Strategies to Overcome and Prevent (STOP) Obesity Alliance

Media Kit
STOP Obesity Alliance Media Kit

STOP Obesity Alliance

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The Strategies to Overcome and Prevent (STOP) Obesity Alliance is a diverse coalition of consumer, provider, government, business and health insurer organizations working together to stop, think and change how we perceive and approach the problem of obesity, overweight and weight-related health risks, including heart disease and diabetes. Based at The Milken Institute School of Public Health at The George Washington University, the Alliance is directed by William H. Dietz, M.D., Ph.D. Founding Director Christine Ferguson, J.D., serves as the Alliance’s Strategic Initiatives Advisor. As Medical Director, Scott Kahan, M.D., M.P.H., provides counsel and oversight for the Alliance’s ongoing research, writing and initiatives.

The Alliance’s goal is to help reverse America’s rising trend in obesity and related conditions such as diabetes, heart disease and certain cancers by:

- Leading innovation
- Strengthening systems of care for patients with overweight and obesity
- Convening diverse stakeholders to address issues related to the care of patients with overweight and obesity
- Defining and catalyzing an innovative research agenda for the care of patients with overweight and obesity
- Identifying, implementing, and evaluating strategies to increase physical activity for patients with obesity
- Reducing stigma to improve health outcomes

Steering Committee Members

The Alliance Steering Committee is comprised of leading public and private sector organizations. Each organization was selected for its diverse expertise in areas related to obesity, chronic disease and health care.

- America’s Health Insurance Plans
- American Diabetes Association
- American Heart Association
- American Medical Group Association
- American Society for Metabolic & Bariatric Surgery
- The Obesity Society
- Donna Ryan, M.D.
- National Business Group on Health
- Trust for America’s Health
- Obesity Action Coalition
- Weight Watchers International, Inc.

Government Liaison Member

The Alliance Government Liaison Members provide direction and participate in core activities, including guidance of research projects and priorities, but do not play a governance role in the Alliance.

Centers for Disease Control and Prevention: Division of Nutrition, Physical Activity and Obesity
Associate Members

The Alliance Associate Members add their voices to the substantive discussions related to the fight against obesity through inclusion in Alliance Task Forces, participation in public events and internal communications.

- Academy of Nutrition and Dietetics
- American Association of Diabetes Educators
- American Association of Nurse Practitioners
- American Board of Obesity Medicine
- American College of Obstetricians and Gynecologists
- American College of Preventive Medicine
- American College of Sports Medicine
- American Council on Exercise®
- American Institute for Cancer Research
- American Medical Women’s Association
- American Sleep Apnea Association
- American Society for Nutrition Association
- Association of Clinicians for the Underserved
- Association of Women’s Health, Obstetric and Neonatal Nurses
- Binge Eating Disorder Association
- Campaign to End Obesity
- Canadian Obesity Network
- Commissioned Officers
- Association of the U.S. Public Health Service
- COPE
- DiabetesSisters
- Egg Nutrition Center
- Endocrine Society
- Ginger Winston, MD, MPH
- Healthcare Leadership Council
- HealthCorps®
- Healthy Weight Partnership
- HealthyWomen
- Hepatitis Foundation International
- Institute for Health and Productivity Management
- Institute for the Advancement of Multicultural & Minority Medicine
- International Health, Racquet & Sportsclub Association
- Jacobs Institute of Women’s Health
- Jefferson School of Population Health
- Joslin Diabetes Center
- Lisa W. Martin, MD, FACC
- Medicaid Health Plans of America, Center for Best Practices
- Melissa A. Napolitano, Ph.D.
- Microclinic International
- Monique M. Turner, Ph.D.
- National Association of Chronic Disease Directors
- National Association of Social Workers
- National Black Nurses Association
- National Council of La Raza
- National Hispanic Medical Association
- National Indian Health Board
- Obesity Medicine Association
- OWL – The Voice of Women 40+
- Peter D. Vash, MD, MPH, FACE
- Rebecca Puhl, Ph.D.
- Red Hot Mamas
- Stephen R. Cook, MD, MPH
- Tallahassee Memorial HealthCare
- The American College Of Physicians
- The Aspen Institute
- The COSHAR Foundation
- The Ohio State University
- The Society of Behavioral Medicine
- TogoRun
- Women in Government Foundation, Inc.
- WomenHeart
- World Obesity Federation
**State-Level Members**

The Alliance State-Level Members represent state-level and national organizations with a focus on state-level health issues.

- American Heart Association, Office of State Advocacy
- Georgia Department of Public Health
- Illinois Chapter of the American Academy of Pediatrics
- Medicaid Health Plans of America, Center for Best Practices
- Mississippi State Department of Health
- National Academy for State Health Policy
- Nebraska Medical Association
- Virginia Department of Health, Central Virginia Health District

**How to Get Involved**

Visit our website [www.stopobesityalliance.com](http://www.stopobesityalliance.com)

Email us obesity@gwu.edu

Follow us on Twitter @STOPObesity

Like us on Facebook [www.facebook.com/stopobesityalliance](http://www.facebook.com/stopobesityalliance)

*Sign-up for our Monthly E-Newsletter*

[http://www.stopobesityalliance.org/newsroom/e-newsletter/](http://www.stopobesityalliance.org/newsroom/e-newsletter/)

The Strategies to Overcome and Prevent (STOP) Obesity Alliance has received funding from its founding sponsor, Sanofi U.S. LLC, and its supporting sponsor Novo Nordisk Inc. Additional generous support has been provided by Eisai, Co., Ltd., Ethicon U.S. LLC, Takeda Pharmaceuticals U.S.A., Inc. and members of STOP.
Strategies to Overcome and Prevent (STOP) Obesity Alliance

Leadership

William H. Dietz, M.D., Ph.D.

Director

William H. Dietz, M.D., Ph.D. serves as Director of the STOP Obesity Alliance, providing his wealth of obesity expertise to enhance and develop the Alliance’s research, writing and initiatives. A noted public health figure, Dr. Dietz has devoted the majority of his career to topics related to obesity including obesity prevention, nutrition and physical activity. Dr. Dietz also heads the Sumner Redstone Global Center on Prevention and Wellness at George Washington University. From 1997-2012, he was the Director of the Division of Nutrition, Physical Activity, and Obesity in the Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control (CDC). He is the author of over 200 publications in the scientific literature, and the editor of five books, including Clinical Obesity in Adults and Children, and Nutrition: What Every Parent Needs to Know.

Christine C. Ferguson, J.D.

Strategic Initiatives Advisor

Christine C. Ferguson, J.D. is the Director of the Rhode Island Health Benefits Exchange and a Professor at the School of Public Health and Health Services at The George Washington University. Ms. Ferguson’s prior professional experiences, including serving as Commissioner of the Department of Public Health in Massachusetts under Governor Mitt Romney, have made her adept at evaluating, prioritizing and working to address significant public health issues, skills that guided her in her role as former director of the Alliance.

Scott Kahan, M.D., M.P.H.

Medical Director

Dr. Kahan is a physician trained in both clinical medicine and public health, Dr. Kahan specializes in obesity prevention and treatment. He lends his clinical expertise to the Alliance, which includes providing knowledge from his practice and broader perspective on medical research. Dr. Kahan is also the Director of the National Center for Weight and Wellness.

Morgan Downey, J.D

Policy Advisor

Morgan Downey, J.D. serves as Policy Advisor of the STOP Obesity Alliance, providing daily counsel and oversight for the Alliance’s ongoing research, writing and advocacy efforts. Mr. Downey is among the most respected names in obesity policy, having served as executive vice president of The Obesity Society and executive director and chief executive officer of the American Obesity Association.
Strategies to Overcome and Prevent (STOP) Obesity Alliance Accomplishment

2008- Present

Employer Survey of Obesity in the Workplace (2008)
Commissioned surveys to determine the attitudes and beliefs of employees and employers on obesity in the workplace. The Jan/Feb 2009 issue of Health Affairs included the survey results.
http://www.stopobesityalliance.org/research-and-policy/research-center/survey-results/

National Employee Wellness Month (2008-Present)
Created National Employee Wellness Month with Virgin Pulse in 2009 and co-sponsored for the past six years.
http://www.stopobesityalliance.org/events/past-events/top-tips-for-creating-a-healthy-engaged-workforce/

First navigation tool for public and private decision makers to guide development of policies and programs geared toward reducing the overweight and obesity epidemic.
http://www.stopobesityalliance.org/research-and-policy/policy-room/obesity-gps/

Primary Care Research (2009 - 2010)
Hosted a roundtable on adult primary care treatment and management of obesity. Commissioned national survey to assess patient and provider attitudes toward weight and health with Harris Interactive. Released a paper, "Improving Obesity Management in Adult Primary Care," which outlined five areas to explore to improve the treatment of obesity in primary care. Released "Improving Obesity Management in Primary Care and Community Health Centers" paper that details key areas where community health centers can focus to increase the effectiveness of obesity management.
http://www.stopobesityalliance.org/research-and-policy/research-center/primary-care/

Formed Task Force on Women - the “Chief Health Officer” (2010)
Formed a Task Force on Women, a sub-group of the Alliance's members, which worked to promote discussion and advance understanding among public and private sector decision makers about the unique and disproportionate impact obesity and weight-related conditions have on women's health.
http://www.stopobesityalliance.org/research-and-policy/alliance-initiatives/task-force-on-women/

Reshaping the Conversation on Health and Weight: Media Recommendations (2010)
Partnered with the National Eating Disorders Association to convene an expert panel to discuss the role of the media in communicating positive and negative messages on weight and health. Developed recommendations for the media, based on the discussion, which featured essential messages for media to convey about weight and health.
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<td><strong>Weigh In: Talking to Your Children About Weight and Health (2012)</strong></td>
<td>Convened an expert roundtable that included experts from pediatrics, psychology, and obesity research. In partnership with the Alliance for a Healthier Generation, produced “Weigh In: Talking to Your Children about Weight and Health,” a guide for parents of children 7-11 years old to help them discuss weight and health with their children, also available in Spanish. Developed toolkit community leaders materials needed to host a group discussion with parents. <a href="http://www.stopobesityalliance.org/research-and-policy/alliance-initiatives/families/">http://www.stopobesityalliance.org/research-and-policy/alliance-initiatives/families/</a></td>
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<td><strong>Changing the Dialogue: the Obesity Drug Outcome Measures Project (2012)</strong></td>
<td>Convened roundtables with stakeholders, including FDA, to transform the process used to evaluate pharmacotherapy and developed a consensus report that explored challenges in the development and approval of obesity drugs. <a href="https://publichealth.gwu.edu/pdf/obesitydrugmeasures.pdf">https://publichealth.gwu.edu/pdf/obesitydrugmeasures.pdf</a></td>
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<td><strong>Survey on Weight and Quality of Life (2012)</strong></td>
<td>Conducted an Internet-based nationally representative survey of more than 2,000 adults + 658 individuals with BMI&gt;35 to examine patient preferences, experiences, values, needs, and priorities. Currently submitting survey results for publication.</td>
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<td><strong>GW Obesity Decision Aid project (2012-Present)</strong></td>
<td>Developed a Decision Aid for primary care physicians on treatment of obesity based on the Edmonton obesity staging system. Held a roundtable with primary care providers and experts in May 2014. Kicking off project to pilot the tool in Rhode Island in fall 2014.</td>
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Invited a cross-section of leaders from medical societies, disease groups, health systems and health plans to a roundtable to develop and identify provider knowledge gaps. Formed a Task Force to develop and review a Provider Discussion Tool with potential scenarios, tools, knowledge, and situations to facilitate effective conversations about weight between providers and patients.
**Fast Facts: Benefits of 5 to 10 Percent Weight Loss**

*This fact sheet is one in a series of ‘Fast Facts’ that provides information to help shed light on the complexity of obesity.*

**What Amount of Weight Loss Results in Health Improvement(s)?**

- Research shows that modest weight loss (5-10% of baseline weight) is associated with improved health outcomes and a reduction in risk factors for chronic disease, including lower blood glucose levels, lower blood pressure, and reduced cholesterol levels.¹

- The American Heart Association, the American College of Cardiology, and The Obesity Society (AHA/ACC/TOS) recommend slow, progressive weight loss over rapid weight loss because rapid weight loss carries health risks and may be more difficult to maintain over time.²
  - According to AHA/ACC/TOS guidelines, treatment of obesity should focus on producing slow, progressive weight loss with a weight-loss goal of 10% of baseline weight after six months.
  - Treatment may include diet, physical activity, and behavioral modification, as well as pharmacotherapy and surgery, depending on the individual’s medical profile.
  - AHA/ACC/TOS recommend that after the initial weight loss goal is reached, patients should focus on weight maintenance or additional weight loss, as advised by their physician.

**What Are Some of the Effects of Modest Weight Loss?**

- There is some evidence that a small amount of intentional weight loss is associated with lower all-cause mortality rates among men and women.³
  - The use of behavioral interventions to improve health-related quality of life has been shown to produce beneficial effects.

- Many individuals who undergo weight loss interventions regain some weight over time.
  - The health outcomes of weight loss followed by weight regain are not well understood, and more research is needed to determine whether health benefits achieved through weight loss persist despite weight regain.⁴
  - Improvements in health-related quality of life may not be solely dependent upon weight loss but may also result from lifestyle changes such as an improved diet and increased physical activity.

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**Lifestyle Interventions**

- Modest weight loss achieved through lifestyle interventions is particularly effective for reducing the risk of developing type 2 diabetes.⁵

- Diabetes Prevention Program results showed that participants who received lifestyle interventions (including intensive individual counseling and motivational support on diet, exercise, and behavior modification) achieved an average 58% reduction in their risk of developing diabetes.⁶
About the Strategies to Overcome and Prevent (STOP) Obesity Alliance

The Strategies to Overcome and Prevent (STOP) Obesity Alliance is a collaboration of more than 80 consumer, provider, government, business, and health insurer organizations working to drive innovative and practical strategies that combat obesity. With an academic home at the Milken Institute of Public Health at The George Washington University, the Alliance focuses on developing reports, policy recommendations, and tools for consumers and policymakers that are evidence-based and approved by consensus. The Alliance receives funding from founding sponsor, Sanofi U.S. LLC, and supporting sponsor, Novo Nordisk Inc. For more information, visit www.stopobesityalliance.org and follow the Alliance on Facebook at STOP Obesity Alliance and Twitter @STOPObesity.

References


6 Ibid.
Fast Facts: Gender and Obesity

This fact sheet is one in a series of ‘Fast Facts’ that provides information to help shed light on the complexity of obesity.

Living With Obesity and Gender

- Many studies have shown that men and women experience living with and being treated for obesity very differently.
  - Women tend to report worsening quality of life as obesity increases, with Caucasian women reporting the largest effects.
  - Women report significantly higher impairment of self-esteem with obesity, even when compared within racial groups.
  - Men were most likely to report the most impairment in physical function.
- Physicians tend to treat overweight and obesity differently in men and women.
  - Physicians are more likely to recommend weight loss to women in the overweight category (BMI 25 – 30) than to men of equal height and weight.
  - Physicians are less likely to recommend weight loss to women in the obese category (BMI >30) than to men of equal height and weight.
- In a study of stigma, women were less likely to have a negative response to peers with obesity than men. Of the groups studied, African-American women were the least likely to have a negative response to peers with obesity.

Historic Trends

- The prevalence of obesity showed little change from 1960-1980. However, this was followed by an increase of almost 8 percentage points between 1976-1994, with a similar increase between 1988-2000.
  - During this time of rapid growth in obesity, average BMI increased more rapidly in women than in men.
- Over the period from 1999-2008, however, there were smaller changes in the prevalence among men than seen previously and no significant change in prevalence among women.

The Current State of Obesity and Gender

- In 2009-2010, the prevalence of obesity was 35.5% among adult men and 35.8% among adult women.
- Regardless of race, women have a higher risk for having obesity and overweight than men.
- In 2004, wages were $8,666 less for females with obesity and $4,772 less for males with obesity.
- In 2008, women with obesity experienced a 14.6% wage penalty ($5,826) compared to women with a BMI in the “normal” range.
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References

6 Flegal 2012.
Fast Facts: Obesity-Related Chronic Disease
This fact sheet is one in a series of ‘Fast Facts’ that provides information to help shed light on the complexity of obesity.

Diabetes and Obesity
- Diabetes is the seventh leading cause of death in the US and accounts for $174 billion in total U.S. health care costs.\(^1\)
- Having overweight or obesity significantly increases an individual’s risk of type 2 diabetes.\(^2\)
- The CDC projects that as many as one in three U.S. adults could have diabetes by 2050.\(^3\)
- Research has shown that losing weight can significantly reduce the risk of developing type 2 diabetes.\(^4\)

Coronary Heart Disease and Stroke and Obesity
- Having overweight or obesity raises the risk of having high blood pressure, high levels of harmful blood fats known as triglycerides, and high levels of low-density lipoprotein (LDL), also known as “bad cholesterol.” It can also lead to lower levels of high-density lipoprotein (HDL), also known as “good cholesterol.”\(^5\)
- These conditions can raise the long-term risk of heart disease or stroke.\(^6\)

Hypertension and Obesity
- Having overweight or obesity increases the risk for hypertension, or high blood pressure, which can cause damage to an individual’s arteries, heart, brain, kidneys, eyes, and other body functions.\(^7\)

Arthritis and Obesity
- Obesity prevalence is 54% higher among adults with arthritis compared with adults without arthritis.\(^8\)
- About 66% of adults with doctor-diagnosed arthritis have overweight or obesity compared to only 53% of those without arthritis.\(^9\)
- Currently, 52.5 million Americans have arthritis.\(^10\)

Cancer and Obesity
- Obesity-related cancers include kidney, endometrial, colorectal, gallbladder, pancreas, thyroid, and postmenopausal breast cancer.\(^11\)
- Approximately 20% of cancer in women and 15% of cancer in men is attributable to obesity.\(^12\)
- One in three deaths from cancer per year (approximately 190,650) are related to obesity, poor nutrition, or physical inactivity.\(^13\)

What Chronic Diseases Are Associated With Obesity?
- The risks of many medical conditions and diseases grow with increasing Body Mass Index (BMI) and abdominal obesity.
- The five most common and highest-cost chronic diseases associated with obesity are type 2 diabetes, coronary heart disease and stroke, hypertension, arthritis, and obesity-related cancer.\(^14,15\)
- More than 85% of people who have type 2 diabetes have overweight and more than 50% have obesity.\(^16\)
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References

6. Ibid.
Fast Facts: The Cost of Obesity

Do Individuals With Overweight and Obesity Incur Greater Costs?\(^1,2\)

- Obesity is associated with a number of co-morbid diseases and conditions that require treatment. The rising rate of obesity has resulted in significant increases in direct medical spending for individuals with obesity and overweight.
- Other individual costs associated with having obesity include lost wages, presenteeism and absenteeism, and higher costs associated with the purchase of personal goods.

What Are the Societal Costs of Having Overweight and Obesity?\(^3,4,5,6\)

- While individuals bear the full burden of some costs, such as the value of lost life or lost wages, employers and employees share the burden for many other costs such as direct medical costs, short-term disability, and productivity losses. The government pays a significant portion of costs associated with obesity for Medicare and Medicaid beneficiaries.
- Estimates of the medical cost of adult obesity in the United States range from $147 billion to nearly $210 billion per year.
- The majority of the spending is attributable to treating obesity-related diseases such as diabetes and cardiovascular disease, among others.
- Obesity is responsible for $61.8 billion in Medicare and Medicaid spending.
  - In the absence of obesity, Medicare and Medicaid spending would be 8.5% and 11.8% lower, respectively.
- If obesity rates continue on their current track, medical costs associated with obesity are estimated to increase by $48 - $66 billion per year in the US, and the loss of economic productivity could be as high as $580 billion annually by 2030.
- However, reducing average BMI by just 5% by 2030 could significantly reduce health care costs across the country.
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References

Fast Facts: Employer and Employee Attitudes Toward Obesity

This fact sheet is one in a series of ‘Fast Facts’ that provides information to help shed light on the complexity of obesity.

What Are Employer and Employee Attitudes Toward Obesity?

The findings below are from a 2008 survey conducted by the STOP Obesity Alliance to assess employers’ and employees’ attitudes regarding obesity and weight management programs in the workplace.¹

- A large majority of employers view obesity as a preventable disease associated with poor lifestyle choices and/or lack of willpower.
- Findings indicate that eight out of ten employees, regardless of weight, believe weight management programs belong in the workplace and are effective.
- Nearly 90% of employees believe onsite exercise facilities and subsidized healthy foods in workplace cafeterias are helpful in reaching and/or maintaining a healthier weight.
- Employees, especially those with obesity, are willing to contribute slightly more for premiums so as to ensure that all workers are covered for various prevention and wellness services.
- Employees, especially those who have obesity, strongly support positive financial incentives for participating in workplace programs to address obesity and promote wellness.
- Of the employees surveyed, 77% support discounts on health insurance or other monetary incentives for participating in health risk appraisals, 70% for participating in weight management programs, and 66% for participating in health coaching.

Do Worksite Wellness Programs Save Money?

- Evidence shows that worksite wellness programs can result in significant savings, averaging around $2.73 in savings for each dollar spent.²

What Are Employers Doing Now?³,⁴

- To reduce health care costs and improve productivity in the workplace, many companies are offering workplace wellness programs centered on general health and fitness. For instance, many companies offer:
  - onsite exercise facilities and/or voluntary health risk appraisals through health plans,
  - subsidies for the cost of health club memberships,
  - bike racks and shower facilities to promote exercise,
  - healthy meal and snack options in cafeterias and vending machines,
  - office sports teams, and
  - health education materials.
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References

3. Ibid.
**Prevalence**

- The prevalence of obesity and overweight has dramatically increased, moving from 46% of the population during 1976-1980 to 66% in 2003-2004, according to the CDC’s National Health and Nutrition Examination Survey (NHANES).

**Obesity Trends**

- As of 2011-2012, approximately 69% of all adults had overweight or obesity.
- Approximately 35% of all adults had obesity.
- Between 1999-2000 and 2009-2010, the prevalence of obesity increased among men but not among women.
- The latest survey results for 2011-2012 reveal 68.8% percent of the adult population has overweight or obesity and 35.7% of the adult population has obesity.

**Graph 1: Prevalence of Adult Obesity, 2009-2010**

Source: CDC/NCHS, National Health and Nutrition Examination Survey, 2009-2010

**Racial Disparities**

- The prevalence of obesity among blacks, Caucasians, and Hispanics was approximately 48%, 33%, and 43%, respectively;
- The prevalence of obesity and overweight was 77%, 80%, and 77%, respectively.
- The prevalence of overweight and obesity has risen consistently among every population group in the United States, albeit at various rates. For example, the adult population is becoming obese and overweight at a faster rate than the child population.

**Projected Obesity Trends (Based on 2030 Predictions):**

- If obesity trends continue on their current path, more than 60% of adults in 13 states would have obesity; more than half of adults in 39 states would have obesity; and more than 44% would have obesity in all 50 states.
- If average BMI is reduced by just 5%, obesity rates would still rise but significantly less than current projections. No state would have an obesity rate above 60% but still more than half of adults in 24 states would have obesity.
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References


5. Ibid.


7. Ibid.


The Strategies to Overcome and Prevent (STOP) Obesity Alliance on Wednesday released a tool for healthcare providers that offers guidance and suggestions on how to initiate conversations with adult patients about weight and health. "Why Weight? A Guide to Discussing Obesity & Health With Your Patients" is a unique tool designed to help providers build a safe and trusting environment with patients to facilitate open, productive conversations about weight.

Weight is a complex and sensitive issue, and conversations surrounding the topic can be challenging. Because obesity and overweight affect two-thirds of Americans, healthcare providers increasingly are being called on to support their patients in matters dealing with weight.

"This tool offers providers a unique and much-needed resource that can help them to facilitate conversations about weight."

Many providers have concerns about how to begin discussing weight in ways that are empowering and nonjudgmental. The tool discusses potential scenarios providers may face and suggests ways to approach the conversation.

“Research has shown that behavioral and medical treatment can be effective, but improvised and uninformed discussions may stigmatize, shame or fail to engage patients, to the detriment of the provider-patient relationship and patient outcomes,” said STOP Obesity Alliance director William Dietz. “This tool offers providers a unique and much-needed resource that can help them to facilitate conversations about weight.”

In addition to skills for building a safe, trusting environment with patients and facilitating productive conversations about weight, the guide also includes practical information on coding and patient accommodation.

STOP developed the guide using a comprehensive process that included conducting an audit of available research on provider-patient communication and consultation with a range of experts from obesity practice and research, primary care practice, nutrition education, women’s health, minority health and the patient community to offer insight based on their expertise and to guide development of the tool.

“We are thrilled to have taken part in the process to develop this tool and think it does an excellent job of responding to a real need among providers for resources to initiate these difficult conversations,” said Wendy Nickel, director, Center for Patient Partnership in Healthcare for the American College of Physicians. “It is a well-informed and valuable resource.
U.S. Obesity Rate Levels Off, But Still An Epidemic

USA TODAY
October 18, 2014
Nanci Hellmich

Obesity among U.S. adults is continuing to level off after several decades of skyrocketing growth, new government data show.

In 2012, about 34.9% of the people in this country were obese, which is roughly 35 pounds over a healthy weight. That is not significantly different from the 35.7% who were obese in 2010.

In both 2010 and 2012 about 78 million adults were obese; more than 50 million of those were white, according to the latest statistics from the National Center for Health Statistics, part of the Centers for Disease Control and Prevention.

"Even though it looks like a slight drop in the percentage of adults who are obese, this difference is not statistically significant," says Cynthia Ogden, an epidemiologist with the National Center for Health Statistics. "This is more evidence that we're not seeing a change in adult obesity."

Harvey Grill, president of the Obesity Society, says, "The fact that we're at 35% of adult Americans who are obese is extremely troubling because their obesity will result in health problems for the majority of them."

Obesity over time

Scott Kahan, director of the STOP Obesity Alliance at George Washington University, an obesity policy think tank, says, "The numbers are still at epidemic levels, and we need to continue to create smart strategies to address this health problem."

There has been no significant change in obesity rates since 2004 when the obesity rate was about 32%, Ogden says.

The prevalence of obesity increased dramatically in the 1980s and 1990s after being relatively stable in the USA between 1960 and 1980 when about 15% of people fell into the category.

The latest statistics did not include obesity rates for children and adolescents, but there has been some indication in the last CDC statistics on children that those rates have leveled off too.

This new analysis is based on data from the National Health and Nutrition Examination Survey, which is considered the gold standard for evaluating the obesity epidemic in the USA, because it is an extensive survey of people whose weight and height are actually measured rather than being self-reported.

Obesity is determined by calculating people’s body mass index, a number that takes into account height and weight. Adults are considered obese if they have a body mass index (BMI) of 30 or greater. BMI measures body mass; it doesn't distinguish between fat and muscle.

A 5-foot-4 adult would be classified as obese if he or she weighed 174 pounds or more; a 5-foot-9 adult would fall into that category at 203 pounds or more.
Obesity takes a huge toll on people's health. It contributes to a long list of serious health problems including type 2 diabetes, cardiovascular disease, liver problems, degenerative joint disease, and some types of cancer.

Other new statistics:

- There was no significant change in obesity among men and women. In 2010, 35.8% of women were obese; in 2012, 36.1%. In 2010, 35.5% of men were obese; in 2012, 33.5%.
- The middle-age spread is still a problem. The prevalence of obesity is higher among middle-aged adults (39.5%) than younger (30.3%) or older (35.4%) adults.
- The obesity rate is higher among black adults (47.8%) and Hispanics (42.5%) than whites (32.6%) adults. It's lowest among Asian adults (10.8%).
- Obesity was higher among black women (56.6%) than Hispanic (44.4%) and white (32.8%) and Asian women (11.4%).

"The percentage of obesity in Asians is quite low, but BMI is not a perfect measure of body fat," Ogden says. Studies have shown that Asians may have more body fat at lower BMI levels than whites so some countries, such as Taiwan, have adopted lower BMI cutoff points for overweight and obesity for Asians, she says.

People who are concerned about being obese and want to drop extra pounds should try to lose 10% of their weight, says Patrick O'Neil, director of the Weight Management Center at the Medical University of South Carolina in Charleston. "We know that losing 10% of your body weight can produce a significant improvement in your health. You will feel better and be able to do more things. After you've lost 10%, you can determine how much more you wish to lose."
“Mom, Dad, am I fat?”. Talking to Your Kids About Weight and Health
Philly.com
October 17, 2014
Alexis Skoufalos

“Mom, Dad, am I fat?” It’s a question that many parents aren’t sure how to answer.

There’s no escaping the fact that people make judgments about who we are based on how we look. For kids who are overweight, especially in the teen years, the bullying can be devastating and have a negative effect for years to come. And now that school districts are including Body Mass Index assessments as part of children’s physicals, there is the added confusion over what to do if the dreaded “fat letter” arrives saying your child is at an unhealthy weight.

It’s hard for parents to know how to talk to their kids about the relationship between weight and health. This is a crucial conversation, now that 1 in 3 American children is overweight, to encourage the healthy behaviors that can lower our kids risk of developing diabetes and other weight-related disorders.

How to answer that difficult question? Some things that you can say to your child depending on their age are:

“I love you and I don’t have a problem with how you look, but as your parent, I’m concerned that you are carrying around extra weight and this can hurt your health. It can also mean that you don’t have as much energy or get to do the things that you really like to do.”

“Weight is a measure of your health and carrying extra weight can hurt your health.”

“Carrying extra weight means your body has to work harder than it needs to. Just like when you don’t like it when your teacher gives you extra homework, your body doesn’t like to do more work than it has to. If we can help your body stop overworking, we can make sure you have enough energy to do things that you like to do and what makes you happy.”

This is just one aspect of Weigh In: Talking to Your Children About Weight and Health, an online resource developed by the Strategies to Overcome and Prevent (STOP) Obesity Alliance and the Alliance for a Healthier Generation, offers to parents to help them start important conversations with their children about weight and health. The Philadelphia Health Initiative, a local group of community leaders, recently rolled out a local edition of this online tool.

This free e-guide available in English and Spanish for parents of kids ages 7-11 includes important practical information and strategies. It also has ideas for becoming more physically active as a family; meal preparation and shopping; and ways to start those important conversations with your kids about how important it is to do the things we need to become healthier...together.

We are surrounded by contradictory messages about food, health, and fitness at every turn. Turn on the TV, your cell phone, or just log onto your favorite website. Chances are it won’t be long before you encounter pop-up ads for giant burgers, extra large soft drinks and pizza with extra meat, extra cheese and a cheese-stuffed crust...followed by commercials for weight-loss programs, diet drinks and plastic surgery centers.

With all these messages, it's important to help our kids establish good habits at home. We know that it's not an easy task. Parents who are overwhelmed by their own hectic schedules, struggle to put healthy food -- that their kids will actually eat -- on the table. At times, it can sound like a battleground trying to get
kids to eat healthy food. Are you going to eat all that? Is that all you’re going to eat? Finish your vegetables or there’s no dessert! Children are easily influenced by what’s popular with their friends, what they see on TV, and what they see their parents do.

Here are a few steps parents can take with their children to become healthier together:

- Increasing the total number of minutes being active in a day (parking farther from the door, taking stairs instead of elevators, joining after school activities/sports)
- Limiting screen time and increasing amount of outdoor play time
- Shopping for healthy foods together
- Creating a family play time (tag in the yard, riding bikes after dinner)
- Increasing the amount of fruits and vegetables you eat
- Limiting the number of sweets (foods and beverages) you eat a week

At the Jefferson School of Population Health, we have worked to spread the word by encouraging local community agencies and groups to host meetings to introduce the guide to families. We’re committed to working with partners in the community to make Philadelphia a healthier place to live, work and play. We would be happy to provide you with additional information or materials, or by presenting at a meeting for your school, community group or place of worship. Let us know how we can help you by sending your questions or suggestions to us at weighinphilly@jefferson.edu.
Happy National Employee Wellness Month!
BenefitsPro
June 3, 2014
Dan Cook

National Employee Wellness Month — which is this month — owes its existence to a corporation with a stake in corporate wellness. But with companies, universities, government agencies and others jumping on the bandwagon, it might be an idea whose time has come.

Virgin Pulse launched National Employee Wellness Month six years ago in an attempt to focus executive minds on offering wellness programs to employees. This year, Virgin Pulse reports, more than 200 organizations have signed on to offer special wellness opportunities to employees this month.

Virgin Pulse grabbed the URL nationalemployeewellnessmonth.com, and uses it to host ideas about engaging workers in wellness; to honor workers who’ve participated in wellness plans and make significant gains; and to track competition among companies, dubbed the National Employee Wellness Month Challenge. Workers can share their wellness stories via social media through the website.

National Employee Wellness Month “showcases how companies can support employees by creating healthy cultures, improving their health and well-being while lowering healthcare costs and driving engagement,” Virgin Pulse said in a release.

Major players on board with the concept include AOL, Coca-Cola, Nationwide Insurance and Walgreens. Another venerable institution, Ohio State University, posted a slew of activities for faculty and staff to mark the month. Among them:

- Cooking tips and health food options, delivered through webcasts and interactive webinars;
- Fitness breaks offered free across the campus, including yoga classes, training with your dog, and stair climbing;
- Sharing healthy activities via selfie videos, with prizes for the top contenders; Wellness walks led by university coaches.

The month also will provide an opportunity for a national discussion about the generally sad state of most Americans’ health, with obesity running rampant, more people than ever suffering from multiple chronic illnesses, and drug, alcohol and tobacco abuse continuing to plague the population.

“Fostering and maintaining a culture of wellness in the workplace is more important than ever. With so many Americans affected by obesity, type 2 diabetes, heart disease and other health conditions, National Employee Wellness Month is an outstanding effort to help people work toward addressing our country’s obesity epidemic,” said Scott Kahan, director, Strategies to Overcome and Prevent Obesity Alliance.
Fat and Thin Find Common Ground
The New York Times
October 10, 2013
Abby Ellin

When binge eating disorder gained legitimacy as a full-fledged mental condition in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders in May, many people in the eating disorders and obesity communities wondered: Will this inspire us to finally get along?

It was a good question, since historically, the two groups have been at odds.

Unlike people with anorexia or bulimia, who tend to be excessively thin, many binge eaters are overweight or obese. And much of the focus of anti-obesity efforts — listing calories at restaurants, banning cupcakes in schools, sending students home with body mass index “report cards” — are decried by eating disorder activists, who say such measures can encourage anorexia or bulimia.

Anti-obesity activists, in turn, worry that the eating disorder community minimizes the medical risks of obesity, which the American Medical Association classified as a disease in June, and plays down the discrimination many obese people face.

“They come out of different traditions,” said Kelly Brownell, dean of the Sanford School of Public Policy at Duke University. “Obesity was mainly dealt with in medical professions, and eating disorders were dealt with more in psychology professions.” But binge eating disorder, symptoms of which include consuming enormous amounts of food in a two-hour window without purging at least once a week for three months, could bridge the gap between the two worlds, while also reducing the stereotype that only thin people suffer from eating disorders.

“We cannot address obesity and not eating disorders,” said Chevese Turner, 45, founder of the Binge Eating Disorder Association, which lobbied heavily for binge eating disorder’s inclusion in the D.S.M.-5. In September, clinicians, researchers and advocates who work in the eating disorders and obesity communities, or have struggled with the food and weight issues themselves, held a Congressional briefing in Washington to focus attention on the intersection of obesity and eating disorders.

“Part of what drives me crazy is that the obesity community and policymakers dismiss eating disorders as a small group of people, when in fact it is 30 million and growing — with more and more evidence that the focus on obesity and restriction, and growing weight stigma in the culture, is contributing to this rise,” said Ms. Turner, who spoke at the event.

Susan Rappaport knows all about this. At 26 and a petite 5-foot-4, she weighed nearly 200 pounds — the result, she maintains, of years of dieting. She would starve herself during the day and then get out of bed in the middle of the night to binge.

When she told her doctor that she thought she had an eating disorder, he brushed it off, said Ms. Rappaport, 50, who now weighs about 120 pounds and runs the NuYu Revolution Fitness Studio on the Upper West Side of Manhattan. “It was like, ‘You’re not skinny enough to have an eating disorder.’ But I was a fat eating disordered person.”

Indeed, an September study in Pediatrics found that nearly half of adolescents with eating disorders had a history of obesity, but because of their higher weight their symptoms often went unrecognized and
untreated. Other studies have found that among individuals with a current or past history of binge eating disorder, approximately 20 percent are of normal weight, 40 percent are overweight and 40 percent are obese.

“I don’t want to say that the eating disorder is causing their obesity; some people with B.E.D. are normal weight,” said Jennifer J. Thomas, co-director of the Eating Disorders Clinical and Research Program at Massachusetts General Hospital and the co-author of “Almost Anorexic,” a book about sub-threshold eating disorders. “But there’s definitely a huge overlap, and if the two communities aren’t working together there is a huge missed opportunity.”

Statistics from the 2001-2003 National Co-Morbidity Survey Replication reported a 3.1 percent prevalence of binge eating disorder among women and 1.9 percent among men. Nearly 39.8 percent of respondents with binge eating disorder were obese.

Still, despite differences in physical characteristics and symptoms, those suffering from an eating disorder like anorexia or bulimia and those with obesity have “shared psychological components, commonalities and underpinnings,” said Dr. Scott Kahan, director of the Strategies to Overcome and Prevent (STOP) Obesity Alliance at the George Washington University School of Public Health and Health Services, a nonprofit obesity policy organization.

“Low self esteem is extremely common in both, as is body dissatisfaction. They are both very much environmentally driven. Both place excessive emphasis on appearance and body size. In the same way, many of the same psychological underpinnings play into both.”

Another area where the two fields converge is weight stigma, said Rebecca Puhl, deputy director of the Rudd Center for Food Policy and Obesity at Yale. A July study in PLoS One found that the more people feel stigmatized or bullied about their weight, the greater their risk for obesity. Other studies have shown that experiencing weight bias contributes to risk of eating disorders.

Jenni Schaefer, 37, Dr. Thomas’s co-author, is adamant that the two groups work together to ease confusion among recovering patients. “Recently, a teenager in recovery from bulimia said to me, ‘My therapist tells me not to talk about my weight and that my body is fine. But my doctor keeps weighing me and says that I need to lose weight,’” Ms. Schaefer said. She had a similar experience with her own recovery from a 10-year struggle with anorexia.

“My body had changed far more quickly than my mind. While that was confusing in and of itself, it was even more difficult to understand why my doctors were giving me different perspectives regarding my new weight. In many ways, I hit a standstill at that point. I didn’t know what to do.”

With all this in mind, a growing number of eating disorder treatment facilities are treating obese patients with and without binge eating disorder in groups with anorexics and bulimics.

“It makes no sense to separate people based on their size,” said Dr. Susan McClanahan, founder of Insight Behavioral Health, which has four locations in Chicago.

She is aware of the inherent conflict. “You’re telling one group ‘You have to eat’ and the other ‘It’s O.K. not to eat everything on your plate,’” she continued. “But I think it’s been a real relief for the anorexics to see someone who is overweight and have them realize, ‘They’re just a person, it’s nothing to be afraid of.’ And the overweight folks can say, ‘Just because you’re skinny doesn’t mean you’re going to be happy.’ You can be absolutely miserable when you’re thin.”

Many treatment methodologies are also similar within the two groups, like eating regular meals, not skipping meals and learning to listen to one’s body for cues of hunger or fullness.

Some patients say that being in a mixed group is helpful. Ann Schaffer, 46, an administrative assistant and musician in Chicago, has struggled with binge eating disorder off and on for 12 years. At her heaviest...
Ms. Schaffer, who is 5-foot-7, weighed 207 pounds and found it challenging to be in the same room with 80-pound anorexics.

“Sometimes it was almost like envy — ‘I wish I had your problem,” Ms. Schaffer recalled.

“After a while it was like camaraderie. The problem is not the food; the problems are the issues in your life, and you turn to food because you can’t handle them.”

This model of treating the two groups together is not without controversy. At Walden Behavioral Care in Waltham, Mass., individuals with binge eating and anorexia used to attend the same groups, but that stopped about five years ago.

“Patients were uncomfortable,” said Stu Koman, a clinical psychologist and the clinic’s founder and chief executive. “A lot of what they were dealing with in therapy was their discomfort at being in the group with someone who was anorexic, rather than focusing on what they needed to focus on: these binge episodes. The anorexic patients were terrified that they would end up looking like the heavier patients suffering from B.E.D.”

One thing nearly everyone agrees on is that the cultural conversation around food and body size must shift, along with media messages promoting images of waiflike models and an estimated $61 billion a year weight loss industry, in which the vast majority of dieters regain their weight within five years.

“The focus should be on behaviors, not weight,” said Dianne Neumark-Sztainer, a professor in the School of Public Health at the University of Minnesota, who has written extensively on obesity prevention and eating disorders.

“We know from our research that talking about weight and diets is not effective, and for many leads to weight gain over time,” said Dr. Sztainer, the author of “I’m, Like, So Fat!”

“We really want to focus on providing a community that makes it easy to engage in healthy eating and physical activity.”

Dr. Brownell believes that the two communities could work together as a powerful political force, sharing a goal of better food- and health-related messages and policies. “Better access to healthy, locally grown foods might be such an example,” he said. “The extreme presence in our society of unhealthy, highly processed foods are a problem for both of these camps. Some people respond by eating too much, and others respond by extreme control so it becomes an eating disorder. A healthy food environment would be a benefit in both worlds.”
Medicare to Pay for Obesity Prevention

USA Today
November 29, 2012
Kelly Kennedy and Nanci Hellmich

Medicare announced Tuesday it will pay for screenings and preventive services to help recipients curb obesity and the medical ailments associated with it, primarily heart disease, strokes and diabetes.

"Obesity is a challenge faced by Americans of all ages, and prevention is crucial for the management and elimination of obesity in our country," Donald Berwick, administrator of the Centers for Medicare and Medicaid Services, said in a news release. "It's important for Medicare patients to enjoy access to appropriate screening and preventive services."

According to the STOP Obesity Alliance, the overall costs of being overweight over a five-year period are $24,395 for an obese woman and $13,230 for an obese man. Thirty-four percent of U.S. adults are obese, according to the alliance, which expects that percentage to rise to 50% by 2030.

"As small of a weight loss as 5% to 7% can lead to a huge health improvement," said Christy Ferguson, director of the STOP Obesity Alliance, which sent recommendations to Health and Human Services Secretary Kathleen Sebelius in September.

The new Medicare benefits will include face-to-face counseling every week for one month, then one counseling appointment every other week for the following five months for people who screen positive for obesity.

If the person continues to lose weight, he or she may continue face-to-face counseling every month for six additional months.

"This is good news for the millions of Americans who struggle with obesity and its serious consequences and for their doctors who care for them," said Gary Foster, director of the Center for Obesity Research and Education at Temple University in Philadelphia.

Patrick O’Neil, president of the Obesity Society, a group of weight-control researchers and professionals, said the change recognizes the medical significance of obesity. However, it doesn’t cover treatment provided by dietitians and psychologists.

In a report released to HHS in October, the Institute of Medicine recommended that all American adults participating in the new health exchanges created by the health care law be screened for obesity.

In announcing the changes, HHS said obesity is associated with several chronic diseases that disproportionately affect racial and ethnic minorities.

A recent alliance survey showed that 60% of people had tried to lose weight and that 50% are trying to lose weight now.

Ferguson said programs need to go beyond helping people lose weight: Americans need to understand that quality of food matters, too.

"It's not necessarily weight loss so much as it is increased fitness level and increased health," she said.
Tips for Talking Weight with Kids

The Washington Post

August 23, 2012

Jennifer LaRue Huget

I blogged last fall about a survey that found parents are more comfortable discussing sex, drugs and alcohol with their kids than addressing the should-be-less-weighty topic of their excess pounds.

Why is it so hard to talk about weight with our kids? It shouldn’t be so challenging to say to a child, “Those extra pounds you’re carrying around are hard on your body and not so good for your health. Let’s see what we can do together to change that.”

But we’ve managed to layer everything related to weight — our own and our kids’ — with all kinds of emotional, cultural, psychological and otherwise unhelpful baggage that it seems impossible to cut to the practical quick.

But a new guide for parents does just that. “Weigh In: Talking with Your Children About Weight and Health,” produced by the STOP Obesity Alliance and the Alliance for a Healthier Generation, focuses on excess weight as a health issue that requires effort to manage. The guide acknowledges the many forces — a parent’s own obesity, misunderstanding of BMI measures, body image, bullying, cultural norms that favor larger body shapes — that work against such a pragmatic approach and helps parents navigate around them. In fact, it provides scripts that you can follow, providing just the right words for you to say.

For instance, consider the sticky situation that occurs in families in which one sibling is of normal weight and another is overweight, a scenario in which teasing often takes place. (The guide cites research showing that nearly half of overweight females and a third of overweight males report having been teased by family members.)

The guide suggests that a parent in such a family might take the teasing sibling aside and say, “I don’t know if you know this, but your sister is dealing with a health issue,” and “Like some of your friends who may have asthma or trouble concentrating, your sister carries around too much weight and that can hurt her health too.”

And, the parent might add, “What’s most important for us as her family is that how much she weighs is not a measure of who she is as a person. Because we know she is (FILL IN with positive attributes, e.g., caring, a good friend, smart, a hard worker).” From there, the sibling can be enlisted to help think of simple, easy-to-monitor-and-implement things the family can do together to help promote a more healthful lifestyle.

Press materials announcing the release of this “conversation guide” note that the document “was created and reviewed by experts from a cross-section of fields including pediatrics, obesity research and psychology, but most importantly, these experts have children of their own.”

That last bit is important. Throughout, the guide keeps the temperature low and promotes compassion and a spirit of cooperation; there’s no pity, condescension, criticism, guilt or anger here.

Have you had “the talk” with your overweight child? What did you do right — and what do you wish you had done differently?
Know your BMI: Docs Urged to Screen for Obesity
Yahoo! News via The Associated Press
June 26, 2012
Lauren Neergaard

Chances are you know your blood pressure. What about your BMI?

Body mass index signals if you’re overweight, obese or just right considering your height. Some doctors have begun calling it a vital sign, as crucial to monitor as blood pressure.

But apparently not enough doctors check: A government panel renewed a call Monday for every adult to be screened for obesity during checkups, suggesting more physicians should be routinely calculating their patients’ BMIs.

And when someone crosses the line into obesity, the doctor needs to do more than mention a diet. It's time to refer those patients for intensive nutrition-and-fitness help, say the guidelines issued by the U.S. Preventive Services Task Force.

Don't assume your weight's OK if the doctor doesn't bring it up.

Patients "should be asking what their BMI is, and tracking that over time," says task force member Dr. David Grossman, medical director for preventive care at the Group Health Cooperative in Seattle.

By the numbers: A normal BMI is less than 25. Obesity begins at 30. In between is considered overweight.

The advice sounds like a no-brainer, considering the national anxiety about our growing waistlines. Two-thirds of adults are either overweight or obese. Some 17 percent of children and teens are obese, on the road to diabetes, heart disease and other ailments before they're even grown.

The task force has recommended adult obesity screening previously, and similar guidelines urge tracking whether youngsters are putting on too many pounds.

Yet BMI remains a mystery for many people. A 2010 survey of members of the American Academy of Family Physicians found up to 40 percent of those primary care doctors were computing their patients' BMIs. Surveys show only about a third of obese patients recall their doctor counseling them about weight loss, even though people whose doctors discuss the problem are more likely to do something about it.

Doctors can struggle with the pounds, too, and Johns Hopkins University researchers recently reported that overweight physicians were less likely than skinnier ones to advise their patients about weight loss.

Why the reluctance? One reason: Few doctors are trained to treat obesity, they’re discouraged by yo-yo dieting but they don't know what to advise, says Dr. Glen Stream, president of the physicians' group. His Spokane, Wash., practice uses electronic medical records that automatically calculate BMI when a patient’s height and weight is entered.

"Our American culture is always looking for an easy fix, a pill for every problem," Stream says. "The updated recommendation is important because it makes clear exactly what doctors should do to help."
In Monday's Annals of Internal Medicine, the task force concluded high-intensity behavioral interventions are the best non-surgical advice for the obese, citing insufficient evidence about lasting effects from weight-loss medications.

The task force's Grossman says a good program:

- Includes 12 to 26 face-to-face meetings over a year, most in the first few months. Makes patients set realistic weight-loss goals. Losing just 5 percent of your initial weight — 10 pounds for a 200-pound person — can significantly improve health. Analyzes what blocks each patient from reaching those goals. Do they eat high-calorie comfort foods to deal with depression? Spend too much time at a desk job? Tailors ways to help people integrate physical activity into their daily routine. Requires self-monitoring, such as a food diary or a pedometer to track activity.

Last year, Medicare started paying primary care doctors for obesity screening and weight-loss counseling for seniors for a year, including weekly meetings for the first month.

But many insurance companies don't pay for all the suggested interventions, and comprehensive programs aren't available everywhere, says Dr. Scott Kahan of George Washington University and the STOP Obesity Alliance. He runs a clinic that provides a medical, psychological and nutritional evaluation before tailoring a plan. In other programs, primary care doctors may offer some counseling and send patients to nutritionists or other specialists for extra help.

Another problem: "Doctors tend to shoo away people who have obesity. They say, 'Don't come back to me and tell me your back hurts or you have acid reflux or high cholesterol until you will do something about it,'" laments Kahan, who is teaching medical school students to motivate patients.

What about the overweight? The task force said more study is needed on how best to help them.

But in Reno, Nev., Dr. Andy Pasternak calculates BMI for every patient at his family medicine practice — and particularly targets the overweight in their 40s and younger for fitness counseling. He says if they wait until they're heavier or older to get active, arthritis exacerbated by the pounds will be another barrier.

Patients seldom know what their BMI should be, but "at least twice a day people say, 'What should be my optimal weight?'" Pasternak says.

He thinks saying to lose 60 pounds is too discouraging: "What I try to get them to focus on is: How much are you working out? How many servings of vegetables do you get a day?"
Medicare Anti-Obesity Initiative Triggers Treatment Debate
USA Today
December 1, 2011
Nanci Hellmich and Kelly Kennedy

The decision that Medicare will pay for screening and counseling services to help obese patients lose weight has opened an old debate about who can best help people slim down. More than 30% of people in the Medicare population are obese.

Top national weight-loss experts salute the ruling as good news, but they are concerned that many doctors and their staffs are ill prepared and haven't the time to help obese patients. "This is an incredibly positive move by the government in recognizing obesity as a contributor to many of our health problems," said Donna Ryan, an obesity researcher at the Pennington Biomedical Research Center in Baton Rouge. "But the devil is in the details, and many physicians have no training in weight-loss counseling — zero."

In a recent survey of primary care physicians, 78% said they had no prior training on weight-related issues, said Christy Ferguson, director of the STOP Obesity Alliance. Of those, 72% said no one in their office had weight-loss training.

"I don't think we have spent enough time thinking about that," Ferguson said. "But things change in increments, and this is a step in the right direction."

The rule means that doctors can now be paid for weight-related counseling, and therefore may seek out training, she said. The Medicare benefits from the Centers for Medicare and Medicaid Services (CMS) will include screening for obesity and counseling for eligible beneficiaries by primary care providers in settings such as physicians' offices.

The services include face-to-face counseling every week for one month, then one counseling appointment every other week for the following five months for people who screen positive for obesity. CMS will require counseling be given by physicians, nurse practitioners, clinical nurse specialists or physician assistants.

More than 30% of people in the Medicare population are obese, which increases their risk of type 2 diabetes, heart disease and many types of cancer.

Some research suggests that physicians can assist patients in weight loss.

Thomas Wadden, director of the Center for Weight and Eating Disorders at the University of Pennsylvania's Perelman School of Medicine, published a study earlier this month that found physicians, with the aid of their medical assistants and meal-replacement plans, helped obese patients lose and keep off 10 pounds over two years. The medical assistants and physicians got weight-loss training before they started counseling patients.

He said he hopes insurance companies will follow CMS' "bold lead" and pay for obesity treatment.

Wadden also said he believes that CMS should consider reimbursing a range of weight-loss options, including telephone- and Internet-based programs, which have been shown to be effective. "Such programs could be coordinated with primary care providers efforts and delivered at a far lower cost than having physicians or nurse practitioners deliver lifestyle counseling."
Several other large clinical trials show that dieters who followed intensive weight-loss programs with trained professionals and a lot of one-on-one counseling lost an average of 9% of their starting weight, Ryan said.

However, most physicians can't spend huge amounts of face time with their patients, she said. "The physician should probably be part of the assessment team and the primary motivator, but someone else in the office should teach the lifestyle changes that will lead to weight loss.

"The problem is going to be how to make this efficacious and affordable. It's a question of economics," Ryan said.

Not everyone agrees that counseling is the best approach. Deborah Cohen, a physician and senior natural scientist at the RAND Corp., a think tank, said that as dieting, counseling and nutritional information have increased, the obesity epidemic has continued to grow. "It shouldn't be doctors," she said.

"We should have a professional food industry that sees itself as a health care provider," Cohen said. "Instead, we're being encouraged to eat food that makes us sick."

Policy should focus on changing an environment that encourages eating too much: large portion sizes in restaurants, "fourth meal" at fast-food joints, super-sizes only for food that causes heart conditions and fatty snacks within easy reach at the ends of grocery aisles. "How many people had nutrition counseling before the obesity epidemic hit?" Cohen said. "It's not about knowledge — we've changed people's behaviors."