread adoption of a pharmacological approach might deter population-based prevention.

Unhealthy weight is up sharply among children and teens

Recommendation: Make routine BMI screening a standard clinical practice.

An essential first step toward individual and societal engagement in preventing and treating overweight and obesity is to make body mass index (BMI) screening a routine practice for children and adults.

The consensus of the AHIP Expert Panel is that BMI is an accurate predictor of increased risk for certain diseases and conditions in childhood and adulthood and should, therefore, become standard clinical practice. The Expert Panel's members believe that the foundation for addressing overweight and obesity is a person's knowledge of his or her health status and associated health risks, which starts with the measurement of BMI through screening.

BMI Screening → **Health Status** → **Associated Health Risks** → **Action**

Using BMI as a screening measure for adults

Nationally and internationally, many expert groups recommend the routine use of BMI to screen for overweight and obesity in adults, including the U.S. Preventive Services Task Force (USPSTF), the American Medical Association (AMA), the World Health Organization, and the United Kingdom's National Institute for Health and Clinical Excellence.

The USPSTF is an independent panel of primary care clinician experts sponsored by the Agency for Healthcare Research and Quality. Task Force recommendations are graded based on a rigorous review of the literature and they are considered the evidence-based, gold standard for most practicing physicians and health insurance plans. The USPSTF recommends that primary care clinicians screen all adult patients for obesity and offer high-intensity counseling and behavioral interventions to promote sustained weight loss for obese adults (see sidebar, Intensive Behavioral Counseling, page 10). The USPSTF concluded there is insufficient evidence to recommend counseling or interventions for adults who are overweight but not obese.[8]

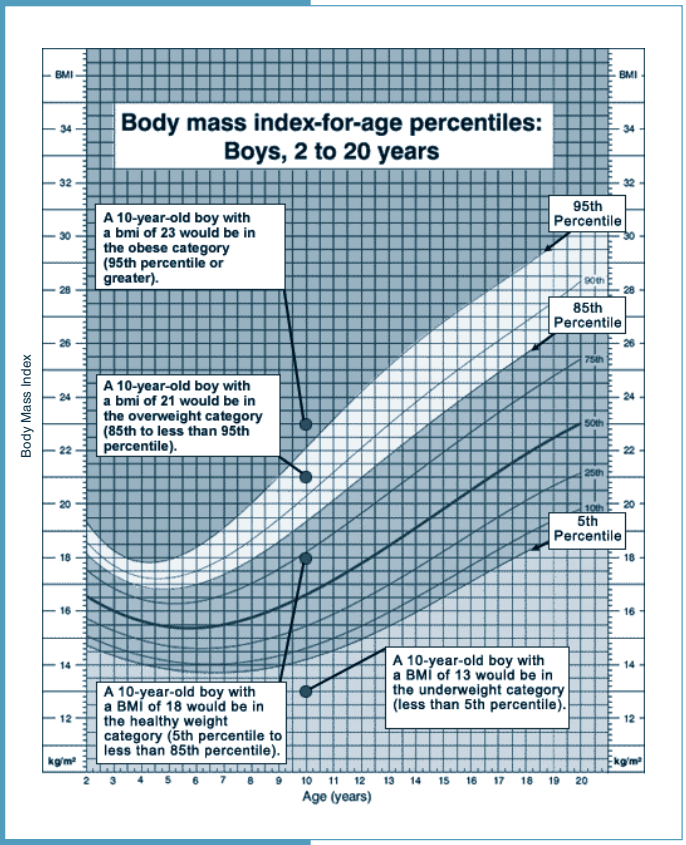
Using BMI percentiles as a screening measure for children

The AHIP Expert Panel concluded that, among children and teens of both sexes, there is a very linear relationship between BMI-for-age above the mean and body fat. It is accurate to say that at high levels of body weight for age, most of the excess weight is fat, particularly above the 95th percentile. Data from the Bogalusa Heart Study, a long-term epidemiological study on the incidence and prevalence of cardiovascular disease risk factors in children, show that the prevalence of one cardiovascular risk factor begins to increase at a BMI just below the 95th percentile and the prevalence of two and three risk factors can be seen at around the 98th percentile.[9]

The American Medical Association, the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) all recommend the use of BMI screening and BMI growth charts to identify overweight and obese children. In January 2007, the AMA's Expert Committee on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity recommended that "physicians and allied health care providers perform, at a minimum, a yearly assessment of weight status in all children, and that this assessment include calculation of height, weight (measured appropriately), and body mass index (BMI) for age, and plotting of those measures on standard growth charts."[10]

Make routine BMI screening a standard clinical practice

In 2005, the U.S. Preventive Services Task Force concluded there was insufficient evidence to recommend for or against routine screening in a clinical setting for overweight in children and adolescents as a means to prevent adverse health outcomes, also citing potential harms, including labeling and stigma, as concerns. The Task Force issued a commentary and a video that addressed the need for a broad research agenda in this area and reinforced the importance for clinicians to respond to the concerns of families, and cited recommendations of other groups including the AAP, the Health Resources and Services Administration (HRSA), and the Institute of Medicine (IOM).[11] These and other expert opinions on how to use BMI to screen children and adolescents, and how to communicate with the children and their parents, are important resources that provide additional guidance to health insurance plans and clinicians (see Appendix B).



Keeping the predictive value of BMI in perspective

BMI screening is an indirect measure of body fat, not a tool to diagnose a specific condition or to recommend a specific treatment approach, and it needs to be used in conjunction with an assessment of other associated risk factors.

While adult BMI scores closely correlate with body fat content and its attendant health risks, the correlation is dependent on age (for example, BMI correlates least strongly with the elderly), and may vary by characteristics of the population, including ethnicity, gender and socio-economic status. The BMI score may overestimate body fat in people who have muscular builds, and it may underestimate body fat in people who have lost muscle mass because of age or other reasons. For children, there is a reliable correlation between BMI and body fat at or above the 95th percentile for sex and age, but there is a far greater risk of misclassification in the 85th to 95th percentile.[12]

Furthermore, BMI is only one indicator of unhealthy weight. A large waist circumference and/or a high waist-to-hip ratio may indicate risk even for a person with a BMI score in the normal weight category. A waist measurement of more than 40 inches for a man or 35 inches for a woman is an indicator of an accumulation of fat around the waist, which can increase the likelihood of heart disease, type 2 diabetes, and other health problems.[13] The AHIP Expert Panel agreed, however, that waist circumference is a more difficult measure to obtain in both clinical and community settings (at health fairs, workplaces, etc.), while the BMI is a valid, reliable and cost-effective measure that is easy to calculate using simple, readily available tools.

"We need to think of BMI as a screening test for a risk factor for which there might be multiple conditions or multiple treatments to consider, rather than as a screening test for a specific treatment."

– Physician and Public Health Member of the Expert Panel

Anthem Blue Cross *(formerly Blue Cross of California)*

Empowering physicians, members, and the community

In response to the childhood obesity epidemic and the public health nature of the problem, Anthem Blue Cross launched a statewide childhood obesity initiative in 2005. What began as a small number of programs quickly expanded into a multifaceted initiative designed to equip physicians, empower members, and engage communities across California. Anthem Blue Cross is the state's oldest and largest health insurance company with more than 8.4 million members.

Equipping primary care practices

Since 2005, the Physician's Kit for Fighting Childhood Obesity has been distributed to more than 12,000 pediatricians and family medicine physicians. The kit includes: A Childhood Obesity Desktop Reference Tool for Physicians, BMI calculator wheel, BMI CDC Growth Charts, a nutrition and activity guide for parents, and a family workbook and guide to eating well and increasing physical activity for Medicaid and SCHIP members, 6 to 12 years of age, and their families.

Anthem Blue Cross collaborated with Dr. Wendy Slusser, assistant clinical professor of Pediatrics at University of California Los Angeles (UCLA), the local chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), and the California Medical Association (CMA) Foundation to develop an online CME training that addresses prevention, detection, assessment, and management of childhood obesity. Since November 2005, the CME program has been rolled out to over 12,000 primary care practice physicians in the Anthem Blue Cross network. In addition, a CME Bulletin is being developed with the national AAFP for nationwide distribution to AAFP members (including residents) and WellPoint physicians. The CME, authored by a pediatric and family medicine expert, addresses the causes and consequences of childhood overweight and obesity, describes measures to facilitate early identification and management, and recommends provision of directed anticipatory guidance and referral options.

Anthem Blue Cross has also participated in a year-long collaborative effort in California to bring health plans, academia, and public health agencies together to develop standard physician resources around obesity. This endeavor, spearheaded by the CMA Foundation and the California Association of Health Plans (CAHP), resulted in three toolkits, including the Child & Adolescent Obesity Provider Toolkit.

Supporting the use of BMI as a screening measure

After a needs assessment of network physicians identified a lack of standard obesity screening practices and a need for BMI training, Anthem Blue Cross developed and implemented a statewide, three-tiered BMI Training and Promotion program that includes in-person workshops, web-based training, and CD training in BMI measurement, documentation, and tracking. It is tailored to clinical staff (registered nurses, licensed vocational nurses, and medical assistants) in pediatric, family medicine, and internal medicine offices.

In collaboration with the California Child Health Disability and Prevention (CHDP) Program, Anthem has reached out to CHDP primary care practices and extended the BMI training to their clinical staff. Anthem Blue Cross has conducted 51 BMI workshops in California over the last three years that have reached over 2,500 clinical staff and 300 school nurses and health educators across the state.

The program is closely monitored through pre- and post-workshop assessments, as well as a physician-based three-month follow-up with participating practices to assess office-based BMI use and to identify follow-up needs. Physician use of BMI is tracked during the Healthcare Effectiveness Data and Information Set (HEDIS) data collection process, and member knowledge of **"**their numbers,**"** including BMI, is assessed through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. Anthem Blue Cross was invited by NCQA to be one of three health plans to field test the feasibility of a performance measure for childhood obesity in 2007, and its BMI program was featured in NCQA's Leadership Series: Quality Profiles ™.

The Anthem Blue Cross childhood obesity initiative has been instrumental in identifying the best ways to build physicians' buy-in and equip clinical staff and practices. Implemented as a **"**core program**"** that incorporates physician CME and BMI training workshops for clinical staff, these best practices have been replicated in West Virginia (UniCare®), Indiana (Anthem Blue Cross Blue Shield), and Nevada (Anthem Blue Cross Blue Shield), and WellPoint is considering the launch of the core program in several additional states.

An important complement to the screening efforts is to provide physicians with resources and programs they can recommend for members identified as at-risk, overweight or obese. Anthem Blue Cross initiatives for members include:

- **OneToWon! Nutritional and Physical Activity Counseling Pilot:** A personalized one-to-one structured counseling pilot program designed to help children and adolescents 2 to 18 years of age, who have a BMI percentile equal to or greater than 85, develop healthy eating and physical activity routines. The program entails family-style counseling by registered dietitians at primary care office locations.
- **Kids in Charge of Kalories (KICK) health improvement program:** Outreach to families through the use of smart voice technology, access to the KICK website, and educational materials that promote healthy eating and physical activity for children 6 to 12 years of age and their families.
- **SimpleSteps–Choose Better Health:** A customized wellness program that supports employees in leading healthier lifestyles by providing resources to improve nutrition and increase physical activity in the workplace. Strategies include walking challenges, workshops on exercise, stress, and nutrition, as well as collaboration with the on-site cafeteria vendor.
- **Breastfeeding promotion, support and education:** Includes a 24/7 phone line to encourage and support breastfeeding mothers. There is evidence that breastfeeding has a protective effect on childhood obesity.
- **Public-private collaboration and community outreach:** These include partnerships with the California Governor's Council on Physical Fitness and Sports to promote better nutrition and physical activity among youth in low-income communities, and with the Los Angeles Unified School District and UCLA to evaluate whether the placement of fresh fruit and vegetable bars in schools affects children's nutrition and health.

Training and tools for clinicians to communicate effectively with patients about BMI screening, overweight and obesity

Recommendation: Training and tools for clinicians to communicate effectively with patients about BMI screening, overweight and obesity.

Clinicians of all types – physicians, physician assistants, nurses, dietitians, physical therapists, behavioral specialists, medical assistants and other medical professionals – interact daily with patients who would benefit from BMI screening and weight management. It is well known, however, that there is a stigma attached to the term "obesity" – one that can keep clinicians from bringing up BMI with patients and keep individuals from acknowledging the risks and acting in their own best interests.[14]

People's self-perceptions and their perceptions of others are strongly influenced by appearance and body image, and research has shown that clinicians are not immune from bias against their obese patients.[14]

In addition, the Expert Panel discussed the idea that pediatricians and family practice clinicians – especially those who work with young girls – may be more concerned about excessive weight loss and eating disorders among their patients than they are about the risk of overweight.

In order for BMI screening to be fully accepted – and effective – clinicians need to be able to:

- raise the issue of weight with their patients (or the parents of children);
- separate health risks from issues of appearance;
- explain clearly what BMI is and how it is measured;
- be prepared to relate BMI to the patient's complete risk profile;
- be prepared to relate BMI to the patient's overall care, as well as his or her home life, thereby making the information more user-friendly, relevant and palatable;
- recommend steps the patient can take to achieve a healthy weight;
- set realistic expectations of weight loss for the patient; and
- provide feedback and encouragement.

Few clinicians are trained in this complex process of patient communication and fewer still have mastered it, especially when communication is complicated by cultural differences and perceptions, considerations of weight bias, barriers related to health literacy, and the clinician's awareness that patients who are successful at losing weight face a far greater challenge in keeping it off.

Professional organizations that support routine BMI screening, such as the American Medical Association, the American Academy of Family Physicians, and the American Academy of Pediatrics, have developed recommendations, resources and tools to help physicians with the process of obesity evaluation and treatment, including recommendations on how to communicate with patients.

Once counseling takes place and patients know their BMI numbers and the associated health risks, they are more likely to be prepared to talk about BMI and weight management at future office visits.[15] Talking to the parents of obese and overweight children is especially important, since there is an opportunity to improve eating and physical activity habits for a lifetime.

AHIP Expert Panel moderator William Dietz, MD, PhD, Director of Nutrition and Physical Activity for the CDC, co-authored a paper that recommended a "neutral approach" for addressing childhood overweight in the clinical setting. The authors stated that, in the absence of a complication that needs urgent attention, a neutral approach to weight control may help the child to avoid a sense of embarrassment, blame or pressure and also make it easier to assess the family's readiness to change. For example, parents could be asked: "Are you concerned about your child's weight?" and "Has your child's weight caused her any problems?" rather than be told, "Your child needs to lose weight."[16]

The AHIP Expert Panel supports more focused training to help health care professionals with the unique communication challenges related to obesity screening and treatment, and continued research on the communication skills, methods and processes that can help make BMI screening in the clinical practice routine and easy.

The Weight Control Information Network (WIN), a service of the National Institute of Diabetes and Digestive and Kidney Diseases, developed "Talking with patients about weight loss: tips for primary care providers."

What do patients want from health care professionals regarding weight?

- **Talk.** Many patients want to talk about weight with health care professionals who offer respect and empathy for their struggles with weight control. However, before starting a conversation about weight control with your patients, give them a few minutes to discuss other issues that may be affecting their physical or emotional well-being.
- **Non-offensive terms.** Patients prefer the terms "weight" or "excess weight," and dislike the terms "obesity," "fatness," and "excess fat."
- **Advice they can use.** Many patients want help setting realistic goals. They may want to know what to eat and what and how much physical activity is appropriate. For example, some patients will want to know how to become more physically active without causing injury or aggravating problems such as joint pain. Others will want advice on choosing appropriate weight-loss products and services.

"There are pretty good data that suggest that obesity is the most stigmatizing condition in the U.S. other than race, which I think helps explain why physicians are reluctant to raise the issue. They don't know how to ask the first question."

– Physician and Obesity Research Member of the Expert Panel

Case Study: Humana

Offering personalized, high-tech, high-touch Health Coaching

Humana has developed a highly personalized approach to health coaching that helps people make important lifestyle and behavior changes, one step at a time, using a combination of Internet and phone coaching services. Headquartered in Louisville, Kentucky, Humana offers a wide array of health and supplementary benefit plans for employer groups, government programs and individuals. Humana serves approximately 11.5 million medical members, and its regional and national networks include more than 450,000 physicians, hospitals, pharmacies and ancillary providers.

Humana Health Coaching is offered at no additional charge to all of the company's fully insured employer-customers. Members can speak with health coaches in a series of coaching telephone calls, enroll in comprehensive online programs, and receive tailored action plans, email reminders, and ongoing access to resources they need to get and stay healthy. Elements of the program include:

- **Humana Health Assessment** – Members answer questions about their health and receive a confidential profile tailored to them, including health and exercise tips.
- **Preventive Reminders** – Humana encourages health screenings by sending reminders for routine screening tests and immunizations. Members receive preventive-care guidance tailored to their health risk and previous use of preventive services.
- **MyHumana at Humana.com** – On their personal home pages, members can access, store, organize and track their health information, as well as research medical conditions.

Health Coaches help participants with a variety of health improvement options, including:

- weight management, helping them develop a personalized plan to reach a healthy weight;
- physical activity, based on the latest thinking about aerobic fitness, strength training, flexibility, and other ways to become more active; and
- understanding the role nutrition plays in good health.

The integration of a tailored Internet program with a personal health coach drives engagement and increases the success of behavior change. The participant registers on the *MyHumana* website, completes an online health risk assessment (HRA), and chooses whether to use a health coach or a self-directed program. In either case, Humana offers a menu of personalized behavior change strategies based on the HRA and lifestyle survey.

Participants who choose a health coach receive a phone call within 24 hours for a "motivational interview." Those who are found to have a serious medical condition are assigned a personal nurse, while others are assigned a certified behavioral health specialist or health educator. Participants receive five calls, three to five weeks apart, and can make as many inbound calls as they wish. The combination of technology and personal service allows for high-risk participants to receive a call and be coached by a Personal Nurse in a way that seamlessly matches the intervention intensity to the needs of the individual consumer.

Employers can provide an added incentive for employees to increase their activity levels and improve their health-related results by allowing Health Coaching participants to earn *Virgin HealthMiles*, which can be used much like airline miles to purchase gift cards from major retailers.

Tracking results

The goal for Health Coaching participants with BMIs of 30 or more is to lose 5 to 10 percent of body weight. Humana has found that:

- 57 percent of weight management coaching clients who pursued weight management in conjunction with physical activity lost weight;
- of those with a BMI of 30 or more, 29 percent reduced their baseline body weight by at least 5 percent, and 10 percent lost more than 10 percent of their body weight; and
- individuals who lost 5 percent or more of their body weight recorded a drop in work-time impairment from 15.3 percent to 10.4 percent, which equates to a 4.9 percent improvement in productivity. The resultant savings due to increased health and productivity are estimated to average $2,445 per participant.

Recommendation: Acting on the best available evidence – connect BMI screening to successful prevention and treatment options.

Calculating BMI is a valid, reliable, and inexpensive way to begin the process of screening for overweight and obesity and the attendant health risks, but the question for clinicians then becomes: "What should I tell my patients to do now?"

The AHIP Expert Panel acknowledged that some physicians are hesitant about using BMI screening to initiate a treatment process that is lacking a sound evidence base, and for which the outcome will be influenced by multiple behavioral and societal factors beyond the scope of the clinical practice. The gaps in evidence about what works over the long term, along with the difficulty of integrating lifestyle issues into the medical care paradigm, hinder health care clinicians' attempts to support patients' weight management efforts.

Research shows that people want physician counseling and advice about weight and they want their health care clinicians to be involved in helping them achieve their goals. Even short conversations between clinicians and patients during routine office visits can effect changes in behavior. Patients who were counseled in a primary care setting about the benefits of healthy eating and physical activity lost weight, consumed less fat, and exercised more than patients who did not receive counseling. And even one year of weight loss can have a significant, positive effect on an individual's overall health risk profile.[15]

However, while there is ample evidence that many overweight people can achieve modest weight loss through a combination of behavioral changes – reducing total calories, portion sizes, frequency of snacking and the percentage of calories from fat; adding high daily levels of physical activity; and engaging in frequent self-monitoring – maintaining significant, sustainable weight loss in the long term remains a far more elusive goal.

Weight management requires a comprehensive lifestyle approach that is similar to the management of chronic conditions such as diabetes or heart disease, where individuals must adhere to diet and exercise plans, clinical oversight and therapeutic interventions. While health insurance plans and clinicians have, for years, employed evidence-based guidelines to manage chronic conditions, there are significant gaps in the evidence when it comes to obesity. Nevertheless, there are many expert guidelines and recommendations for individual and family treatments that clinicians can use to help their patients identify and overcome barriers to healthy eating and exercise (see Appendix B for guidelines).

The consensus of the AHIP Expert Panel was that the health care community should act on the best available expert evidence and advice and model approaches to prevention and treatment after the most promising practices.

The Expert Panel emphasized that although the clinical-based evidence points to the need for high-intensity interventions in order to maintain weight loss, lower intensity interventions may work in combination with an environment that supports healthy behaviors, especially if low-cost methods for following up with patients, such as phone calls and e-mail reminders, are built into the weight-loss program.

Weight Management Interventions – Levels of Intensity

David Arterburn, MD, MPH, an investigator with Group Health Cooperative's Center for Health Studies and a member of the Expert Panel, has conducted a review of the published literature for obesity interventions at varying levels of intensity. His summary of the evidence on the efficacy of various approaches is as follows:

Many overweight people can achieve modest weight loss through a combination of behavioral changes

Intensive Behavioral Counseling

According to the US Preventive Services Task Force (USPSTF), the most effective weight loss interventions combine nutrition education and diet and exercise counseling with behavioral strategies to help patients acquire the skills and supports needed to change eating patterns and to become physically active. The USPSTF defines intensity of counseling by the frequency of the intervention.

- A high-intensity intervention is defined as more than one person-to-person (individual or group) session per month for at least the first three months of the intervention. A medium-intensity intervention is a monthly intervention, and anything less frequent is a low-intensity intervention. There are limited data on the best place for these interventions to occur and on the composition of the multidisciplinary team that should deliver high-intensity interventions.
- Counseling interventions include a variety of approaches aimed at promoting change in diet and/or physical activity. Behavioral interventions include strategies that assist patients to acquire skills, improve motivation, and develop supports. The 5-A framework (Assess, Advise, Agree, Assist, and Arrange) has been used in behavioral counseling interventions and may be a useful tool to help clinicians guide interventions for weight loss.

Clinical counseling for weight loss:

- **Brief counseling** – May raise awareness, but brief counseling is most likely insufficient to promote weight loss.
- **Intensive behavioral counseling** [see sidebar] – Among adults, it is effective in promoting weight loss, maintaining weight changes over the long-term and improving comorbidities; among children and adolescents, more evidence is needed.

Additional observations on counseling

- Multi-component interventions (targeting diet, exercise, behavior, social support) with high intensity and long duration of treatment appear to be most effective.
- The optimal combination of interventions, intensity and duration is currently unknown.
- Current clinical practice guidelines focus on an individualized approach to selecting interventions and intensity based on discussion with the patient and family members.

Non-clinical and self-directed programs

- **Internet programs** – Modest weight losses are possible; attrition is high among programs that lack in-person support.
- **Telephonic programs** – Evidence is insufficient and conflicting on the effect of telephone-based intervention for weight loss or long-term maintenance.
- **Worksite wellness programs** – Intensity matters; few programs incorporated features that are unique to worksites, such as environmental or peer supports.
- **Commercial weight loss programs** – Weight Watchers and Atkins Diet show modest weight loss; little difference between them after one year; little or no evidence beyond one year of treatment.

High-intensity clinical programs

- **Drug therapy** – Weight loss achieved is generally less than what patients want; weight regain occurs upon discontinuation.
- **Bariatric surgery** – Promotes substantial weight loss, improves comorbid conditions (type 2 diabetes, hypertension, obstructive sleep apnea) and may improve long-term survival; risk of short-term morbidity and mortality but benefits may outweigh risks for many morbidly obese patients.

"My fear is that we're waiting for a solution to obesity, and I think providers recognize that, one, there isn't a single solution to it, and two, we're probably not going to know what the solution is for a long time. So, how do we get past the evidence-base issue and start addressing what is available from the science and from experience?"

– Physician and Health Plan Member of the Expert Panel

Case Study: Kaiser Permanente

Comprehensive programs for clinicians, members and communities

The Kaiser Permanente Weight Management Initiative, launched in 2002, combines clinical strategies for the prevention and treatment of overweight and obesity with a comprehensive approach that addresses the critical role played by communities and the environment. The initiative recognizes that numerous factors outside the clinical setting and health care system influence weight-related behaviors, including a patient's home life, daily routine and schedule, work or school environment, income, and access to safe physical activities and healthy foods, to name a few. In addition, following the example set by the successful management of chronic conditions like diabetes and asthma, the initiative emphasizes helping patients achieve a lifetime of healthy lifestyle changes rather than rapid weight loss.

Kaiser Permanente (KP) serves 8.7 million members in nine states and the District of Columbia. As an integrated health delivery system, Kaiser Permanente provides and coordinates the entire scope of care for its members.

Screening and education in the clinic

KP seeks to have all of its adult and child members screened for overweight and obesity using the BMI, and a method for tracking BMI has been built into KP's state-of-the art electronic health records, KP HealthConnect™. Thousands of KP clinicians and affiliated community physicians have been trained on assessing BMI and communicating effectively with patients about making lifestyle changes. "Low-tech" tools like a BMI wheel, exam room posters, how-to guides for clinicians, and patient tip sheets and action plans supplement the training.

KP does not view the BMI as a proxy for health risk, but as a starting point for other measures related to cardiovascular health. When possible, the KP clinicians also assess the patient's readiness to change, using brief negotiation and motivational interviewing techniques. The training and tools that KP offers, along with an emphasis on taking a team approach that involves physicians, nurses, and other clinic staff, have helped to overcome clinicians' resistance to making BMI screening a routine part of patient care.

Programs and services for members

To help patients deal with weight management in daily life, KP provides online tools and printed educational materials they can use outside an office visit.

- The Balance® program is a free, online interactive tool to help members manage their weight and improve their overall health. It provides a customized program and coaching by e-mail.
- The 10,000 Steps® program, offered in conjunction with HealthPartners, provides a free pedometer and support through an Internet site.
- Several programs designed for children and teens combine education about diet and exercise with problem-solving and behavior change strategies, empowering kids to make better choices.

A public health approach in local communities

Once a patient has been identified by BMI screening as overweight or obese, has had his or her risk factors identified, and has received clinical advice and counseling, the success or failure of weight management becomes largely a personal responsibility. Recognizing that even the most highly motivated individual can be thwarted by environmental barriers to healthy eating and increased physical activity, Kaiser Permanente's weight management initiatives extend beyond the clinical setting into local communities.

Kaiser Permanente hosts 30 farmers markets around the country that offer fresh, locally grown fruits and vegetables to communities where residents cannot easily buy fresh produce. KP also stocks its hospitals' menus with locally grown, organic food, and funds programs to increase green space and opportunities for safe walking in communities. KP's HEAL (Healthy Eating Active Living) initiatives and grants support environmental and policy changes that make it easier for individuals in underserved communities to adopt healthy lifestyle behaviors. Educational theater programs bring messages about healthy eating and active living into schools in KP communities, and a partnership with the TV Turnoff Network raises awareness of the weight-related hazards of too much screen time.

Because community initiatives lack the structure of a randomized controlled trial, KP is committed to tracking and measuring the progress of its Community Health Initiative, so that in five years it will have quantitative data about the effects various interventions have on helping communities become healthier places to live.

Recommendation: Build partnerships among health insurance plans, clinicians, employers and community groups and disseminate best practices.

Clinicians can assess and identify the risks associated with unhealthy weight, and educate and help motivate patients and families to make healthier choices, but it is ultimately the individual patient or parent of the child who makes the daily decisions about eating and physical activity. Because lifestyle is such an important contributor to obesity, members of the AHIP Expert Panel agreed that clinicians cannot have the sole responsibility for addressing this important behavior change.

At the same time, individuals and families who are ready to take action may face daunting environmental challenges related to the cost and availability of healthy food, social, cultural and language barriers, and a lack of safe options for physical activity, which is why collaboration among all the stakeholders is so important.

Lifestyle is such an important contributor to obesity

Working in partnership with health insurance plans and clinicians:

- employers can offer incentives and make healthier nutrition and exercise options available to employees;
- communities can offer safer and more accessible activities, facilities, services and environments for kids and adults;
- schools can improve nutrition and exercise opportunities;
- food sellers can be more transparent with their nutrition information (display calories, fat, sodium, etc.) and offer a choice of healthy options; and
- media and advertisers can to be enlisted to communicate and reinforce messages that promote healthy eating and exercise.

Health insurance plans often act as a nexus within the health care system, linking individuals, clinicians, employers, government programs and communities. As the case studies in this report demonstrate, health insurance plans can take a leadership role in their communities by:

- encouraging healthy behaviors among consumers through information, health improvement tools, incentives and benefit design;
- supporting physicians with information on screening, patient counseling and behavior change techniques;
- helping employers provide healthy lifestyle programs, workplace wellness, and weight management options for employees;
- establishing partnerships with communities, schools and special population groups to develop new programs and fund existing programs for obesity prevention;
- helping influence public policy related to the causes and effects of overweight and obesity;
- encouraging and helping disseminate best practices in prevention, treatment, education and engagement;
- incorporating and disseminating expert recommendations and guidelines; and
- conducting or participating in research and education on obesity prevention and treatment; obesity disparities and communication challenges; and measurement, reporting and recognition of improvement in obesity management.

Public health approaches that support changes in personal behavior

There are many examples in the world of public health that demonstrate what can happen when policies, laws, and environmental changes are aligned to promote healthy behaviors. Public health campaigns have contributed to a decrease in smoking and drunk driving accidents, and an increase in bike and motorcycle helmet usage, to name a few. Personal responsibility is at the root of each of these behaviors, yet when addressed from a public health framework, policies, laws and environmental changes work together to encourage or reinforce healthier choices.

States have considered policies and laws that are intended to create a healthier environment for children, such as limiting the availability of high-calorie/low-nutrition foods and drinks during the school day; promoting healthy foods in school lunches or by providing free, fresh fruits and vegetables; and incorporating physical activity time into the daily schedule.

Some states and school districts are reporting students' BMI percentages to parents along with an explanation of what BMI is, what their child's BMI means, and tips families can use to achieve and maintain a healthy weight. Arkansas has been a leader in this area; a law enacted in 2003 to improve the health of the state's children requires that parents be provided with an annual BMI percentage for their child, as well as an explanation of what BMI means and health effects associated with obesity. The Arkansas Center for Health Improvement (ACHI) was asked to take the responsibility of developing and implementing standardized statewide BMI assessments and reporting, including information for parents regarding any health risks their child may face as a result of being overweight or underweight.

In Arkansas, as elsewhere, some parents and community groups initially opposed measuring BMI in schools because of concerns about possible harms, such as stigma, teasing or encouraging eating disorders. Or, they may believe that a child's weight is an issue to be discussed between the physician and the parent, and that weight monitoring should only take place inside a clinical setting.

Joe Thompson, MD, MPH, the Director of ACHI, explained in a presentation to the AHIP Expert Panel that Arkansas was able to address some of these barriers because the entire state has been working to create an environment of change and momentum around obesity prevention. The momentum began with improvements to the state's employee health plan, including the introduction of a health risk appraisal with a small cash incentive, which 50 percent of the employees voluntarily took.

Before the statewide strategy to capture BMI in schools was put in place, Arkansas set up a child health advisory committee that enlisted the state Board of Education to adopt a number of changes in schools, including healthier food options and restricted access to vending machines, and physical activity requirements, to name a few. Dr. Thompson told the Expert Panel, "I think we've got an environmental change happening that can't be tied to a single intervention; a social climate change is happening and we're seeing the impact."

With support from the Robert Wood Johnson Foundation (RWJF), a research team from the University of Arkansas for Medical Sciences' College of Public Health has evaluated the impact of the law annually. In 2008, the evaluation found that 61 percent of Arkansas school districts now prohibit the sale of junk foods in vending machines, up from 18 percent in 2004, and 72 percent of students had increased physical activity, up 10 percent from the third-year evaluation. The evaluation also found that the once-controversial practice of measuring students' BMIs was no longer an issue for the majority of parents, with most indicating "comfort with receiving a BMI report from school." Finally, the research team found that 83 percent of families reported limiting consumption of junk food and soda, up from 76 percent in 2004.[17]

What can happen when policies, laws, and environmental changes are aligned to promote healthy behaviors and healthy environments for children?

Case Study: Rocky Mountain Health Plans

Creating a "Well Workplace" for employees

Rocky Mountain Health Plans (RMHP) is based in Colorado and provides medical benefit plans and services to more than 175,000 enrollees. In January 2005, Rocky Mountain introduced its awe!™ worksite wellness program, using the acronym for awareness, wellness and education.

RMPH's commitment to wellness starts at the top of the organization. In addition to dedicating an annual budget to wellness and supporting awe! and other initiatives directed at employees, its leaders are active in promoting better health for people of all ages. RMHP has been designated a Well Workplace by the Wellness Councils of America in recognition of the success of the awe! program and also for meeting rigorous health promotion standards within the workplace.

The awe! wellness program

Rocky Mountain developed the awe! program after surveying employees about how the company might help them improve their health and well-being. Its staff includes a program manager who is a certified fitness trainer, and two registered nurses with over 50 years of combined experience in care management.

Five to ten representatives from each of the health plan's departments participate on the awe!some team, which is responsible for sharing departmental needs, determining areas of focus, and finding new and creative ways to promote worksite wellness. The FruitLoops are a division of the awe!some team and they distribute fresh fruits and vegetables weekly to all break rooms. Additionally, the health improvement program myhealthIQ is offered to employees and their spouses.

The myhealthIQ program offers Health Risk Appraisals (HRAs) and medical screenings to employees to provide a data benchmark of their health risk status. Premium discounts are given to employees with "healthy" scores. Program information is made available to staff through a variety of channels, including all-employee meetings, direct communication, and email.

Creating a supportive environment

In order to encourage employee participation, RMHP's leadership team has supported the awe! program by:

- requiring departmental participation on the awe!some teams;
- offering two employer-paid wellness days per year;
- expanding the on-site fitness area from 800 square feet to over 3,200 square feet;
- offering more than 17 classes at the fitness center each week;
- reimbursing half the cost of a 13-week Weight Watchers® program for employees who attend for at least 12 weeks and lose 8 or more pounds;
- adding filtered water machines throughout the facility;
- encouraging departmental walk groups; and
- offering extensive benefits such as Health Club reimbursement and Employee Assistance Programs.

Confidential surveys are conducted asking employees about new interests, quality of life, pre- and post- program results, screenings and testing, and BMI assessments. Employees also provide data through "awareness cards" that help them track how much sleep they get in a week, how much water they drink, their lunch and break times, their activity levels and even their "joy factor."

All data is analyzed and evaluated, after which action plans are designed and implemented. Once a component is in place, random evaluation occurs by monitoring attendance and collecting survey data to evaluate necessary enhancements. Input is continuously solicited from the awe!some teams, the Advisory Board, vendors, and class instructors.

Tracking results

Employees who participated in the first two years of the program achieved the following one-year improvements:

- overall health scores increased from 72 to 76 out of 100;
- high total cholesterol levels decreased from 31 percent to 23 percent of participants;
- high LDL levels decreased from 34 percent to 24 percent of participants;
- the percentage of participants with BMIs that classified them as overweight or obese decreased from 49 to 44 percent;
- 32 participants in the on-site Weight Watchers group lost a total of over 700 lbs in a 6-month period; and
- tobacco users decreased from 16 percent to 9 percent of participants.

Case Study: Highmark Blue Cross Blue Shield

Encouraging healthy change with *Lifestyle Returns*SM

With a 70-year-old mission to help people live longer, healthier lives, Highmark Blue Cross Blue Shield is taking a multifaceted, evidence-based approach, built around incentives, to help their members improve their health practices, make the right lifestyle choices, get the right medical care and get ahead of the chronic disease curve. Based in western Pennsylvania, the company has nearly 19,000 employees and serves approximately 4.6 million people.

Highmark has made employee wellness an important part of its corporate culture and many of their successful health and lifestyle improvement programs were initiated and refined with their own employees before being offered to their employer customers. Since 2005, Highmark has promoted employee participation in Lifestyle Returns℠, which was designed as a series of personalized online programs that focus on weight management, healthy eating habits, stress reduction and smoking cessation.

Making a pledge, and following through

Lifestyle Returns participants begin at the Highmark member Web site, where they make an online pledge to be more involved in their health. They then complete a health risk assessment (HRA), and receive an individual Wellness Profile Report based on the results. To facilitate early detection of chronic disease, including early cancers, participants must also receive age- and gender-appropriate prevention and screening tests, including key health status measures – body mass index, LDL cholesterol, systolic blood pressure, tobacco use, and a HbA1C screen for those self-identified with diabetes. Each of these screenings has a target health goal based on medical standards and personal health data provided in the Wellness Profile.

Participants receive recommendations for health improvement that may be achieved through participation in worksite health promotion classes, online programs, or wellness programs offered through Highmark's community network at local YMCAs and hospitals. In 2003, Highmark built fitness centers at its two largest locations in order to help its own employees meet their goals. The final step in the program is for participants to use one of Highmark's online self-care and health education tools.

Employers provide rewards or incentives to promote employee participation and to encourage completion of the *Lifestyle Returns* program. Some participating employers offer a cash reward, a contribution toward employees' health savings accounts, a reduction in employee health coverage contributions, or a higher level of benefits. Participants who are unable to meet goals due to a medical condition or because it is medically inadvisable, are offered reasonable alternatives to earn points.

Tracking results

Lifestyle Returns generates health risk analysis reports for employers and uses aggregated claims data to compare the acute conditions and preventive screenings of participants with nonparticipants. In comparing 2006 and 2007 results, lifestyle scores improved in health behavior categories such as physical activity, nutrition, skin protection, smoking, and safety, but did not improve in the area of weight management.

Highmark conducted a study of its own employees' participation in the program and estimated savings at $1.3 million during a four-year period, or about $1.65 in avoided health care expenses for every dollar spent on the comprehensive employee wellness program. The rigorous financial design required that all costs of the wellness programs, including incentives, be deducted before calculating the return on investment. Researchers used an analytical approach that compared the health care costs reflected in the medical claims of employees who participated in wellness programs with those of nonparticipants who had comparable health risks. Reduced inpatient costs yielded the highest return on investment, partially due to increased use of recommended screenings and medications among employees. The study's findings were published in the *Journal of Occupational and Environmental Medicine* in February 2008.

Recommendation: Promote cultural competency and reduce racial, ethnic and cultural disparities.

Although the problem of unhealthy weight cuts across all races and ethnicities, and all socioeconomic levels, there are large disparities in obesity prevalence among women of different racial and ethnic groups. (Significant racial and ethnic disparities in obesity have not been observed in men.) According to CDC statistics, approximately 53 percent of non-Hispanic black women and 51 percent of Mexican-American women 40–59 years of age are obese compared with about 39 percent of non-Hispanic white women of the same age.[18]

Chronic diseases and conditions, including type 2 diabetes, hypertension, heart disease, and certain cancers, are also more prevalent among minorities. According to the American Diabetes Association, African Americans are 1.8 times more likely to have diabetes than non-Hispanic whites, while Hispanic/Latino Americans are 1.5 times more likely to have diabetes than non-Hispanic whites. The American Heart Association reports that Hispanic women's heart disease risk is comparable to the heart disease risk level of Caucasian women who are about a decade older.

There are multiple causes for these disparities, including differences in the ways various ethnic groups have historically perceived children's size and related health risks, which may set the stage for unhealthy weight gain at an early age.

- In one study, only half of African American parents perceived their overweight children as overweight, and of those who did, less than half (43 percent) considered obesity a health risk, even in families with a history of obesity and its complications.
- Among Native American children, whose rates of obesity are the highest of any group of U.S. children, only 15 percent of parents and other caregivers (mainly grandmothers) recognize or associate excess weight with future risk of disease.
- Latina mothers with children aged two-to-five years perceive smiling, sitting upright, and healthy-looking skin and hair to be more important aspects of health than the child's weight. Thin children, in contrast to heavier children, are associated with poor health.
- Low income mothers of overweight preschool children commonly believe their children are "thick," not overweight, and that children will grow into their weight. Further, many believe children are destined to be a certain weight that is impossible to change.[19]

There are also differences in how health care clinicians address the issue of excess weight with non-white individuals. According to the 2006 National Healthcare Disparities Report,[20] obese Hispanic adults reported being counseled about exercise less often than non-Hispanic white adults. Low-income status and low education levels were also associated with limited counseling, and obese African Americans and Mexican adults were also significantly less likely than non-Hispanic whites to be told by a provider or health professional that they were overweight.

Finally, members of racial and ethnic minority groups and those with lower family incomes are more likely to be affected by environmental factors that can lead to higher rates of obesity, including:

- the high ratio of fast food restaurants and convenience stores to grocery stores in low-income and diverse communities of color, coupled with reduced access to fruits and vegetables;
- community safety issues that may limit outdoor exercise;
- a lack of public parks and swimming pools; and
- inadequate physical activity programs in schools.[21]

Overcoming the myriad attitudes, environmental factors and communication issues that lead to health disparities will require creativity, persistence and a targeted, whole-community approach to obesity prevention and treatment with a focus on early intervention and cultural sensitivity.

The proportion of obese adults told by a doctor or health professional that they were overweight was significantly lower for Blacks (61.1%) and Mexican Americans (56.5%) compared with Whites (68.8%)

– *AHRQ 2007 National Healthcare Disparities Report*

Health Insurance Plans Reducing Disparities Through Multipronged Approaches

Providing cross-cultural training, toolkits, and outreach to clinicians

HealthPartners in Minnesota developed an intranet site with references for staff and contracted providers including information on diverse groups, translated forms and documents, and language assistance best practices. The HealthPartners Institute for Medical Education developed a series of online CME lectures, featuring an introduction to cross-cultural care, use of interpreters, and meeting the needs of Hmong, Hispanic/Latino, Somali, refugee and immigrant patients, and developed a series of Lunchtime Learning sessions for staff focusing on various cross-cultural care and health disparity topics.

Educating parents and families on healthy lifestyles, preventive screenings, and self-management of chronic conditions through the use of community health workers

CareFirst BlueCross BlueShield (CareFirst) in Maryland collaborated with several organizations to implement its Closing the Gaps program, with outreach and clinical interventions targeted to the high disease prevalence of diabetes in Latinos, cervical cancer among Vietnamese women, and cardiovascular disease among African Americans. Health providers using the Chronic Care Model track client services for ongoing evaluation of interventions. Culturally-competent health educators provide case management and trained peer counselors or *promotores* make home visits to enhance self-management strategies. In addition, CareFirst undertook mandatory cross-cultural training of all internal clinicians to increase awareness and sensitivity to ethnic and cultural issues that impact the health of minorities.

Trained peer counselors or *promotores* make home visits to enhance self-management strategies

Improving access to safer playgrounds in low-income neighborhoods by partnering with community organizations and schools

As part of its mission to help members get care, stay well, and build healthy communities, **Keystone Mercy Health Plan** has taken a special interest in ensuring that children in its communities have a safe place to play. Utilizing tools and guidelines provided by KABOOM!, a national non-profit organization that envisions a safe place to play within walking distance of every child in America, Keystone Mercy Health Plan has helped make safe playgrounds a reality for elementary schools in the Philadelphia area.

Funding and leading community-based obesity prevention activities; participating in local and state-wide coalitions to promote physical activity, access to healthy foods, and health education

UnitedHealthcare collaborates with the University of North Texas and several other health and human services organizations to support and participate in the annual Fort Worth Hispanic Wellness Fair (HWF). Approximately 33 percent of the North Texas population is Hispanic, with almost half uninsured. Attendees at the HWF can receive a variety of biometric screenings such as blood pressure check-up, blood glucose screening, cholesterol testing, body mass index exam, and many more preventive screenings at no cost.

In addition to offering health care services to those who cannot afford them, the HWF aims to introduce the Hispanic population to the community's health resources, break down barriers of communication, and build trust between clinicians and those in need. UnitedHealthcare provides a booth staffed with bilingual UnitedHealthcare employees and clinicians who provide health information, health promotional materials and health tips in English and Spanish to fair attendees. Now in its 10th year, the HWF anticipates more than 20,000 participants in 2008.

Break down barriers to communication, and build trust

Working with community organizations (including schools, churches, businesses, and free clinics) to support healthy eating and physical activity

Community Health Network of Connecticut (CHNCT) serves over 100,000 members who are covered by Medicaid, SCHIP and the State General Assistance programs. In the fall of 2007, CHNCT launched a pilot program, called Faithfully Fit, to provide people in the faith-based community with a high quality and culturally appropriate fitness and nutrition education program. CHNCT developed a faith-based program because there are measurable health disparities between whites and African Americans, who are at risk for obesity, diabetes, heart disease and hypertension and other conditions. Churches are a vibrant, respected source of social support and information in African-American communities, and research indicates that a "culturally-designed" and "culturally-based" health, diet and fitness program can be very successful in the African-American community.

Five churches with predominantly African-American congregations in the state's largest city, Bridgeport, participated in an eight-week program that included weekly Faithfully Fit Academy classes featuring educators from various medical, fitness and nutrition disciplines and modalities. Each Academy session included meals planned by a registered dietitian, in order to model wholesome menus and demonstrate that healthy food can be tasty and nourishing. Teams also participated in a variety of fun, interactive fitness activities and nutrition challenges. All participants were tested before and after the program in a variety of health and fitness measures, and were scored according to these and other criteria. Prizes of $3,000, $2,000 and $1,000 were donated to the winning teams' congregational health ministry programs, and individuals also received small merit awards.

Case Study: Venice Family Clinic

Helping low-income families integrate nutrition and physical activity into their daily lives

Venice Family Clinic provides comprehensive primary health care, mental health services, health education and child development services, as well as public insurance enrollment to more than 21,000 patients, including approximately 5,500 children. The Clinic, at seven locations in Los Angeles County, cares for patients who have low incomes and who lack private health insurance. Sixteen percent of the Clinic's patients are homeless.

With the support of the Simms/Mann Family Foundation, Venice Family Clinic has launched the nation's first health, wellness and integrative medicine program offered at a free clinic. The Clinic's goal is to empower families to integrate nutrition and physical fitness into their daily activities so they can optimize their health and wellness.

Parenting and Nutrition Skills

This program applies social learning concepts and peer counseling to teach the parents of children ages 2 to 4 intervention strategies and skills that can help them improve nutrition and fitness behaviors. The program has three specific aims:

- to maintain or reduce BMI percentiles in the intervention groups over a one-year period, reversing the upward trend in weight;
- to increase fruit and vegetable consumption, decrease fat consumption, and reduce low-nutrient food and liquid intake; and
- to increase physical activity and reduce sedentary activity.

Under the direction of a social worker, parents participate in 90-minute group sessions for seven weeks, learning to apply skills such as increasing their children's preferences for healthy foods; avoiding the use of food as a reward or punishment; increasing physical activity opportunities and reducing screen time; and identifying barriers to healthy lifestyles and developing strategies to reduce them.

Family Weight Management

Based on a curriculum developed by Kaiser Permanente, this program teaches children ages 5 to 12 and their families the skills they need to improve nutrition, increase physical activity and make long-term behavioral changes that will allow them to maintain a healthy weight.

Once a child is a teenager, it takes a lot more effort on everyone's part to reverse unhealthy weight gain, so the Clinic focuses on setting the stage for a healthy lifestyle early in life. For most children, a reduction of only 150 calories per day has a cumulative effect, but the Clinic recognizes that families don't just need information; they need strategies to meet the recommendations. For instance, they encourage family meals because parents can decide what and when to eat while allowing the child to maintain control over how much to eat, based on his or her internal signs of hunger.

Clinical Interventions

Physicians and clinic staff are trained to use several tools to improve patients' health behaviors related to nutrition and physical activity. These include:

- a Community Fitness Directory that lists no-cost or low-cost fitness resources in the communities where patients live;
- a Lifestyle Log that is placed in the charts of all pediatric patients to identify overweight children, track patients' health habits and help families develop strategies for improving physical fitness and nutrition for life;
- an Rx Pad for Fitness with "prescriptions" that encourage patients to exercise; and
- Reach Out and Jump and Reach Out and Walk, using the distribution of jump ropes and pedometers in the Clinic and in local schools to encourage physical activity.

In addition, community health educators provide basic nutrition and fitness education and interactive health- and wellness-focused activities in the waiting room as well as promote and refer patients to the Clinic's health and wellness programs.

"I like being able to give the jump rope because I can recommend a very doable, realistic thing that has no barriers attached, really. It doesn't require a curriculum, transportation, money, or even a safe neighborhood. You just need a patch of space."

Victor Perez, MD, MPH

Environmental Interventions

The Clinic is designed to create an environment that supports patient healing and promotes healthy lifestyles and overall well-being. This design includes new health and wellness-focused programming, activities and resources for patients. To effectively promote patient self-learning, a computer kiosk will give patients access to health and wellness information, and televised health promotion programs will be available in the waiting area of the Clinic. To help staff reach optimal health and act as role models for patients, the Clinic offers them workplace activities focused on nutrition education, physical fitness promotion, stress reduction and overall mental and physical well-being.

The Venice Family Clinic's services are made possible through the generous financial support of individuals, foundations, and corporations such as the Simms/Mann Family Foundation and the Joseph Drown Foundation. Since 2001, Kaiser Permanente has supported the Clinic by providing funding for capital improvements, a physician's salary, and health insurance enrollment. To learn more about the Venice Family Clinic, visit: http://venicefamilyclinic.org.

Addressing Disparities in Health

A significant feature of the current obesity crisis is the disparities in obesity prevalence by race-ethnic group. Non-Hispanic black and Mexican-American women were more likely to be obese than white women.[22] In response to these and other health inequities, AHIP has developed a broad program focusing on cultural competency and disparities in health, which are among the most complex issues that must be addressed to improve the quality of care for all Americans.

AHIP's multifaceted initiative, *Addressing Disparities in Health*, provides technical support for health insurance plans and other health care organizations on issues related to:

- encouraging the collection of data on race, ethnicity, and primary language;
- cultural competency training as a foundation to improve care;
- communication resources that address the cultural diversity of America's racial and ethnic population; and
- the design of quality improvement activities using race, ethnicity and primary language data to reduce disparities.

The series of tools developed as part of AHIP's initiative can assist health insurance plans to identify disparities and strengthen quality initiatives that are culturally and linguistically appropriate for all Americans. AHIP's *Data as Building Blocks for Change*, a data collection toolkit, highlights health plan strategies that can be employed to collect and use race, ethnicity, and primary language data for quality improvement.

AHIP's *Communications Resources to Close the Gap* is a unique compendium for health insurance plans, physicians, and other health care organizations that provides steps on how to incorporate culturally and linguistically appropriate messages into everyday communications with consumers.

In an effort to promote culturally sensitive health care, AHIP partnered with the Manhattan Cross Cultural Group to promote cross-cultural training with physicians, nurses, case managers, and health care professionals on how to effectively communicate with a diverse group of individuals with specific chronic conditions (e.g. asthma, congestive heart failure, diabetes, and hypertension). The Quality Interactions training program aims to:

- increase awareness and knowledge of racial/ethnic disparities in health care and the importance of effective cross-cultural care (e.g. identify the impact of cultural issues on medical decision making, and assist physicians in working effectively with family members and interpreters); and
- provide health care professionals with tools and skills to more effectively communicate with and deliver quality clinical and cross-cultural care to patients from diverse backgrounds.

You can learn more about AHIP's *Addressing Disparities in Health* initiative at http://www.ahip.org/disparities.

Strengthen quality initiatives that are culturally and linguistically appropriate

Recommendation: Measure and report progress in BMI screening through HEDIS®

The health care community often looks to the National Committee for Quality Assurance (NCQA) for direction in developing quality measures through its Healthcare Effectiveness Data and Information Set (HEDIS®).

Since 20 percent of the population accounts for 80 percent of health care costs[23] many HEDIS measures focus on conditions that affect the 20 percent at the high-risk end of the health spectrum. A few years ago, NCQA began looking at ways that quality measurement and reporting could encourage the kinds of interventions and actions that health plans, clinicians or communities can take in selected areas of health risk to keep individuals at the healthy end of the spectrum.

In 2006, NCQA convened an expert panel to help address quality measurement with respect to obesity prevention and treatment, and in early 2008, NCQA proposed two new HEDIS measures, for collection in 2009 and reporting in 2010, that are designed to increase BMI assessment for adults and BMI percentile assessment and nutrition and physical activity counseling for children and adolescents. Following public comment, the Committee on Performance Measurement reviewed and approved the two measures, and NCQA formally incorporated them into HEDIS 2009.

- Adult BMI Assessment looks at the percentage of health insurance plan members 18–74 years of age who had an outpatient office visit and who had their body mass index (BMI) documented. The adult measure will be reported by commercial, Medicaid and Medicare plans.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents looks at the percentage of health insurance plan members 2–17 years of age who had an outpatient office visit during the measurement year and for whom there is evidence of documentation of BMI percentile assessment, counseling for nutrition, and counseling for physical activity. This measure will be reported by commercial and Medicaid plans.

In proposing the new HEDIS measures, NCQA stated that, "The alarming rise in obesity rates in recent years has serious public health implications for the future," and that patient awareness resulting from BMI screening and counseling is the first step in any comprehensive strategy for addressing obesity.

Translating Recommendations into Practice: Current and Future Initiatives

AHIP's member health insurance plans are working in a wide variety of areas to help their enrollees and communities confront the serious health problems associated with obesity at every stage of life. As was demonstrated in the broad-based efforts to reduce tobacco dependence, the American public, physicians, and the health plan community recognize that obesity is a major pubic health threat and that everyone has a role to play. The problem of obesity touches every generation. It will not be solved quickly, and will require a long-term commitment from all stakeholders.

AHIP has implemented an Obesity Initiative that is supporting its members' obesity prevention and treatment efforts. The Initiative includes an ongoing series of forums, programs, grants, educational webinars, and roundtables that bring health insurance plans and other stakeholders together to discuss the challenges of obesity, review the evidence, develop effective strategies, and share models that work. The AHIP Obesity Initiative is guided by an advisory board comprised of health plan representatives (medical directors and program directors) with knowledge and experience in obesity prevention and treatment, from a broad range of health plan types. The AHIP Obesity Initiative is supported in part by the Centers for Disease Control and Prevention (CDC) and Pfizer Inc.

The work of the AHIP Expert Panel on Obesity and Related Screening Measures has been expanded through online, virtual seminars at which health plan and public health leaders share their perspectives on the challenges, potential strategies, and future directions in obesity screening and health improvement. Topics of discussion include presenting promising strategies and tools, including health plan initiatives to promote clinicians' use of BMI screening and counseling; the results of promising pilot studies to reduce health risks through weight reduction in health insurance plan employee populations; and innovative trends in health risk assessment tools that directly link members with various health risks to behavior change programs.

Innovations in Prevention, Wellness and Risk Reduction, released in fall 2008, is the latest in AHIP's *Innovations* series, which highlights health insurance plan programs in areas including disease management and chronic care, health information technology, and improving quality and effectiveness. This new *Innovations* monograph captures health plans' commitment to health promotion and risk reduction programs that prevent disease and improve the lives of their members, as well as their communities, by helping them stay well. With funding support from the CDC, the monograph examines promising health plan practices and innovative initiatives in a number of lifestyle and behavior-related areas of health improvement, including overweight and obesity prevention and control.

Additional information on the AHIP Obesity Initiative is available at the AHIP obesity web site – www.ahip.org/obesity – which contains the latest news and resources on the science and strategies surrounding obesity prevention and treatment.

In recent years, the nation's health insurers have played an increasingly important role in promoting healthy lifestyles and behaviors, enhancing clinical and community preventive services, and helping their members manage chronic conditions. These efforts build on longstanding industry initiatives in areas like performance measurement, clinical quality improvement, provider incentives, and the harnessing of health IT to enhance health system responsiveness and consumer decision making. In each case, substantial progress has been made because of close collaboration among health plans, providers, employers, community leaders, and other health care stakeholders. The scientific evidence around effective strategies for prevention and long-term weight management is still frustratingly elusive, but a necessary first step in solving the problem is for clinicians to screen adults and children and to counsel them on the health risks associated with various BMI levels.

As the case studies in this report demonstrate, there is an abundance of good ideas about how to affect individual behaviors and lifestyles and create healthier homes, workplaces and communities. AHIP believes that the same kind of collaboration, innovation and evidence-based rigor that has been applied to disease prevention and the management of chronic illness can also successfully address the rising prevalence of overweight and obesity in ways that will help reduce the human and financial costs of unhealthy weight and improve the health and well-being of individuals and communities.

Helpful Tools

Anthem Blue Cross Resources: California Online Childhood Obesity CME – www.eventstreams.com/wellpoint/010rde/

Body Mass Index Online Training – http://www.bmi4kids.info/

Kids In Charge of Kalories Health Improvement Program – http://www.kickprogram.com/

Blue Cross Blue Shield of Michigan: Pediatric Healthy Weight Toolkit: The Blues have developed this toolkit in light of the epidemic of childhood obesity, and as part of the company's unique mission to improve the health status of Michigan residents. The materials in the toolkit help to: identify overweight or obese patients and recommend treatment interventions; track patient progress over time using age-appropriate BMI charts; diagnose and treat patients with comorbid conditions; use sensitivity and empathy in communicating with patients and their families to inspire positive behavior change. http://www.bcbsm.com/pdf/pediatric_healthy_weight_toolkit.pdf

The California Association of Health Plans and the California Medical Association Foundation have created provider tool kits that address weight management and the prevention and early identification of obesity for adult, pediatric and pre- and post-bariatric surgery patients. Developed in consultation with a 60-member expert panel, the tool kits include guidelines and educational material based on the best clinical information from health plans, the medical community, and public health experts. http://www.calmedfoundation.org/projects/obesityProject.aspx.

The California Governor's Council on Physical Fitness and Sports is a nonprofit, nonpartisan organization dedicated to promoting physical activity for all Californians, with an emphasis on children and youth. The core initiatives – the Governor's Challenge, Spotlight Awards and Activity Guide – encourage broad community participation in physical activity, with themes such as "Exercise is Medicine," and "Live Like A Champion." http://www.calgovcouncil.org/

HealthPartners' 10,000 Steps program is available to the public and aims to increase physical activity by teaching fun ways to be active, providing motivational tips on incorporating activity and healthy eating into daily life, and helps participants track their progress in the program. http://www.10k-steps.com

Highmark's Childhood Obesity Physician Tool Kit supports physicians and clinicians in caring for pediatric patients with weight management issues. This comprehensive kit features a broad range of useful tools and information to assist in motivating families to improve their eating habits, physical fitness and overall lifestyle to reduce and even prevent childhood obesity. https://www.highmarkblueshield.com/health/pbs-professionals/childhood-obesity-tool-kit-home-page.html

Kaiser Permanente and the **Rudd Center for Food Policy and Obesity** at Yale University collaborated to develop a Weight Bias Toolkit for Providers: Preventing Weight Bias – Helping without Harming in Clinical Practice
http://www.yaleruddcenter.org/what/bias/toolkit/index.html

Let's Go! is a community-based initiative to promote healthy lifestyle choices for children, youth and families in 12 Greater Portland communities. The goal is to increase physical activity and healthy eating for children and youth – from birth to 18. The Let's Go! Healthcare Toolkit includes a color-coded BMI chart. http://www.letsgo.org/For_You/Healthcare_Professionals_Toolkit.php

Keep ME Healthy is a tool kit developed by the **Maine Youth Overweight Collaborative**. By providing tools and resources, the Maine Center for Public Health seeks to provide practical support and guidance to health care practices, organizations and individuals across the state to help improve care and outcomes for overweight youth. For clinical decision support tools, tools for office visits, community resources, PowerPoint presentations and key reference guidelines and research articles visit: http://www.mcph.org/Major_Activities/keepmehealthy.htm

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Appendix A

Expert Panel on Obesity and Related Screening Measures to Improve Health

Case Statement and Goals

There is significant interest and activity around screening for obesity and related conditions. However, there is no clear, accepted guidance on the most appropriate screening measures to use, at what points to screen, and what follow-up strategies are most practical and effective. The time is right for health plan and physician leaders, key researchers, and other stakeholders to come together to discuss, debate, and examine the complex issues behind obesity screening to provide health insurance plans with direction and recommendations on assessing obesity and obesity-related conditions. Goals of the Expert Panel include:

- identifying and articulating the issues around obesity and related screening;
- providing clarity to screening issues while recognizing the evidence gaps on counseling/weight management recommendations;
- highlighting health plan and health care industry attention to the issue of screening; and
- disseminating a report of Expert Panel findings and recommendations to health insurance plans, providers, and stakeholders.

Moderator

- **Bill Dietz, MD, PhD:** Director, Division of Nutrition, Physical Activity, Overweight and Obesity – Centers for Disease Control and Prevention

Panelists

- **David Arterburn, MD, MPH:** Investigator, Group Health Cooperative Center for Health Studies
- **George Blackburn, MD, PhD:** Director, Center for the Study of Nutrition Medicine, Beth Israel Deaconess Medical Center
- **Barbara DeBuono, MD, MPH:** Senior Medical Director/Group Leader, Public Health, Pfizer Inc.
- **Don Fischer, MD, MBA:** Senior Vice President and Chief Medical Officer, Highmark
- **Len Fromer, MD, FAAFP:** Assistant Clinical Professor, Department of Family Medicine, UCLA School of Medicine
- **Trina Histon, PhD:** Practice Leader, Weight Management and Director, Weight Management Initiative, Kaiser Permanente
- **Harlan Levine, MD:** Chief Medical Officer, Health Solutions Group, UnitedHealthcare
- **Kathleen McTigue, MD, MPH:** Assistant Professor of Medicine and Epidemiology, Center for Research on Health Care, University of Pittsburg Medical Center (UPMC)
- **Greg Pawlson, MD, MPH:** Executive Vice President, NCQA
- **Wendy Slusser, MD, MS:** Professor of Community Health Sciences and Assistant Professor Of Pediatrics, UCLA School of Public Health; Director of UCLA's Center for Healthier Children, Families, and Communities
- **Joe Thompson, MD:** Director, Arkansas Center for Health Improvement; Surgeon General, Arkansas

The Expert Panel on Obesity and Related Screening convened on Tuesday, February 6, 2007, in Arlington, Virginia.

Appendix B

Guidelines, Recommendations, and Resources

American Academy of Family Physicians (AAFP)
Prevention and Treatment of Overweight in Children and Adolescents
http://www.aafp.org/afp/20040601/2591.html

American Academy of Pediatrics (AAP)
The AAP has several policy guidelines and endorsed statements related to overweight and obesity, all of which can be found at http://www.aap.org/obesity/PolicyandGuidelines.htm.

Specific guidelines include:

- Prevention of Pediatric Overweight and Obesity
- Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity
- Breastfeeding and the Use of Human Milk
- Children, Adolescents, and Advertising
- Children, Adolescents, and Television
- Identifying and Treating Eating Disorders
- Dietary Recommendations for Children and Adolescents: A Guide for Practitioners
- Prevention and Treatment of Type 2 Diabetes Mellitus in Children, With Special Emphasis on American Indian and Alaska Native Children
- Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years (RE9730)
- Soft Drinks in School
- The Use and Misuse of Fruit Juice

Endorsed statements include:

- Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity
  http://pediatrics.aappublications.org/cgi/content/full/120/Supplement_4/S163/DC1

American Medical Association (AMA)
Roadmaps for Clinical Practice series: Assessment and Management of Adult Obesity
http://www.ama-assn.org/ama/pub/category/10931.html

- AMA Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity, 2007
  http://www.ama-assn.org/ama1/pub/upload/mm/433/ped_obesity_recs.pdf

Centers for Disease Control & Prevention
Overweight and Obesity Resources
http://www.cdc.gov/nccdphp/dnpa/obesity/

Dietary Guidelines for Americans, 2005
U.S. Department of Health and Human Services,
U.S. Department of Agriculture
http://www.health.gov/dietaryguidelines/

Physical Activity Guidelines for Americans, 2008
U.S. Department of Health and Human Services
http://www.health.gov/PAGuidelines/

Guide to Community Preventive Services
Task Force on Community Preventive Services Recommendations
http://www.thecommunityguide.org/obese/default.htm

Healthy People 2010
http://www.maximivanov.com/nutrition6.pdf

Health Resources and Services Administration, Maternal and Child Health Bureau
Obesity evaluation and treatment: Expert Committee recommendations
http://www.pediatrics.org/cgi/content/full/102/3/e29

Institute of Medicine of the National Academies
Childhood Obesity Reports
http://www.iom.edu/project.asp?id=25044

National Conference of State Legislatures
Childhood Obesity – Update and Overview of Policy Options
http://www.ncsl.org/programs/health/ChildhoodObesity-2006.htm

National Heart Lung and Blood Institute (NHLBI)
Aim for a Healthy Weight
http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm

UK Department of Health
Obesity Policy and Guidance
http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Obesity/index.htm

UK National Institute for Health and Clinical Excellence
Obesity Guidance
http://www.nice.org.uk/guidance/CG43

U.S. Department of Health and Human Services
Public Health Service, Office of the Surgeon General: The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity. Rockville (MD): 2001.
http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf

U.S. Preventive Services Task Force

- Screening and Interventions to Prevent Obesity in Adults – Recommendations
  http://www.ahrq.gov/clinic/uspstf/uspsobes.htm &
- Screening and Interventions for Overweight in Children and Adolescents – Recommendations
  http://www.ahrq.gov/clinic/uspstf/uspsobch.htm

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