Patient Advocacy Leaders United for Obesity: Opportunities for Education and Advocacy

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A program of

CENTER FOR PATIENT ADVOCACY LEADERS

PALs UNITED
Patient Advocacy Leaders United for Obesity

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Introduction

Center for Patient Advocacy Leaders

The Center for Patient Advocacy Leaders (CPALs) is a collaborative initiative powered by The AIDS Institute (TAI). CPALs is dedicated to improving the lives of those affected by disease and chronic health conditions by educating and mobilizing health advocacy leaders to work collaboratively in developing impactful policy and advocacy solutions to timely healthcare issues. The Center facilitates engagement, collaboration, and mobilization, creating a broad-based network of health advocacy leaders utilizing a collective impact model that promotes patient-centered, quality, affordable healthcare for all people. We believe that by developing and empowering a network of patient advocates, we can more effectively improve the lives of those affected by disease and/or chronic health conditions. Our advocate-centered model, "By Advocates, For Advocates," focuses on the needs of patients and caregivers, patient advocacy leaders, their organizations, and the diverse communities they serve. Our focus is on long-term meaningful partnerships involving multiple sectors and stakeholders. To further this work, we have created Patient Advocacy Leaders United for Obesity to work with patients, advocates, and caregivers impacted by obesity to help prioritize advocacy outreach and policy ideas and to foster collaboration, mobilization and partnerships.

Purpose of Report

The purpose of this report is to present opportunities for education, advocacy, and collaboration and to help construct a framework for health advocates to develop a common ground approach to and an understanding of the underlying issues related to addressing the obesity epidemic that can be built into their advocacy campaign for policy change and education. Short- and long-term goals for implementing a framework include:

1. Increase awareness and understanding among the health advocacy community that obesity is a chronic disease with physiological and genetic underpinnings, it can occur as a co-morbid condition alongside other chronic illnesses, and it impacts health outcomes and the cost of care.
2. Educate and mobilize health advocacy leaders to help build a common federal and state advocacy plan for improving enhanced access to safe and effective obesity treatment and interventions, and addressing the need for critical social/economic factors for building a healthy lifestyle.
3. Apply lessons learned from other chronic illnesses (i.e., mental health, addiction, HIV) facing stigma and discrimination to help build programs to reduce the stigma and discrimination associated with obesity/unhealthy weight.

The focus of this report is on adults and older adults with a special emphasis on populations facing disproportionate health disparities including populations of color.

What is Obesity?

According to the Centers for Disease Control and Prevention (CDC), weight that is higher than what is considered healthy for a given height is described as overweight or obesity. Obesity occurs when an individual takes in more calories than they burn through daily activities and exercise. Body mass index (BMI) is a measure of weight adjusted for height that is routinely used as a screening tool for overweight and obesity.[i]

- BMI of less than 18.5 falls within the underweight range
- BMI of 18.5 to <25 falls within the healthy weight range

- BMI of 25.0 to <30 falls within the overweight range
- BMI of 30.0 or higher falls within the obesity range

Although BMI has been the standard measure for defining obesity for some time, there are some challenges associated with its use including that it doesn't take into full account important details about age, race, sex, body type, bone structure, and fat distribution.

Public health researchers, physicians, patient advocates, federal and state institutions, and an increasing number of citizens recognize that obesity is a chronic illness. Like other chronic illnesses, obesity has biological and genetic underpinnings, is influenced by social determinants, and is not due to an individual's moral failing. Although there is no cure, obesity is a treatable illness and, if treated effectively, living a healthy life, without discrimination, is possible.

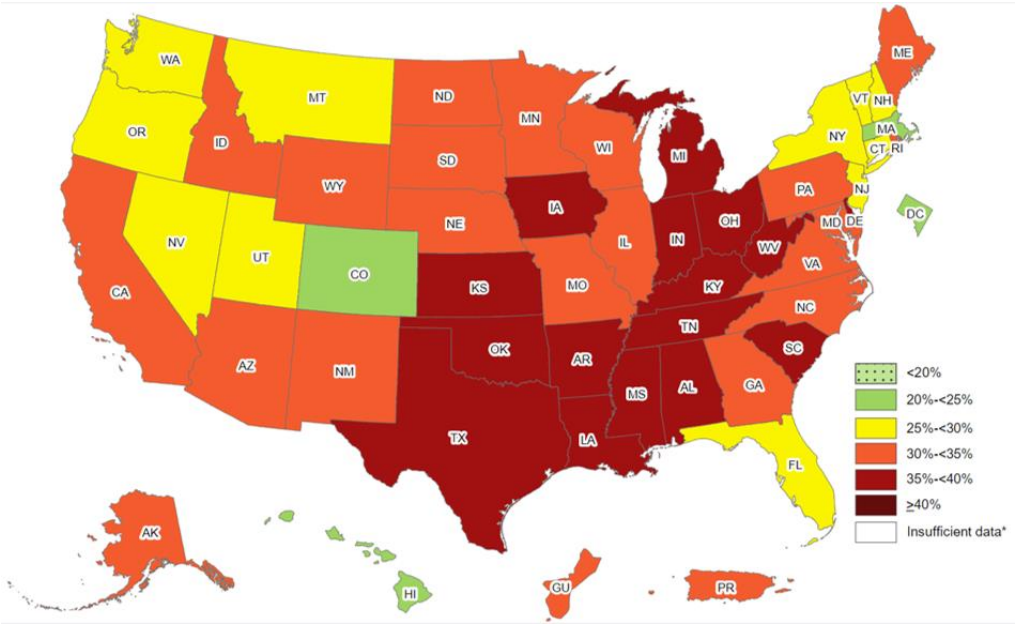
Prevalence of Obesity

National and Regional Rates of Obesity

The prevalence of obesity in the U.S. has risen dramatically over the past several decades. According to CDC, the rate of adult obesity reached 42.4 percent in 2017-2018, surpassing 40 percent for the first time. In 2020, all states had more than 20 percent of adults with obesity and 16 states had at least 35 percent of adults with obesity, up from nine states in 2018 and 12 states in 2019. States with the highest obesity rates include:[ii]

Alabama	Arkansas	Delaware	Indiana
Iowa	Kansas	Kentucky	Louisiana
Michigan	Mississippi	Ohio	Oklahoma
South Carolina	Tennessee	Texas	West Virginia

Prevalence of Self-Reported Obesity Among U.S. Adults by State and Territory, 2020



Source: Behavioral Risk Factor Surveillance System

Health Disparities

Obesity impacts some populations more than others and there are notable differences by race and ethnicity, education, age, and geographic location. The CDC reports that from 2018-2020:

- Race/Ethnicity—Non-Hispanic Black adults had the highest prevalence of obesity (40.7%), followed by Hispanic adults (35.2%), non-Hispanic white adults (30.3%), and non-Hispanic Asian adults (11.6%).
- Education—Adults without a high school degree or equivalent had the highest rates of obesity (38.8%), followed by those with some college (34.1%), high school graduates (34.0%), and college graduates (25.0%).
- Age—Adults aged 45 to 54 years had the highest prevalence of obesity (38.1%) compared to adults aged 18 to 24 (19.5%).
- Geographic Location—The Midwest (34.1%) and South (34.1%) had the highest rates of obesity, followed by the West (29.3%), and the Northeast (28.0%).

Health Impacts of Obesity

Obesity is a serious and costly chronic disease. Individuals affected by obesity are at risk for many other serious chronic diseases including some of the leading causes of preventable, premature death in the U.S. For example, overweight and obesity raises risk of morbidity from the following conditions:[iii]

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Stroke
- Gallbladder disease
- Osteoarthritis
- Sleep apnea
- Respiratory problems

According to the National Cancer Institute, there is also consistent evidence that higher amounts of body fat are associated with an increased risk of certain cancers including:[iv]

- Pancreatic
- Liver
- Breast
- Kidney
- Colorectal
- Endometrial

Obesity has been shown to impact the severity of COVID-19. Individuals affected by obesity may be at increased risk of severe illness, as obesity has been linked to impaired immune function and decreased lung capacity. The CDC reports that risk of hospitalization, intensive care admission, invasive mechanical ventilation, and death from COVID-19 are higher with increasing body mass index (BMI) and that having obesity may triple the risk of hospitalization due to COVID-19.

In addition to the physical health impacts of obesity, adults living with obesity often struggle with mental health disorders including depression and anxiety. The National Council on Aging points to one study, which found that adults with excess weight had a 55 percent higher risk of developing depression over their lifetimes when compared to people who did not have obesity.[v] Research is underway to learn more

about the link between obesity and mental health, including examination of how mental health conditions and certain medications to treat mental illness may affect a person's weight. Additionally, weight stigma and discrimination have been shown to negatively impact health (see below).

Obesity results in higher medical costs. In 2016, the overall medical cost due to obesity among adults in the U.S. was $260.6 billion. Adults affected by obesity experienced $2,505 higher annual medical care costs when compared to those with normal weight, with costs increasing significantly with the severity of obesity. Medical costs were higher in every category of care: inpatient care, outpatient care, and prescription drugs. Increases in obesity-related medical costs were higher for those covered by public health insurance programs ($2,868) than for those with private health insurance ($2,058).[vi] These figures do not include indirect costs related to obesity including lost productivity, absenteeism, and higher insurance costs. Further, obesity is a leading cause of ineligibility for military service and the Department of Defense spends an estimated $1.5 billion annually in obesity-related healthcare costs.[vii]

Advocacy initiatives must consider the intersectionality between obesity and other chronic illnesses in order to develop the most impactful, comprehensive solutions that best address person-centered care. Focusing on one condition without considering the other will lead to less likelihood of making real systemic change. When advocates work closely together on common issues, decision makers hear the voices of many shouting a common message and are more likely to respond positively.

Weight Stigma and Discrimination

"Bias, stigma, and discrimination due to weight are frequent experiences for many individuals with obesity, which have serious consequences for their personal and social well-being and overall health. Given that at least half of the American population is overweight, the number of people potentially faced with discrimination and stigmatization is immense."

Rebecca Puhl, PhD, Deputy Director at the Rudd Center for Food Policy and Obesity at the University of Connecticut

Individuals affected by obesity often face stigma and discrimination. Weight stigma occurs in various settings including places of employment, academic institutions, and healthcare facilities, among others. According to the American Psychological Association, 42 percent of U.S. adults indicate they have faced some form of weight stigma, with physicians, coworkers, family members, and romantic partners listed as common sources.[ix]

Individuals affected by obesity are frequently portrayed negatively and judgmentally in the media and by society at large. In addition, information about the causes of and solutions to obesity are often framed in ways that reinforce negativity and criticism, suggesting moral failure. These stereotypes contribute to weight stigma, bias, and discrimination.[x]

Healthcare professionals are common sources of weight stigmatization. Negative attitudes and beliefs about people living with obesity have been documented among medical students, physicians, nurses, mental health professionals, and dietitians. In one study of people living with obesity, the majority of participants pointed to doctors as the first or second most common source of weight bias.

The healthcare community can play an important role in reversing the adverse effects of weight bias and stigmatization among individuals who are experiencing obesity. Education and training are needed to raise awareness among healthcare professionals about how to avoid weight stigma, discrimination, and conscious and unconscious bias that may impact patient care.[viii]

Weight stigma poses significant consequences for emotional and physical health. Weight stigma in healthcare settings may lead to avoidance of seeking healthcare, reduced medical adherence, and lower trust and communication with healthcare professionals, which may in turn contribute to reduced quality of care, poorer health outcomes, and increased health disparities. In addition, stigmatizing experiences combined with associated discrimination in multiple settings can impact mental health and lead to depression, anxiety, low self-

esteem, and sometimes suicidal behaviors. Weight stigma, including self-stigma, can also lead to unhealthy behaviors that exacerbate obesity, such as binge eating and avoiding exercise.[xi]

Causes of Obesity

Obesity is a complex health condition with many causal factors. The primary causes of obesity include:

- **Genetics and family influences**—Inherited genes may affect metabolism, the amount of body fat one stores, and where in the body fat is distributed. Obesity may run in families, both for genetic reasons and because family members often share similar eating and activity habits and socio-economic conditions.
- **Age—**Although obesity can occur at any age, risk increases with age due to factors such as hormonal changes, changes in metabolism, and less active lifestyles.
- **Social determinants of health**—The conditions and environments in which people live, work, learn, play, and worship have a profound effect on quality of life and their health outcomes. Limited access to healthy food, unsafe places for physical activity, public safety issues such as crime and homelessness, racism and discrimination, poor quality education, and lack of employment opportunities and transportation all contribute to higher obesity risk. Adults and children who experience food insecurity—the disruption of food intake due to lack of money—may be at increased risk for obesity.[xii] Additionally, structural racism, demonstrated as racial inequality in socioeconomic status, is associated with higher rates of obesity.[xiii]
- **Lifestyles**—Often related to social determinants, poor eating habits and physical inactivity are primary causes of obesity. Contributing factors include diets that are high in calories, but low in nutrients—due to large portion sizes and consumption of processed foods, fast foods, sugary beverages, and alcohol—and sedentary lifestyles including lack of exercise and excess screen time. Sometimes a number of these factors may not be in the control of the individual.
- Other factors that may contribute to obesity include certain diseases and medications, pregnancy, quitting smoking, lack of sleep, and stress.

Obesity Prevention and Treatment for Adults Affected by Obesity

Prevention

Preventing obesity requires a multifaceted approach that includes both individual and community-based interventions. At the individual level, adopting a lifestyle that includes healthy eating and regular physical activity is key. The U.S. Department of Health and Human Services publishes nutrition and physical activity guidelines, which outline specific recommendations for various populations including adults, older adults, pregnant women, and adults with chronic health conditions.

Nutrition guidelines include:[xiv]

- Follow a healthy dietary pattern at every stage of life.
- Customize and enjoy nutrient-dense foods and beverages to reflect personal preferences, cultural traditions, and budgetary considerations.
- Meet food group needs with nutrient-dense foods and beverages within calorie limits.
- Limit foods and beverages high in added sugars, saturated fat, and sodium; limit alcoholic beverages.

Physical activity guidelines for adults include:[xv]

- Move more and sit less throughout the day.
- Engage in at least 150-300 minutes a week of moderate-intensity or 75-150 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of both. More physical activity beyond the minimum will result in additional health benefits.

- Engage in muscle-strengthening activities of moderate or greater intensity on two or more days a week.

At the community level, obesity prevention is focused on creating social, physical, and economic environments that promote health and well-being. Implementing a public health approach that addresses the social determinants of health is crucial to reducing obesity, improving physical and mental health, and reducing health disparities. Community-level efforts must focus on policies that support healthy eating and improve opportunities for physical activity in multiple sectors including healthcare, government, business, schools, community, and childcare. Examples of community-level prevention interventions include land use and design that facilitates physical activity such as public transportation, walking and bike paths, and safe parks; eliminating food deserts by improving access to nutritional, reasonably priced foods in retail settings; establishing community and school gardens; and improving food and physical environments in all workplace and educational settings. If we truly are to reduce the obesity epidemic, a public health approach that addresses these issues across the lifespan is critical. In the long run, these upstream actions promote healthy weight, improve overall health, and save money. (See recommendations below for more information.)

Treatment and Recovery

The goal of obesity treatment is to achieve and maintain a healthy weight with the aim of improving overall health and lowering the risk of obesity-related complications, including comorbid illnesses. Individuals may work with their health professionals to determine the best treatment methods for them depending on their overall health, severity of obesity, other co-morbid illnesses, and willingness to participate in recommended options. Steady weight loss over time is considered the safest way to lose weight and keep it off permanently. Obesity treatment options include:

- **Dietary changes**—Practicing healthier eating habits will help to achieve weight loss. Efforts may include reducing calorie intake; improving nutrition by eating more plant-based foods, lean proteins, and whole grains; reducing portion sizes; and restricting calorie-dense, processed, and fast foods, as well as sugar-sweetened beverages.
- **Exercise and activity**—Regular physical activity is an essential component of obesity treatment. Gradually increasing physical activity as fitness and endurance improve is recommended. Once weight loss has occurred, moderate-intensity activities can also help to maintain healthy weight and prevent further weight gain.
- **Behavioral interventions**—Mental health professionals can provide support to those wanting to make lifestyle changes. Individual therapy can help address emotional and behavioral issues that may underly unhealthy behaviors.
- **Weight loss medications**—Weight loss medications have been available for many years, however, in the last decade newer FDA approved medications that are safe and effective have come to market helping individuals with obesity or excess weight lose 5%-10% of their weight in the first year. Weight loss medications may jump start weight loss, especially when used in conjunction with a nutrition treatment plan, behavior modifications, and/or exercise. Some medications are not recommended for those with a personal or family history of certain endocrine or thyroid tumors, specifically, medullary thyroid cancer. It is critically important that, as with any medication, individuals work with their healthcare providers to establish treatment goals and a plan of action and determine how the medication fits into the overall plan.
- **Medical procedures**—Weight loss surgeries such as gastric bypass surgery, gastric banding, and gastric sleeves are intended to limit the amount of food one can comfortably eat. Other less invasive medical procedures include endoscopic sleeve gastroplasty and intragastric balloons.
- **Support groups**— In many cases, support groups are not only focused on sustaining the benefits of a surgical or medical intervention but are ongoing, and often serve a variety of individuals in

their journey to address obesity and sustain their recovery. Support groups connect people with others who share similar challenges or face issues that arise due to stigma and discrimination. These groups help individuals recognize they are not alone in their desire to address their weight and each member can learn from others what might work for them. Often, individuals share their lived experiences and offer approaches they have used to overcome the feelings associated with the stigma felt or discrimination experienced in any number of social settings.

Obesity treatment often involves an integrated team approach that includes multiple interventions including a physician to manage medication, a behavioral health specialist focused on addressing emotional and behavioral issues, and a nutritionist assisting with dietary changes, all working collaboratively with the patient and sometimes family members as equal partners in the care team to assure the best treatment for the individual. In addition, if there is another co-occurring chronic condition such as diabetes or hypertension that is being treated by another provider, then that provider should also be part of the care team. Bottom line, effective treatment outcomes are more likely when there is clear communication among and between the team members and treatments are integrated.

Recommendations for Education, Advocacy, and Policy Interventions

For more than a decade there have been multiple legislative attempts at both the federal and state levels to pass legislation that provides coverage for the prevention, treatment, and recovery from obesity. Despite these efforts, only limited insurance coverage exists to provide access to a broad range of obesity treatments and professional therapeutic and support services. At the same time, research and public education has helped improve the understanding of obesity as a chronic illness, programs are in place to reduce the stigma and discrimination associated with obesity, and new treatments have become available. However, there still remains limited access to a range of treatment options, including medications, support services, and education and awareness programs, to address and reduce the obesity epidemic.

A number of advocacy organizations across the nation are working to address the critical issues associated with obesity such as: expanded coverage, access to a broader range of treatments and reimbursement for those treatments, and comprehensive psycho-education and therapeutic support services. In addition, advocacy groups are developing and implementing anti-stigma programs and activities. These advocacy organizations focus directly on obesity as a chronic illness and/or obesity as a co-morbid condition associated with a primary illness such as diabetes or heart disease. Policy and advocacy initiatives must not only address individual needs and direct medical and behavioral health care, but must also consider the economic and cost burdens on natural and family support networks, businesses, and educational institutions, especially those that provide education and training for healthcare providers. Identifying, gaining support, and sustaining that support from policy makers to promote legislation to fully address obesity requires considerable time and resources. Focused efforts need to be placed on research and data gathering to learn about treatment effectiveness, tools, and technologies to address stigma and discrimination; building coalitions; identifying and supporting advocacy leadership; and creating effective communications programs. Work has been done, but much more is needed.

Established in 2014, the Roundtable on Obesity Solutions brings together diverse sectors and voices to explore and advance effective solutions to the obesity crisis. The Roundtable examines efforts that advance progress in reducing the impact of obesity and applies equity strategies to address obesity-related disparities.

With recognition that more efforts are needed to move policy makers and advocates, CPALs in 2021 conducted an online survey of a diverse groups of patient advocacy leaders and advisors to help refine areas of focus for a potential PALs United for Obesity event. In total, 121 partners responded to the survey. Key survey findings include:

- Lack of coverage for obesity treatment was mentioned most often as a major barrier to a comprehensive approach for treating obesity and promoting healthy weight.
- Other barriers mentioned include:
    - Stigma and weight discrimination;
    - Health disparities;
    - Limited patient/family knowledge about effective treatments; and
    - Cost of obesity care.
- When asked whether federal, state, or local policy changes are worthy of investment of time and resources, most respondents indicated all three, followed by federal level policies.
- Advocacy strategies and tactics found to be most effective include:
    - Personal stories presented to legislators;
    - Effective messaging;
    - Mobilizing patient voices, storybooks, and/or rallies;
    - Building relationships with policy and decision makers; and
    - Collaborating with other advocacy groups across therapeutic areas (e.g., building a common agenda with obesity, heart, mental health, and food advocacy groups).
- Obesity Action Coalition was mentioned as one organization that has been effective in addressing the obesity epidemic.

Given the CPALs survey findings and because the obesity epidemic continues to grow in the U.S. impacting certain populations disproportionately, we believe, any successful policy and advocacy campaign must recognize and address the complexity of this public health issue and, at minimum, should include the following components:

CPALs survey respondents indicated it would be helpful to collaborate and coordinate efforts across patient advocacy organizations to more effectively address obesity. They suggested building alliances among and between organizations that focus solely on obesity (i.e., Obesity Action Coalition) and those that focus on obesity as a comorbid condition (i.e., the American Heart Association).

- A breadth of **resources** (human and financial) that are sustained over the long run;
- **Collaboration** across multiple health and socioeconomic sectors to develop and advocate for an approach that benefits multiple therapeutic areas and communities (i.e., obesity advocates should work closely and collaboratively with other advocacy groups such as the American Heart Association, American Diabetes Association, or American Nutritionist Association);
- Open, honest, and regular **communication** across the representatives from these sectors supported by technology and structures;
- As trust and relationships among stakeholders grow, formulation of a **common agenda** is critical so that each sector does not operate in a silo, but works in concert with others for greater effectiveness;
- Identification of competent and committed **leadership** for the policy and advocacy work is agreed upon by the stakeholders;
- Most importantly, **individuals with lived experience** are given opportunities to play meaningful roles in the campaign and are respected for their work by other advocates and professionals;
- Finally, any obesity campaign must be inclusive, assure that a high priority is given to the inclusion of communities of color in all phases of the work. All activities should be processed through an equity lens so that health equity is promoted and disparities are fully addressed in education and policy efforts. (Helpful resources in this arena include the U.S. Department of Health and Human Services, Office of Minority Health, local and state minority health organizations, and allies such as state Nursing and Hospital Associations, local health equity coalitions and state Public Health Associations.

Below are examples of policy interventions that can be promoted at the federal, state, and/or local levels, along with related opportunities for advocacy and education. Keep in mind that making policy is often a step-by-step process that takes time and perseverance that may begin with education and awareness activities, eventually moving into advocacy for a particular policy that has been proposed to address obesity or comorbid obesity issues.

Recommended Policy Interventions	Recommended Opportunities for Advocacy & Education
Expand insurance coverage by Medicaid, Medicare, and State Employee Health Plans to include obesity prevention, screening, and comprehensive treatment (e.g., behavioral therapy, nutrition counseling, pharmacotherapy, and/or surgery) including long-term treatment, if necessary, Coverage should be offered as a standard benefit as for any other chronic illness.	• Meet with federal legislators and staff members, health plan administrators and medical directors, state departments of health care services, and others who have influence and decision-making capacity to advocate for increased and expanded coverage. • Educate stakeholders about defining obesity as a chronic disease and the health and financial impact obesity has on the healthcare system. • Engage health advocates representing a variety of health issues and chronic diseases, as well as biomedical leaders and public health officials, to join forces in this effort.
Because Medicaid is considered a "medical service," **broaden the definition** of medical service to include such interventions as nutritional food, basic equipment necessary for physical activity (e.g., sneakers, weights, bicycles), and gym memberships.	• Educate stakeholders about disparities in access to healthy foods and opportunities for safe physical activity, as well as the relationship between food insecurity, food desserts and obesity. Generally, link the need to address social determinants of health as a vehicle for improving health and access to obesity care.
Pass the **Treat and Reduce Obesity Act**, which will remove barriers to and provide for the coordination of programs to prevent and treat obesity.	• Advocate with federal legislators and staff members to encourage support for this bill. Sponsors of the bill include Senators Tom Carper (D-DE) and Bill Cassidy (R-LA) and Representatives Ron Kind (D-WI), Tom Reed (R-NY), Raul Ruiz (D-CA) and Brad Wenstrup (R-OH). • Additional information can be found at the Obesity Action Center and the Obesity Care Advocacy Network.
Expand access to healthcare for all Americans and continue access to Medicaid for populations that were included during the "Covid Health Emergency." (As noted above, Medicaid and Medicare should cover prevention and treatment for obesity.)	• Advocate with federal and state legislators and staff members to encourage expansion of public insurance programs.
Enact a **"Health in all Policies"** approach, whereby local, state, and federal governments assess all proposed policies for their impact on healthy equity and the health of all citizens (including impact on obesity).	• Advocate with federal, state, and local policy makers to encourage consideration of policies that have a positive impact on health equity.
Implement interventions and policies that are intended to **improve nutrition and food environments**. Examples include strengthening and expanding federal nutrition safety net programs such	• Advocate with federal legislators and staff members to encourage them to expand and strengthen federal nutrition safely net programs and educate

as WIC, SNAP, Child and Adult Care Food Program, and National School Lunch Program; expansion of universal school meals; local school district wellness policies; vouchers for purchase of healthy foods; and expansion of regional food systems and local food production.	stakeholders on the impact these programs have on food security and obesity. • Meet with local school board members to encourage district wellness policies that support healthy food environments. • Meet with local farmers, advocacy organizations, and policy makers in support of local food systems and food production.
Implement interventions and policies that are intended to **improve physical activity and built environments**. Examples include complete streets community design; safe routes to schools; development of safe parks, playgrounds, and walking/biking paths; and development of active transportation.	• Meet with city managers, city planners, public health and public safety representatives, building industry leaders, and transportation and health advocates in support of healthy community design and active transportation. Join forces to form local coalitions to address these issues or seek out organizations already working in this area.
In healthcare and hospital settings, utilize community benefit and other funding to implement **community improvements and health-related interventions** such as food as medicine programs, food pantries, walking and exercise programs, and breastfeeding support for new mothers.	• Meet with hospital and health system administrators, clinicians, and local health advocates to encourage their support for healthy organizational policies and practices.
Enact policies that are intended to **address the social determinants of health** and root causes of obesity and other chronic conditions (e.g., end racial discrimination and implicit bias, reduce poverty, improve affordable housing, reduce food insecurity, expand affordable early care and education).	• Advocate with federal, state, and local policy makers for policies that will improve equity and social justice. • Educate policy makers about the impact of social determinants of health on obesity and other chronic diseases. • Identify examples, through personal stories, that can be used to illustrate the impact of social determinants on individuals' lives
Encourage anchor institutions (e.g., hospitals, universities, corporations) to **invest resources in underserved communities**.	• Meet with community leaders from anchor institutions to encourage financial investment in local communities, with particular emphasis on communities of color and populations with health disparities.
Institute policies related to **price interventions** such as implementing taxes on sugar-sweetened beverages, expanding the Healthy Food Financing Initiative and New Markets Tax Credit programs, limiting government subsidies that support production of unhealthy foods and other policies that result in increased rates of obesity, and tax credits and incentives for businesses that promote consumption of health foods.	• Advocate with federal legislators and staff members in support of expanding economic policies that can be effective in improving public health and reducing obesity. • Meet with local policy makers to discuss the benefits of taxing sugar-sweetened beverages (e.g., health improvements and increased municipal revenue).
Provide mandatory **training on obesity prevention and treatment** for physicians and other clinical providers as a requirement for licensure or for maintaining a license through continuing education. Training should include information on best practices, tools, and resources for obesity treatment; causes and impact of health disparities; effective strategies for discussing obesity with patients in a trauma-informed manner;	• Advocate with decision-makers of state medical boards to require training on obesity prevention and treatment for licensure and require this training for reciprocal licensing. • Advocate with American Medical Association (AMA) leaders to recommend that its members take in-service training to better understand obesity

cultural beliefs and differences; and addressing weight stigma, discrimination, and bias, including exploring clinicians' own beliefs about overweight and obesity.	prevention and treatment and address implicit bias and discriminatory practices.
Agree on and widely distribute **comprehensive clinical standards of care** for obesity treatment.	• Engage healthcare champions and health plan leaders to encourage development, adoption, and dissemination of standards of care for obesity including screening, diagnosis, evaluation, selection of therapy, treatment goals, and individualization of care.
Limit marketing of unhealthy foods and beverages, particularly to children and populations disproportionally impacted by obesity.	• Meet with business leaders, policy makers in support of limiting marketing and promotion of unhealthy foods.
Increase funding for research on obesity treatment and outcomes/effectiveness of obesity prevention and/or treatment programs.	• Advocate with leaders of public and private institutions that provide funding for medical research. • Funders may include Centers for Disease Control and Prevention, National Institutes of Health, universities, biomedical companies, and private foundations.
Encourage employers to incorporate information on weight bias and discrimination in mandatory in mandatory trainings on equity, diversity, and inclusion.	• Meet with business leaders and chambers of commerce to educate them about the impacts of weight bias and discrimination. • Invite chamber members to be part of any newly formed coalitions addressing the obesity epidemic.
Improve health and wellbeing in communities by **aligning** healthcare providers, public health departments, and social services agencies to work together across systems to address the goals and needs of the individuals and communities they serve. Include a diverse mix of healthcare providers (e.g., physicians, nurses, dietitians, nurse practitioners, social workers, behavioral health providers, community health workers).	• Encourage and support resources for conditions necessary for cross-sector alignment including funding for "backbone" organizations to convene partners from multiple sectors. • Encourage integrated health options that bring together health providers, mental health providers and social services organizations to comprehensively address obesity.

Next Steps

PALs United for Obesity is committed to fostering collaboration, mobilization, and partnerships for the purpose of advancing optimal health and patient-centered care. Moving forward, efforts may include hosting a convening of multi-sector partners, including patients, advocates, and caregivers impacted by obesity (and other chronic conditions) to develop and/or support a policy agenda and prioritize education, awareness, and advocacy activities.

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