Kelly Brownell:

Hello and welcome to Policy 360. I'm Kelly Brownell, the Dean of the Sanford School of Public Policy at Duke University. My guest today is Lisel Loy. Lisel is Vice President of Programs and Director of the Prevention Initiative at the Bipartisan Policy Center in Washington, D.C. The initiative seeks to reduce obesity and chronic disease and their associated health care costs through engagement with public and private stakeholders across multiple sectors.

Lisel was an attorney with more than 20 years of experience in policy and politics. She served in the Clinton administration where she was Assistant to the President and was responsible for overseeing the flow of information to and from the Oval Office. Previously, she served as special counsel for the Deputy Secretary of the Department of the Interior, where she worked on Native American treaty rights, water and endangered species issues. Lisel help establish the Bipartisan Policy Center's first project, the National Commission on energy policy and served as the Commission's deputy director from 2002 to 2006. Welcome, Lisel.

Lisel Loy:

Thank you.

Kelly Brownell:

Let me begin by asking about the Bipartisan Policy Center. Tell us about the center and what it seems [inaudible 00:01:18].

Lisel Loy:

BPC was founded by four former Senate Majority Leaders, two Democrats and two Republicans in 2007. And our goal is really to bring together the best research that we have on policy issues. And through a process of creating bipartisan consensus, advanced some policy recommendations among decision makers, whether they're on Capitol Hill, or in the administration or otherwise.

Kelly Brownell:

Well, given how famous American politics is for being polarized and partisan at the moment, is it still possible to reach bipartisan agreement on issues?

Lisel Loy:

As you can imagine, we get that question a lot. And while it is true, that our current government sees more discord than we would like, and than we have historically, there are things getting done on Capitol Hill. And for example, last year, there was a lot more that got done that didn't quite make it into the public consciousness. We'd like to see more obviously, and part of our work focuses on how we strengthen the enterprise, the organization, the institutions of the Senate, and the House in particular, we have a democracy project that looks at those issues.

But we are all 100 of us working there on the belief that there is a lot more that we can do, there is room for constructive engagement. We have a lot of good ideas and a lot of talking in Washington and our hope is really to pull together the people who through their conviction and their compromise can come to some real solutions and actually push forward and have some impact.

Kelly Brownell:

Well, never more important time that now for the work that you do. Given the almost infinite number of issues that Bipartisan Policy Center could address, why our Food and Nutrition Policy issues on the list?

Lisel Loy:

Food is a deeply personal issue as you know, and it affects the lives of all Americans. And I think given our political system, that is a good setup for political engagement. Food and nutrition also have deep bipartisan roots, as you know, Senator Dole, Senator McGovern and others who came together around nutrition, malnutrition, hunger, and improving our school lunch program, for example. So, from our perspective, food and nutrition, while they are highly politicized, as you say at the moment, or can be cut across all sectors of society, all classes, all races, all political parties.

And if we can figure out the right way to talk about them and to reach out and constructively engage with multiple sectors, I think we can really bring people along.

Kelly Brownell:

So one of the efforts of the center is partnering on a new program to train doctors on obesity prevention strategy. Given how often doctors encounter obesity in their practices, one might assume that they get lots of training on this topic. Is that true?

Lisel Loy:

No, that is not true. Historically, by far, a minority of doctors get any training in nutrition or physical activity. The way our system has been for a long time and something that we're hoping to change.

Kelly Brownell:

So is this because doctors focus primarily on the end products of the lifestyle patterns and then don't get involved too much in those decisions people make with respect to diet and physical activity in the first place?

Lisel Loy:

I think there's several reasons. Three I'll mention. One is that our system as you suggest is really oriented towards care for people who are sick at the end of a process that has taken a long time to develop into disease. And so they are looking at people who are more at the end stage and looking at surgery and medication and other strategies that are effective, but they have missed a window for prevention further upstream.

Second, I think we just have not had as clear an understanding of the role of diet and nutrition and health writ large for a long time. And because of that, we haven't trained our health professionals to really understand that linkage. And finally, a lot of the work I do now touches on the ways in which doctors are trained to engage with patients, whether it's through motivational interviewing or other strategies to engage an individual on his or her individual concerns. We haven't typically trained our health professionals to engage in that way either.

Kelly Brownell:

Your work and the work of others shows that only one in eight visits with a doctor involves any mention of healthy diet. Were you surprised by this?

Lisel Loy:

No, from my personal experience, I was not surprised by this. I've had several of my own health issues were diet was a factor, and even though I raised diet, nope, I couldn't get anybody to engage with me on that issue. From my personal perspective, I was not surprised. Given how much we understand about the role of diet and nutrition and health, I think it is surprising that we don't do that. Changing a system is hard. We're trying to change a system. That takes time, but it's time to start.

Kelly Brownell:

What are you and your colleagues proposing to do?

Lisel Loy:

We are proposing to do two things at the same time. The first thing is to improve the way we train not just doctors, but all health professionals to address issues of nutrition and physical activity. And second is to change the way we pay for that kind of care. And the theory of our case, the reason that we are seeking to advance both of those issues at the same time, is because one without the other, we don't believe is going to lead to the kind of change we're looking for. So in other words, if you have physicians trained to do this in school, but that kind of care is not covered by payers, by insurance companies or Medicare or Medicaid, it's unlikely that doctors and others will have the incentive to provide that kind of care.

On the other hand, we have some evidence that if payers take a leadership role and offered a cover that kind of counseling, for example on obesity prevention, but doctors and others are not trained to provide the care, there's a mismatch again. And so we are fortunate to be working collaboratively with the Alliance for a Healthier Generation, the American College of Sports Medicine, and a working group at the Institute of Medicine, with support from the Robert Wood Johnson Foundation to advance both of those objectives at the same time.

Kelly Brownell:

So in terms of the payment issues, who are the gatekeepers, and what institutions, organizations, agencies, whatever, are responsible for making those decisions on whether doctors get reimbursed for addressing these issues in the clinical setting?

Lisel Loy:

We are looking at both public and private payers, meaning we are looking at the Centers for Medicare and Medicaid Services. And we are also looking at private insurance plans, different decision makers in each of those categories. But if we take the federal side first and CMS, state Medicaid directors have a big role to play. And within Medicare, we are seeing increasingly an expansion of coverage for counseling and some types of obesity prevention.

I think some would argue that is not enough. Others would argue that we have not implemented some of those changes sufficiently. So the world is changing, but slowly and I think there's more to do. On the private side, I would mention a program that the Alliance for a Healthier Generation initiated called the Healthier Generation Benefit where for example, Blue Cross Blue Shield, North Carolina, among other payers offered to cover for counseling and for treatment visits per year, per child to address childhood obesity.

The feedback from that program informed our work and suggested that we needed not just leadership from companies like Blue Cross Blue Shield, North Carolina, but also the training for the professionals to be able to meet that and provide that care.

Kelly Brownell:

So there's been a long history of discouraging attempts for health professionals to address obesity even with very intensive programs, they go way beyond the number of visits, you're talking about what the physician. But you must have reason to be optimistic about the impact of this. Is there any information that would suggest this would be helpful or at what level, do you think?

Lisel Loy:

One piece of information we've received loud and clear from a number of institutions that we've talked with is that, as you suggest, there are many efforts at reform. And Deans of medical schools and those in charge of training, health professionals are sort of throwing up their hands and saying, "Please, no more, our curriculums are crowded, we are maxed out, we cannot handle more curriculum from the top down." So the approach that we've designed focuses on developing core competencies as opposed to an actual standardized curriculum. And by that, I mean, the IOM is leading a group to identify a consensus set of core competencies behaviors and activities that we believe health professionals need to be able to do as they engage with patients.

But this will not be a prescription for how any individual institution should go about doing that, because we think it won't work, as you suggest. And so giving some flexibility at the local level for institutions to adapt and achieve these competencies in the way that suits them, we think is a better recipe for change.

Kelly Brownell:

What would be a few examples of core competencies?

Lisel Loy:

One I mentioned was sort of motivational interviewing or engaging people with specific strategies that have been developed for bringing them out, addressing some of the emotional components of some of the health issues that I think we can all appreciate. Others include sort of the disparate ways in which some of these diseases and including obesity appear in a population. So we don't see a uniform level of obesity across class, age, race, et cetera. And ways in which we can train our professionals to both be sensitive to those things, recognize them engage appropriately with patients as an example.

Kelly Brownell:

Will there be any focus in this context of things that might make overweight people in particular more comfortable in medical settings. So blood pressure cuffs, they're large enough chairs that are large enough language to use by people in the doctor's office to refer to weight, things like that?

Lisel Loy:

It's interesting that you asked that. The most recent working group meeting we had discussed, for example, accommodations in a waiting room, for example, so that people feel comfortable with the seating options that are available. Another thing I think probably is one of the most important thing is using so called people first language. And so instead of referring to an obese person, we would talk about a person with obesity. That person is a person first and foremost, he or she happens to have a medical condition in this case, for example, it might be obesity, but using that people first language I think is critically important and will definitely be one of the competencies.

Kelly Brownell:

So when the physician's office, there might be other more there are obviously other health care professionals like nurses and some might have connections with dieticians and others, is it important to have a multidisciplinary team involved?

Lisel Loy:

Absolutely. And this touches on another component of our work at BPC and I've been gratified to be able to work on both at the same time. But I think this notion that increasingly we want to connect our clinical providers with you're talking about other clinical providers, nurse practitioners, dieticians, but also non clinical providers. Sometimes we are talking about referring a patient to a weight loss program or Diabetes Prevention Program at a local YMCA, or another institution in a community.

We don't have a great network yet for doing that individual offices are looking for ways to use technology, electronic medical records, health coaches and others to help connect those dots for patients. It's an area of growth I hope, it's complicated, we shouldn't be naive about that fact. But I think particularly when you're talking about food, nutrition, health, obesity, and overweight, there's a huge opportunity to engage a full suite of health professionals beyond just the physician.

Kelly Brownell:

I admire the fact that you're taking this on because the outcome could be very positive and the lives of a great many people can be affected in positive ways. It's not an easy task, because you have the physicians who one by one will make decisions about whether to do this or not. And then as you said, have big institutions, you've got medical schools having to decide on what their curriculum will look like. You have private and public payers that have to decide in ways that would profoundly affect their policies. Are you optimistic that this will take place?

Lisel Loy:

I think you've outlined the challenge as well, Kelly, I appreciate that. And BPC is really in the business of linking what we know about research and evidence with policy change. That policy change could be public policy change at the federal level. Or it could be institutional change in the form of policies at a medical school, for example. The process we have designed to develop this program includes engaging multiple stakeholders throughout. Anyone who does public policy knows that that's important.

We will engage the societies and components of the health profession that will care about this outcome upfront. And BPC's role in this work is to make sure that we have heard them we have gathered their input. And not just that we hand off some content at the end of the day, but that rather we have a process that engages those stakeholders, so that we are set up to succeed at the end and have their help in implementing these changes at the institutional level.

Kelly Brownell:

Are our elected leaders interested in this? And do you see this as an opportunity for bipartisan support?

Lisel Loy:

Congressman Tim Ryan, has introduced legislation, bipartisan legislation last year that would support curriculum development in medical schools. He is a wonderful champion for this issue on the Hill. We have... It's an area where there could be a lot of bipartisan support. I think there is bipartisan support.

The question always is, "Does this rise to the level of priority on the Hill relative to other things that people are worried about?" That something real can get done? I don't know the answer to that.

Kelly Brownell:

Well, thank you for sharing the experience you've had with this. It sounds like you're off to a wonderful start. And this is a very important area to be working in. So I wish you the best of luck.

Lisel Loy:

Thank you very much, Kelly.

Kelly Brownell:

Thank you for joining us Lisel. Lisel Loy is the Director of the Prevention Initiative at the Bipartisan Policy Center. We've recorded several conversations as part of this mini series called The Future of Food Policy, and you can find them on iTunes or on SoundCloud. Just look for Policy 360. Until next time, I'm Kelly Brownell