



June 14, 2023

USPSTF Coordinator
c/o USPSTF
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Dear United States Preventive Services Task Force,

Thank you for the opportunity to provide comments on the United States Preventive Services Task Force's (USPSTF) *Draft Research Plan: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Interventions*. The Obesity Action Coalition (OAC) is the leading patient advocacy organization representing 80,000 members. Established in 2005, OAC raises awareness, provides support and education, and advocates for people living with obesity. As you know, obesity is a complex chronic disease that affects almost half of the population. Coverage and access for evidence-based interventions are critical to our members and the health of the Nation. We appreciate your consideration of the following comments on the Draft Research Plan.

General Comments

- OAC applauds USPSTF for reviewing and updating the topic of interventions to prevent obesity-related morbidity and mortality. Since the last recommendation five years ago, the USPSTF [recommended interventions](#) (Grade B) for Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults, including intensive behavioral therapy, but not pharmacotherapy. These interventions were designed to help individuals with obesity achieve or maintain a $\geq 5\%$ weight loss through a combination of dietary changes and increased physical activity. We agree, it is imperative that pharmacotherapy be reevaluated for an updated recommendation.
- Please consider rephrasing the title of the research plan to place focus on the overall desired outcome, reduced morbidity and mortality. We suggest changing the title to, "Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults."



- To be consistent with FDA-approved medication labeling, please update the terminology “weight loss or weight loss maintenance” used throughout the draft research plan and change to “chronic weight management”.¹
- As innovations like anti-obesity medications evolve, we suggest that USPSTF recommendations include language that ensures consistency with FDA-approval label updates.

Proposed Key Questions

- For key questions 1 and 2, we recommend including together “primary care relevant behavioral AND/OR pharmacotherapy.” These interventions are oftentimes used in conjunction with one another. FDA-approved labels for anti-obesity medications note that the medications are indicated in adjunct to intensive behavioral therapy for chronic weight management. Clinical trials demonstrate efficacy in treatment of obesity with medication and intensive behavioral therapy combined.
- It is also important to note that the draft research plan key questions 1 and 2 specifically reference care delivery in the primary care setting. In reality, most evidenced-based obesity care takes place with specialty providers like endocrinologists, dietitians, obesity medicine specialists, etc. The majority of primary care providers are not trained or adequately equipped to deliver effective chronic weight management interventions.
- For key question 3, we recognize that any treatment or intervention comes with a level of risk. Our members report that the potential risks associated with many evidence-based treatments are worth it for the health and quality of life improvements that come with access to quality obesity interventions. The other major and real risk for many patients is lack of access and health insurance coverage for interventions. Most patients face high out of pocket costs, which often results in no care and worsening in disease severity and health outcomes.

Proposed Contextual Questions

- We appreciate USPSTF including the importance of issues related to weight stigma and bias in the clinical setting.
 - Weight bias and stigma keeps patients affected by obesity from seeking help and health professionals from offering it.
 - Weight bias is the last socially acceptable form of discrimination.

¹ <https://www.fda.gov/media/71252/download>



- Weight bias hampers our nation’s efforts to effectively combat the obesity epidemic.
 - Weight bias is a primary driver around the current limitations of access to obesity treatment.
 - Recognizing and combating weight bias, both on one’s own and in the community, is an important step in addressing obesity and improving health outcomes.
 - Studies demonstrate that quality of care with provider interactions is affected by less time spent in appointments, less discussion with patients, more assignment of negative symptoms, reluctance to perform certain screenings, and fewer interventions.²
- There is a well established body of evidence that demonstrates the effectiveness of bariatric surgery.³ Bariatric surgery can address several complications of obesity like diabetes, improve quality of life, and increase life expectancy.⁴ While we recognize that primary care providers are not surgeons, they are at the forefront of identifying the intervention as an option and it is important for them to know how to refer a patient if needed.
 - We also applaud the USPSTF for including a contextual question on inequities in relation to weight management interventions. The National Health and Nutrition Examination Survey (NHANES) data shows:
 - 41.9% of all adults in the United States live with obesity.
 - Black American (adults) have the highest rate of obesity at 49.9% followed by Latinos at 45.6%.
 - 45.7% of Latina women in the U.S. have obesity, second only to Black women at 57.9%.
 - Latino men have the highest rates of obesity at 45.2%, compared to White (43.1%) and Black (40.4%) counterparts.

² Bocquier, A., Verger, P., Basdevant, A., Andreotti, G., Baretge, J., Villani, P., & Paraponaris, A. (2005). Overweight and Obesity: Knowledge, Attitudes, and Practices of General Practitioners in France. *Obesity Research*, 13(4), 787-795. doi:10.1038/oby.2005.89; Bertakis, K. D., & Azari, R. (2005). The Impact of Obesity on Primary Care Visits. *Obesity Research*, 13(9), 1615-1623. doi:10.1038/oby.

³ O'Brien PE, Hindle A, Brennan L, et al. Long-Term Outcomes After Bariatric Surgery: a Systematic Review and Meta-analysis of Weight Loss at 10 or More Years for All Bariatric Procedures and a Single-Centre Review of 20-Year Outcomes After Adjustable Gastric Banding. *Obes Surg*. 2019;29(1):3-14. doi:10.1007/s11695-018-3525-0

⁴ Hua Y, Lou YX, Li C, Sun JY, Sun W, Kong XQ. Clinical outcomes of bariatric surgery - Updated evidence. *Obes Res Clin Pract*. 2022;16(1):1-9. doi:10.1016/j.orcp.2021.11.004



- Other inequities stem from lack of access to health coverage for obesity interventions. Access to care shouldn't only be for people who work for the right company, live in the right zip code, or make a lot of money. Policy changes need to address expanded access to care for Medicare recipients through the Treat and Reduce Obesity Act in Congress and prioritize access to obesity treatments at the state level (Medicaid, SCHIP, state employee health plans, and ACA health exchange plans).
- We appreciate the flexibility in the proposed research approach by assessing health equity and variation in evidence across populations. It would be most comprehensive to extend the literature search beyond randomized controlled trials to ensure capture of key under-represented sub-populations.

Settings

- Evidence based intensive behavioral therapy programs are widely available in the community. We note that the prior evidence reviews on interventions to treat obesity relied on evidence from interventions that were provided in the community in person, through online virtual means, or through telephonic coaching. We urge USPSTF to use language in the inclusion criteria to capture community based settings of care.

Thank you for the opportunity to provide comments on the Draft Research Plan. Millions of Americans stand to benefit from an updated USPSTF recommendation. For questions or to discuss any of the comments, please reach out at tzvenyach@obesityaction.org.

Sincerely,

Tracy Zvenyach

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