OBESITY, DIABETES AND RACIAL HEALTH EQUITY

WHAT EMPLOYERS CAN DO

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Obesity, Diabetes and Racial Health Equity
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Introduction

COVID-19 has exposed the severity of racial health disparities in the United States more clearly than ever. Age-standardized data shows that Black, Hispanic[1] and American Indian/Alaska Native people are at greater risk of infection and at least twice as likely to die from COVID-19 as their white counterparts.[2] Public officials, healthcare leaders and social justice activists have seized this moment to acknowledge this problem and educate others on the root cause of these inequities—structural racism—and to work on system level changes to advance racial health equity and dismantle structural racism's underpinnings.

At the same time, employers across the country have been building their diversity, equity and inclusion (DE&I) capacity to tackle equity issues at a corporate level, including those related to recruitment and hiring, career progression, pay transparency and the employee experience.

Employers are in a unique position to help advance racial health equity in the context of DE&I* to ensure more equitable access to quality care for employees of color.

* diversity, equity and inclusion

1 "Hispanic" appears in this guide when referencing studies using this terminology.

2 https://www.kff.org/racial-equity-and-health-policy/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/

Obesity and diabetes have long been top conditions of concern for employers because of their prevalence, connection to other serious illnesses, and high direct and indirect costs. People with obesity and diabetes have suffered complications and poor outcomes from COVID-19 at rates that highlight the need for employers to address these conditions in their employee populations with renewed focus. BIPOC (Black, indigenous and people of color) populations suffer from obesity and diabetes in disproportionate numbers, so it is critically important to pursue strategies aimed at reducing inequities in care and treatment.

What is health equity?

According to the Robert Wood Johnson Foundation (RWJF), "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and healthcare."[3]

What is racial equity?

The Racial Equity Tools glossary[4] defines racial equity as the condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. According to Race Forward, "Racial equity is a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems and structures by prioritizing measurable change in the lives of people of color."[5]

3 https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

4 https://www.racialequitytools.org/glossary

5 https://www.raceforward.org/about/what-is-racial-equity-key-concepts

Background

Obesity as a disease

The Obesity Medicine Association defines obesity as a chronic, relapsing, multifactorial, neurobehavioral disease in which an increase in body fat promotes adipose tissue dysfunction that results in adverse metabolic, biomechanical and psychosocial health consequences.[6] The inflammatory nature of excessive adipose tissue—or body fat—is a critical risk factor for development of insulin resistance, type 2 diabetes and many other chronic diseases.[7] Obesity is associated with nearly 60 comorbidities.[8] Body mass index (BMI), waist circumference and body fat percentage are some of the most common methods used to diagnose the disease.

The science of obesity is unequivocal that obesity is a disease, not an individual's fault or merely a product of lifestyle choices or environmental conditions.[9] Still, many people believe that simply eating less and exercising more will transform a person with obesity into a healthy person with normal weight. People with obesity are often viewed as lacking willpower or self-control and having psychological problems that limit their ability to restrict food intake. These misconceptions fail to recognize the biological component of obesity, thus stigmatizing those with the disease and contributing to underused but effective methods of addressing it such as the use of anti-obesity medications (AOMs) and surgical intervention.

Diabetes and weight

Diabetes affects the body's ability to produce or respond to the insulin hormone and therefore how the body turns food into energy. There are four different types of diabetes: prediabetes, type 1, type 2 and gestational. Prediabetes is a condition in which insulin levels are

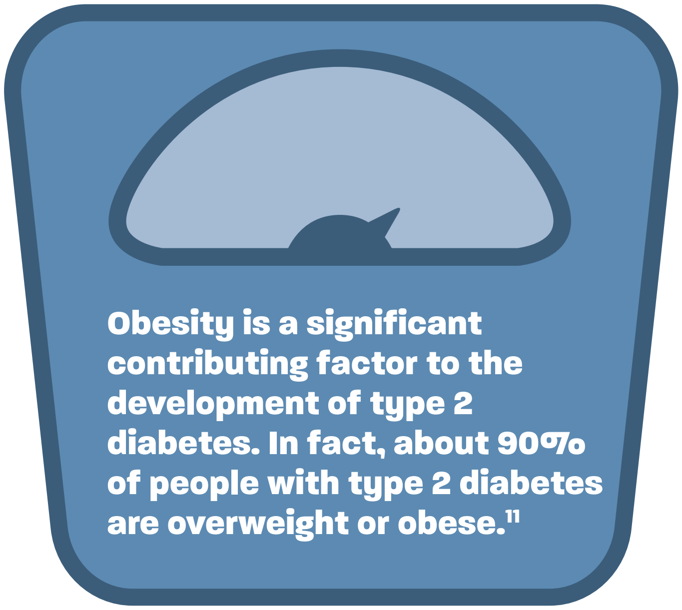
6 https://obesitymedicine.org/definition-of-obesity/

7 https://www.frontiersin.org/articles/10.3389/fphys.2019.01607/full

8 https://www.rethinkobesity.com/disease-progression/comorbidities-of-obesity.html

9 https://nam.edu/clinical-perspectives-on-obesity-treatment-challenges-gaps-and-promising-opportunities/

higher than normal but not high enough for a diagnosis of type 2 diabetes. People with prediabetes may develop type 2 diabetes if they don't make changes that frequently involve losing weight.[10] Type 2 diabetes, also known as adult-onset diabetes, is the most common form of diabetes. It occurs when the body either doesn't produce enough insulin or resists insulin.



Type 1 diabetes is a chronic condition in which the body makes little to no insulin and is usually diagnosed in children and young adults.[12] Gestational diabetes presents itself during pregnancy when insulin production is not high enough to counter insulin resistance caused by hormones secreted by the placenta, causing blood glucose to rise. In most instances, blood glucose levels return to normal after delivery, but gestational diabetes is also a risk factor for prediabetes.

Uncontrolled diabetes and prediabetes can lead to other serious health problems such as hypertension, kidney and nerve damage, depression, anxiety, heart disease, visual impairments and stroke.[13] Prediabetes and some type 2 diabetes can be managed through lifestyle modifications such as diet, exercise, weight loss and stress management. For many people, though, glucose monitoring and medications to control insulin are also needed. In addition, the same AOMs and surgical interventions used to treat obesity can have a significant positive effect on type 2 diabetes control.

10 https://www.cdc.gov/diabetes/basics/prediabetes.html

11 https://pubmed.ncbi.nlm.nih.gov/20647979/

12 https://www.cdc.gov/diabetes/basics/diabetes.html

13 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431576/

Racism and health disparities

Obesity and diabetes disproportionately affect people of color. Racial and ethnic disparities are pronounced in both the prevalence and treatment of obesity.[14]

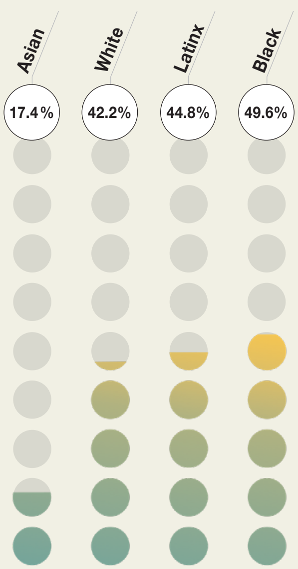
Diabetes and Obesity in the United States

Black Americans are **50%** more likely to have type 2 diabetes.[15]

Native Americans are **2x** as likely as whites to have diabetes.[16]

The risk and prevalence of diabetes among Hispanics/Latinos are higher than in non-Hispanic whites.[17]

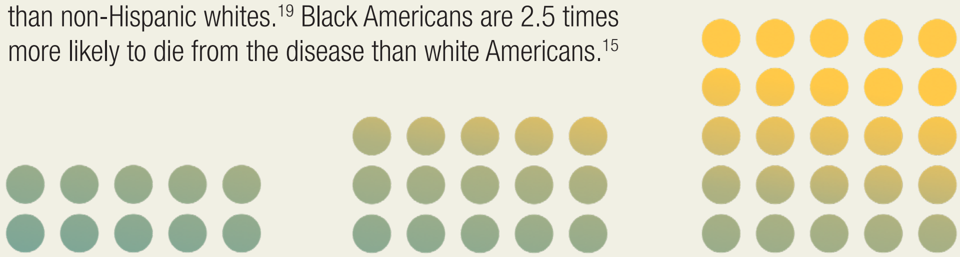
Nearly **40%** of Hispanics/Latinos with diabetes have not been formally diagnosed.[18]



Adult Obesity Rates in the U.S.[20]

Risk of Death from Diabetes

Mexican Americans are 50% more likely to die from diabetes than non-Hispanic whites.[19] Black Americans are 2.5 times more likely to die from the disease than white Americans.[15]



A growing body of research suggests that experiencing racism damages a person's health by triggering the release of stress hormones as well a chain of biological events that can cause premature aging, potentially increasing the risk of chronic disease.[21] For example, for Black women, release of the stress hormone cortisol can lead to higher rates of obesity, which increases the risk of heart disease and other chronic illnesses.[22]

14 https://link.springer.com/article/10.1007/s13679-018-0301-3

15 https://www.forbes.com/sites/allisonnorlian/2020/11/01/four-black-womenall-ceoshave-created-a-call-to-action-to-close-the-health-gap-for-black-americans/?sh=1fb8002114b4

16 https://www.cdc.gov/vitalsigns/aian-diabetes/index.html#:~:text=Native%20Americans%20are%20twice%20as,Americans%20between%201996%20and%202013

17 https://pubmed.ncbi.nlm.nih.gov/26348752/

18 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5687125/

19 https://www.hindawi.com/journals/ijpr/2013/571306/

20 https://www.tfah.org/report-details/state-of-obesity-2020/

21 https://www.prb.org/resources/racism-related-stress-is-linked-to-premature-aging-and-chronic-disease/

22 https://3hqwxl1mqiah5r73r2q7zll1-wpengine.netdna-ssl.com/wp-content/uploads/2021/01/BWHI_NHPA_2020-21.pdf

As reported in the December 2021 *American Journal of Epidemiology*, the Sister Study found that women who reported experiencing major racial or ethnic discrimination had a 25% higher risk of developing type 2 diabetes.[23] Another study by April D. Thames and colleagues said that exposure to racism and discrimination could potentially account for more than 50% of the difference in the activity of inflammation-triggering genes between Black and white adults.[24]

Researchers suggest that racial discrimination should be perceived as a health risk factor on par with smoking, obesity, high blood pressure and substance abuse.[24]

Racism affects people of color regardless of education, income or profession. Racism may not be overt but experienced through a lifetime's worth of subtle comments, microaggressions and longstanding inequities that permeate society's institutions. This type of chronic stress or "wear and tear" has an impact on the body and mind and is referred to as allostatic load[25]—the cumulative biological burden exacted on the body through daily adaptation to physical and emotional stress. It is considered to be a risk factor for several diseases including obesity and diabetes, and several studies have shown that Black people and other racial and ethnic minorities have higher allostatic load scores than white people.[26]

> **It's not daily racism, it's lifetime racism—every day you are going in to do this work—not being valued or respected mostly because of the differences in how you appear. Access is great, treatment is great, but how do we make it so the environment feels safe and comfortable—with transparency—and create actionable steps to change any of the inequitable treatment that we might see?**
>
> Fatima Cody Stanford, MD, MPH, MPA, MBA, FAAP, FACP, FAHA, FAMWA, FTOS, Obesity Medicine & Nutrition, Massachusetts General Hospital, Harvard Medical School

Racism is one of many social determinants of health (SDOH), which are the conditions and environments in which people live, work and play that affect health risks and outcomes. Other SDOH such as economic stability, neighborhood and built environment are heavily influenced by race and racism. Unfavorable social determinants of health such as lack of access to nutritious food, green spaces for exercise, and safe spaces for community

23 https://academic.oup.com/aje/advance-article/doi/10.1093/aje/kwab189/6313069

24 https://www.prb.org/resources/racism-related-stress-is-linked-to-premature-aging-and-chronic-disease/

25 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2874580/

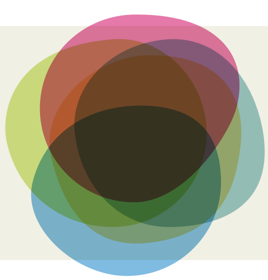
26 https://pubmed.ncbi.nlm.nih.gov/16380565/

interaction contribute to greater risk and poorer outcomes for diseases including obesity and diabetes. (*For more information on SDOH and their impact on health outcomes, see the NEBGH guide,* Social Determinants of Health: What Employers Can Do *at https://nebgh.org/initiative/social-determinants-of-health/*)

Racism can be found across all institutions in our society—healthcare systems are no exception. **Inequities in access to quality care are a major driver of health disparities and can be found in the ways in which people of color are related to by physicians and others in healthcare.**[27] For example, one study showed that insulin pumps are more frequently used among white children than Black and Hispanic children, a fact that cannot be explained by differences in socioeconomic status alone.[28] Another study found that over the last few years, while the use of insulin pumps and continuous glucose monitors increased among Medicare beneficiaries with type 1 diabetes, disparities in usage between Black and white patients also rose. From 2017 to 2019, the prevalence of insulin pump use increased among white patients to 18% from 14%, but only to 4.6% from 3.8% among Black patients.[29]

The dual burden of weight bias and racism

People with obesity often experience social stigma and discrimination in the form of fewer employment opportunities and pay inequities.[30] The combination of weight bias and a person internalizing the idea that obesity is their fault can have a damaging effect on a person's mental health, hinders prevention and treatment efforts, and further stigmatizes the disease. For people of color already confronting interpersonal and systemic racism, obesity and its accompanying stigma and bias creates an even heavier burden.[31] This dual burden is considered a type of intersectionality.



Intersectionality

Intersectionality is the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism and classism) combine, overlap or intersect, especially in the experiences of marginalized individuals or groups.[32]

In an opinion piece in *Newsweek* published in June 2021, author Michael Knight, a Black internist certified in obesity medicine, cited a recent study showing that negative perceptions from the medical community are all too common for people living with obesity, particularly members of the Black and Latinx communities. The study found that up to 74% of people felt shamed or belittled when visiting a doctor, making them less likely to seek care.[33]

27 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540621/

28 https://pubmed.ncbi.nlm.nih.gov/25687140/

29 https://www.medpagetoday.com/endocrinology/type1diabetes/96206

30 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6452122/

31 https://pubmed.ncbi.nlm.nih.gov/28579331/

32 https://www.merriam-webster.com/dictionary/intersectionality

33 https://www.newsweek.com/stigma-obesity-hurts-black-latinx-communities-most-opinion-1602167

Combatting weight stigma and bias is important for promoting a healthy work environment and for society as a whole.[34] Weight by itself is not necessarily a measure of health or well-being. It's important to recognize that race and ethnicity play a role in what people consider to be healthy and attractive, and how they think about and respond to issues relating to weight. In some cultures, larger bodies may be preferred and sought after.

Cultural beliefs about weight, body type and obesity include western culture's admiration of thinness, even when unhealthy, and the high regard some communities place on obesity, believing it to be a sign of affluence.[35] That said, obesity is a disease and needs to be treated as such.

Some anti-weight bias resources appear in the Appendix *on page 28.*

> **There are cultural differences in body shape and size, and how bodies are accepted, but with very few exceptions, there are no cultures in which a BMI of 50 is OK. We shouldn't confuse cultural takes on what average body size is for obesity. These are two different things that get conflated all the time. We are missing the fact that there's a fundamental biological basis as to why someone develops obesity, and there is a social stigma around this. The stigma and bias around obesity is the problem.**
>
> Nadia Ahmad, MD, MPH, Medical Director, Obesity Product Development, Diabetes Business Unit, Eli Lilly and Co.

34 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5386399/

35 https://pubmed.ncbi.nlm.nih.gov/17264547/

What Employers Can Do: Racial Equity in Obesity and Diabetes Treatment and Outcomes

Effective treatments for obesity and diabetes exist. However, equitable access to effective treatments does not exist across different racial and ethnic populations, and the same is true for employee populations. BIPOC employees may be related to in insensitive or dismissive ways by clinicians or may not be comfortable approaching or sharing personal information with healthcare providers that don't look like them. And if benefits coverage is not adequate, they may have difficulty paying for the care they need. Employer-sponsored wellness and disease management programs may not be sufficiently tailored to suit the needs and preferences of diverse employee groups, and communications about health benefits may be unintentionally tone deaf. For all these reasons and more, employers need to pursue specific strategies aimed at achieving racial equity in obesity and diabetes prevention, treatment and outcomes.

Strategies for employers

1. Address racial disparities in health outcomes through DE&I efforts.
2. Design benefits that support best practices in obesity and diabetes care.
3. Improve health and benefits literacy.
4. Reduce financial barriers to care for obesity and diabetes.
5. Ensure access to racially sensitive mental health support.
6. Evaluate healthcare vendors on DE&I practices and hold them accountable.
7. Advocate and invest.

Each of these strategies are outlined in detail in the next section.

Guidance for Implementing Strategies Aimed at Achieving Racial Equity in Obesity and Diabetes Prevention, Treatment and Outcomes

1. Address Racial Disparities in Health Outcomes Through DE&I Efforts

Addressing health disparities in your employee population can be addressed in two main ways:

- In the context of your organization's overall DE&I strategy
- In your commitment to achieving racial health equity communicated as part of a broader equity plan

The work of combatting health disparity needs to be rooted in leadership and demonstrated through tangible actions to improve the overall work environment for employees of color.[36]

Collaborate with DE&I leadership

DE&I leaders in your organization may have insights into the level of trust between employees of color and organizational leadership. They may also know how mistrust may have developed in the past. Collaborating with DE&I leadership may provide opportunities to recognize these issues and chart a path to building the trust required to advance health equity.

I think our biggest hurdle is developing trust. If you don't develop trust with someone, you are never going to get to that next level of involvement or engagement. This is true from the provider perspective and the employer perspective. Employers need to critically ask 'what have I done in the past that has hurt my employees?' We have to address this question first before we re-engage.

K. Andrew Crighton, MD, Founder, Crighton Consulting; Retired Chief Medical Officer, Prudential Financial

36 https://hr.harvard.edu/files/humanresources/files/cwd_antiracism_resources_workplace.pdf?m=1596461840

Your organization's DE&I leadership can be a valuable partner in your efforts to improve obesity and diabetes care and outcomes for employees of color. Through collaboration with your DE&I leadership, you should be able to identify actions to take, resources to leverage and opportunities to align with other organizational race equity efforts. A first step in working with your DE&I leadership might be sharing information about inequities in access to healthcare and disparities in outcomes. Having data to share that's specific to your employee population is ideal but not critical to starting this work.

Leverage employee resource groups

An effective way for benefits and DE&I teams to explore health disparities in their employee populations is through employee resource groups (ERGs). Employees are not expected to be experts on health issues like obesity and diabetes, but they can share experiences, raise issues and describe challenges they and others may face. ERG participants might, for example, share their experiences of how racial and weight bias show up in the workplace, and suggest ideas for organizational changes that would support building and strengthening relationships with employees of color. They might also express concerns about their benefits and how and why they fall short of meeting their needs.

In many organizations, ERGs have been helpful in addressing the needs of LGBTQ+[37] employees and those with mental health issues,[38] and thus they may also be a valuable model for pursuing racial health equity.

Identify inequities in benefits and programs

Analyze your data

Analyzing data on race and ethnicity can help you evaluate the effectiveness of your benefits and programs. A systematic approach to collecting benefits data can help you identify unmet needs, flag barriers to health and work engagement, and pinpoint cultural mismatches that may be contributing to health disparities among employee groups with the same coverage options.[39]

Some approaches include:

- Use payroll data to establish salary bands and overlay information on race and ethnicity. Zip code information can be a proxy in obtaining information across various populations when race and ethnicity data is not available. Consider the affordability of health coverage premiums, deductibles and co-pays for employees within various categories.
- Analyze healthcare claims by race and ethnicity to understand health risks and healthcare utilization. Think about how expanding access to preventive care and certain high-value medications and services might support those with obesity, diabetes and as other conditions.

37 https://prideatwork.ca/wp-content/uploads/2017/09/Beyond-Diversity-LGBT-Guide.pdf

38 https://hbr.org/2020/05/how-to-form-a-mental-health-employee-resource-group

39 https://www.healthaffairs.org/do/10.1377/hblog20201217.850341/full/

Consider whose voices are at the table when decisions are made about healthcare benefits and programs. How have these voices shaped what you offer?

Talk to your employees

Asking employees what they want in benefits and programs, how existing offerings may not be adequate, and what your organization might do differently to support them can provide valuable information about developing more effective obesity and diabetes interventions. Shifting the conversation from "why aren't you engaging in what we offer?" to "what about our benefits and programs isn't working for you?" assures people that their opinions are valued, more effectively invites them to get involved in a process, and encourages them to remain engaged. As noted earlier, trust is key in involving employees in this process.

2. Design Benefits That Support Best Practices in Obesity and Diabetes Care

Employee wellness programs can be helpful in preventing obesity and diabetes but are less effective in helping people already struggling with these diseases and who need more targeted interventions.

> **Many people still think that obesity is their fault and they need to change behaviors because this is what all of the focus is on—you just need to eat better. It really is not that simple. We wish it were that simple. For years, we've been offering solutions for employees like covering their gym memberships and workplace weight management programs, and offering healthy food in the cafeteria. That's not working. These are great for overall health and well-being but not to treat the disease of obesity. Only about 10% of people with obesity respond to lifestyle intervention to see significant weight loss that substantially impacts their health.**
>
> Angela Fitch, MD, FACP, FOMA, Co- Director, Massachusetts General Hospital Weight Center; Assistant Professor Harvard Medical School

> **Sometimes you hear people talk about the success of their wellness programs: 'Across all employees, we lost 700 pounds,' for example. But is that really a meaningful way of measuring weight management? The goal is to reduce, prevent and delay comorbid conditions to improve quality of life. It's not a target body weight, shape or size.**
>
> Andrew Schneider, PharmD, Medical Accounts Associate Director, Novo Nordisk

Wellness programs can certainly support employees in turning to more nutritious foods, maintaining a healthy weight, exercising, reducing stress and improving sleep. Wellness programs should take into account the needs and preferences of employees—in this case, employees of color. Food is often a big part of cultural identity, for example, and recommendations about how to make beloved dishes healthier will have a bigger impact than telling people what not to eat.

> **Coverage of AOMs [anti-obesity medications] is determined by insurance and the 'progressiveness' of the employer. In most places across the country, AOMs are seen as an option, not a standard benefit of insurance. We shouldn't be able to discriminate against people in that way and not cover this.**
>
> Angela Fitch, MD, FACP, FOMA, Co-Director, Massachusetts General Hospital Weight Center and Assistant Professor Harvard Medical School

> **By not covering treatment, we are increasing the disparities - it's a complex issue so people will continually say 'it's so complex' - but I like to simplify it. We aren't giving obesity the status of a true chronic disease.**
>
> Nadia Ahmad, MD, MPH, Medical Director, Obesity Product Development, Diabetes Business Unit, Eli Lilly and Co.

Address the underuse of effective obesity treatments…diabetes treatments too

Despite robust clinical evidence about their effectiveness, obesity treatments such as intensive behavioral interventions, AOMs and bariatric surgery are significantly underused among eligible individuals who would likely benefit from their use.[40] **Underuse is even greater among populations of color.** One study abstracted in the National Library of Medicine found that Black people were 46% less likely to use AOMs than white people.[41] Another by researchers at the Beth Israel Deaconess Medical Center found that "whites are twice as likely as African Americans[42] to have weight loss surgery" despite the fact that "just as many African American patients as Caucasian patients said they would consider weight loss surgery if their doctor recommended it."[43] Significant disparities in terms of who does and does not undergo bariatric surgery exist according to race, income, education level and insurance type.[44]

40 https://www.healthaffairs.org/do/10.1377/forefront.20210902.136368/full/

41 https://pubmed.ncbi.nlm.nih.gov/22554395/

42 "African American" appears in this guide when referencing studies using this terminology.

43 https://www.ajmc.com/view/understanding-the-connections-between-race-and-bariatric-surgery

44 https://pubmed.ncbi.nlm.nih.gov/19782647/

Inadequate education among primary care physicians and other non-obesity specialists, inconsistent or inadequate provider reimbursement, and insufficient health insurance coverage are frequently cited as reasons for the underuse of effective obesity treatments. Employers can play a key role in ensuring that these treatments are accessible for employees who need them by making sure they are covered in benefits offerings. Among BIPOC employees, lack of trust in the healthcare establishment may also play a role in under-treatment; advocating for diversity in provider networks and the inclusion of trusted community-based advisors in intervention efforts are additional actions employers can take. (*See also section 7–* Advocate and Invest *on page 26.*)

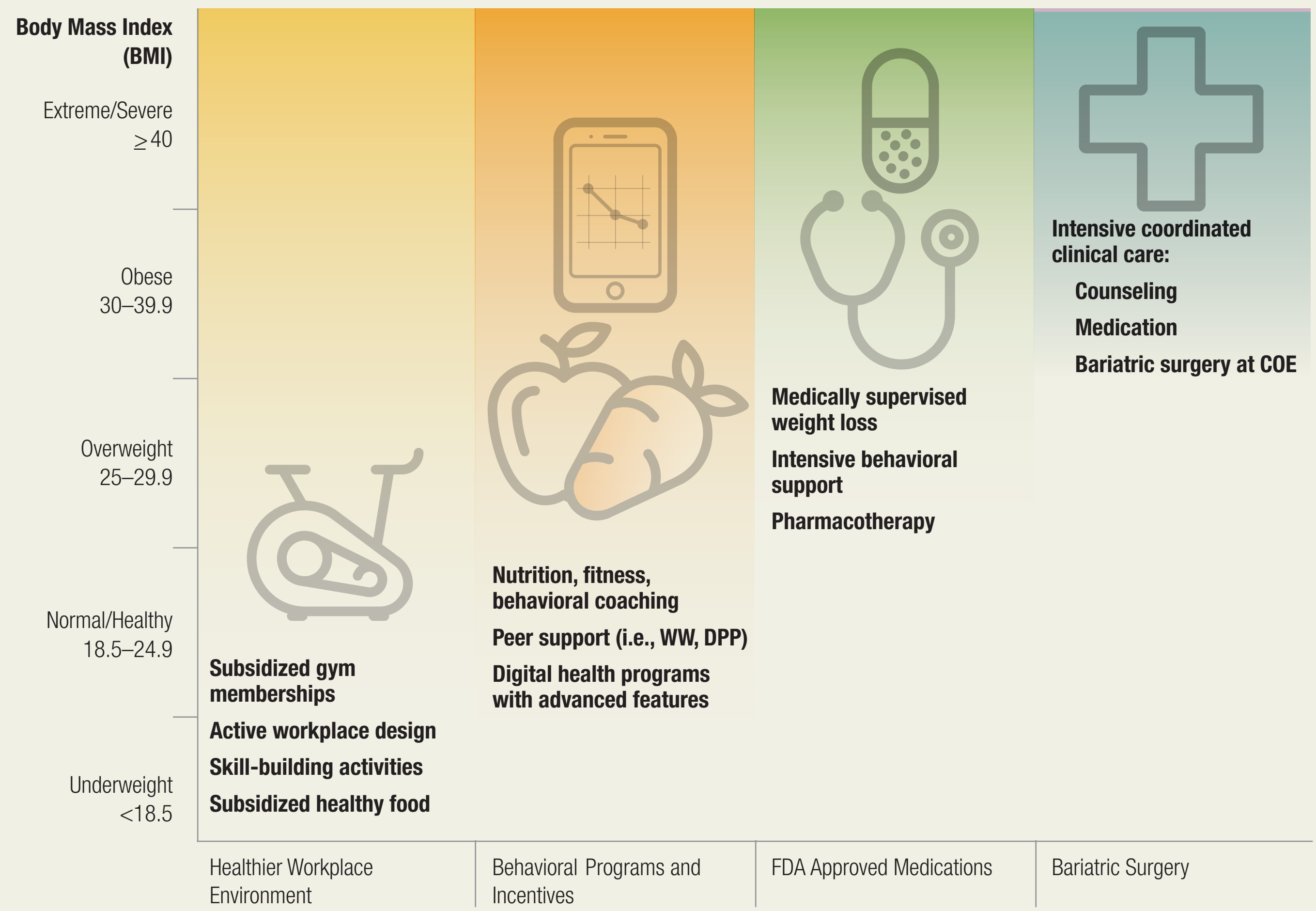
> **The coverage landscape for obesity is still patchy and fragmented. We know some payers have a 'one per lifetime benefit' rule for bariatric surgery. Other payers ask for mandatory medical management prior to surgery for 3 months, 6 months or even 12 months, but then may not provide coverage. There is still an impression with some that bariatric surgery is cosmetic and unnecessary, and this stigma exists at the policy level. This is then translated into many coverage decisions. There's a lot of opportunity for standardization of care.**
>
> Santosh Agarwal, MBA, MS, BPharm, Director, Healthcare Economics, Policy and Reimbursement, Medtronic

> **We cover diabetes programs and everything else but we don't cover obesity, so how do we expect employees to get help if it's not covered? We need benefits plans that actually cover the treatment and management of obesity. Employers are more likely to cover metabolic/bariatric surgery than medications. This sends the message that employers are willing to treat the extremes of obesity but not the in-between. That's a problem.**
>
> Fatima Cody Stanford, MD, MPH, MPA, MBA, FAAP, FACP, FAHA, FAMWA, FTOS, Obesity Medicine & Nutrition, Massachusetts General Hospital, Harvard Medical School

The core components of comprehensive obesity coverage should include prevention and screening, intensive behavioral therapy, medication therapy, surgery and weight maintenance programs and supports.[45] Similarly, for diabetes, coverage should include prevention, screening, monitoring and affordable treatment. HEDIS® measures should be tracked and reported including hemoglobin A1c (HbA1c) testing and control, periodic retinal eye exam, screening for kidney disease and blood pressure control.[46] Treatments including AOMs and bariatric surgery should be included where weight is a significant factor.

Review your current coverage with your health plan partners and make changes that support these components.

Weight-related health interventions



45 https://stop.publichealth.gwu.edu/sites/stop.publichealth.gwu.edu/files/Comprehensive%20Obesity%20Care%20PDFs/Comprehensive%20Obesity%20Care%20v.%209.1.21.pdf

46 https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Significant clinical benefits are associated with losing weight. For example, for participants in a study of the National Diabetes Prevention Program,[47] every kilogram (2.2 pounds) of weight loss resulted in a 16% reduction in risk for diabetes.[48] Modest weight loss of 2-5% has measurable positive impacts on systolic blood pressure and triglycerides. At 5-10% weight loss, diastolic blood pressure and HDL cholesterol improvement begins. For some other comorbid conditions, 10-15% weight loss is needed to translate into clinical improvement. This is true for obstructive sleep apnea and non-alcoholic steatotic hepatitis (fatty liver disease).[49]

Over the last several years, the FDA has approved a number of new weight loss drugs to combat obesity with clear-cut indications for long-term use. These drugs are significantly different from older, short-term-only use medications such as Phentermine, and have been shown to reduce weight by 5-10%, improve glycemic profiles significantly and reduce cardiovascular risk in patients with diabetes.[50]

Medications such as semaglutide[51] (Ozempic®, Rybelsus® for diabetes, Wegovy® for weight loss) can result in weight loss of up to 15%. As such, they hold the potential for transforming the medical management of obesity and diabetes but coverage—among even large employers—is highly variable.

Other medications include:

- GLP-1 analogues - Liraglutide (Saxenda®)
- Sympathomimetic/anticonvulsant - Combination of Phentermine/Topiramate (Qsymia®)
- Opioid receptor antagonist/dopamine and noradrenaline reuptake inhibitor - Bupropion/Naltrexone (Contrave®)
- Gastric Lipase Inhibitor -Orlistat (Alli® – OTC, Xenical® –Rx)

47 https://www.cdc.gov/diabetes/prevention/index.html

48 https://pubmed.ncbi.nlm.nih.gov/16936160/

49 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5497590/

50 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4285049/

51 https://www.nejm.org/doi/full/10.1056/NEJMoa2032183

Among the most effective obesity treatments, bariatric surgery has been shown to improve outcomes for patients with type 2 diabetes by lowering blood sugar and reducing the need for medications.[52] Studies show that a 5% weight loss from baseline improves the most commonly used measure of blood sugar, HbA1c, by 0.5%, and a 15% weight loss improves HbA1c by about 1.0%.[53] For patients with an HbA1c level of more than 7% (the target for people with diabetes is typically less than 7%), a 1% reduction in HbA1c was associated with a significant drop in diabetes-related and overall healthcare costs.[54] Mary-Elizabeth Patti, MD, a Joslin Diabetes Center principal investigator, summarized her research conducted along with colleagues in a 2021 paper by saying, "many people with type 2 diabetes, especially early in the course of the disease, should think about bariatric surgery as a treatment approach."[55] Centers of excellence (COEs) and certified bariatric programs should also be taken advantage of for surgery.

It can be difficult for patients to find obesity expertise among physicians.

> **With obesity, people don't know who to go to. Primary care isn't necessarily equipped for this. We are so far behind when it comes to obesity management landscape, and we have a population void of any systematic treatment approach.**
>
> Andrew Schneider, PharmD, Medical Accounts Associate Director, Novo Nordisk

A study published in January 2022 on the geographic accessibility of obesity medicine specialists in the U.S. between 2011 and 2019 found that while access has increased, there are a limited number of facilities that can help patients achieve sustainable weight loss and improvements in corresponding clinical outcomes. That's an especially noteworthy finding given the rise of telemedicine. According to the study: "whether access to obesity medicine diplomates is virtual or physical, there are not enough to adequately serve all patients. Health policymakers should develop strategies that focus on how to provide additional training for physicians in obesity medicine."[56] The study said that worldwide, medical schools and residencies should include minimal obesity medicine training and that integrating comprehensive obesity medicine education at an early stage would better equip the broadest possible provider population with core competencies to treat obesity.

More than 5,000 physicians are certified in obesity medicine in the country, and the American Board of Obesity Medicine has a collated list of doctors you can reference to ensure that your plan provides adequate coverage for those in your area.[57]

52 https://www.medicalnewstoday.com/articles/bariatric-surgery-type-2-diabetes#risks

53 https://spectrum.diabetesjournals.org/content/30/4/250

54 https://pubmed.ncbi.nlm.nih.gov/32643451/

55 https://www.joslin.org/about/news-media/how-stomach-surgery-makes-cut-diabetes

56 https://www.nature.com/articles/s41366-021-01024-9

57 https://obesitymedicine.org/find-obesity-treatment/

Think about families

Children of parents with obesity are at significantly higher risk of developing obesity themselves compared with children who have normal-weight parents.[58] Family-based behavioral treatment can be an important mitigator to childhood obesity and encourages the entire family—rather than just parents or children—to engage in healthier behaviors like eating healthy and increasing physical activity.[59]

In a study of diabetes in obese teenagers conducted by Joslin Diabetes Center, researchers concluded that there is a need to find better ways to treat type 2 diabetes in this population, including developing more family-based approaches to weight management or starting lifestyle programs at an even younger age. The study also found that bariatric surgery could potentially be an effective option for very obese adolescents with type 2 diabetes, lowering blood glucose levels, improving weight loss and returning cholesterol and blood pressure levels to normal.[60]

3. Improve Health and Benefits Literacy

Educate employees about obesity as a disease

It wasn't until 2013 that obesity was officially recognized as a disease by the American Medical Association.[61] Even now, the misconception exists that if people with obesity just ate less and exercised more, they would achieve a healthy body weight. While much of the messaging around obesity continues to reinforce this false narrative, employers can combat it by making educational material on obesity as a disease available. The Obesity Action Coalition can be a useful resource for up-to-date brochures, guides and fact sheets.[62] Novo Nordisk has extensive (unbranded) resources available for both employers and employees at *https://www.novonordiskworks.com/impact-of-obesity.html*.

> **If employers can say, 'Look, obesity is not your fault. It's a disease, and we want to make sure you have access to treatment that will help you be your best self,' this would go a long way toward equipping people to get help with available resources. It validates the people who have been struggling for a long time and doing things for themselves through diet and exercise.**
>
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Resources for employees need to be culturally relevant and accessible with respect to language and health literacy. **Benefits leaders need to be intentional about making sure employee populations can see themselves reflected in health and benefits communications.** Messag-

58 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5463282/

59 https://www.apa.org/monitor/2019/04/ce-corner-childhood-obesity

60 https://www.joslin.org/about/news-media/obesity-surgery-linked-positive-outcomes-very-obese-teens-diabetes

61 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4988332/

62 https://www.obesityaction.org/get-educated/public-resources/brochures-guides/

ing about obesity and diabetes needs to be sensitive to race and ethnicity. The emphasis needs to be on health rather than body size so employees understand what steps need to be taken to reduce their risk of serious illness and comorbid conditions and improve their quality of life.

Make sure benefits information is accessible and understandable[63]

Employees need to be able to understand what is and isn't covered by insurance, what their options are, and how much care will cost them. When they don't have answers to these questions, their capacity to manage their health is undermined and your healthcare investments aren't optimized.

Here are some questions to ask about your benefits communications:

- Are there opportunities for people to learn in different formats (e.g., videos, flyers, webinars, etc.)?
- Can employees access information in different languages?
- Are there multiple times set aside for employees to learn and ask questions?
- Are there people available who employees can talk to about their benefits?
- Are there tools that show how different benefits options affect employees' individual circumstances?
- Is it easy for employees to identify which options cover prevention and care management for conditions like obesity and diabetes?

4. Reduce Financial Barriers to Care for Obesity and Diabetes

Studies have shown that employees with high BMI levels are associated with significantly more costs and absences and lower self-reported productivity than employees without obesity. In fact, obesity is associated with a 46% increase in inpatient costs, 27% increase in non-inpatient costs, and 80% increase in prescription medication costs compared with costs for people at normal weight.[64] Nonsurgical interventions such as prescribing AOMs combined with lifestyle modification can result in significant healthcare cost reductions—weight loss between 5% and 10% resulted in a $135.35 per person per month reduction in healthcare costs, increasing to $193.54 per month with weight loss of 10-20%.[65] Results can be long-lasting, with associated reductions in healthcare costs likely outweighing the cost of such interventions. Downstream savings associated with bariatric surgery are estimated to offset the initial costs in two to four years.[66]

63 https://www.benefitspro.com/2021/08/18/5-health-plan-design-strategies-that-promote-inclusion/

64 https://pubmed.ncbi.nlm.nih.gov/24451611/

65 https://pubmed.ncbi.nlm.nih.gov/33164723/

66 https://pubmed.ncbi.nlm.nih.gov/18778174/

Reducing financial barriers such as high deductibles and out-of-pocket cost sharing has been shown to improve medication adherence, reduce health care spending and mitigate health disparities among certain racial and ethnic groups, including Black and Hispanic people.[67]

For obesity care, reducing financial barriers may include:

- Working with health plans and other healthcare partners to incorporate CDC-recognized lifestyle change programs into benefits.
- Making regular check-ups, BMI screenings and consultations with obesity specialists exempt from high deductibles or co-payments.
- Making AOMs exempt from deductibles and cost sharing, or setting a low, fixed-dollar co-payment.
- Ensuring that any rebates or discounts for medications that employees pay for are passed on to them at the point of sale.
- Providing coverage for bariatric surgery—and post-surgical maintenance care—when recommended.

For diabetes care, reducing financial barriers may include:

- Working with health plans and other healthcare partners to incorporate CDC-recognized lifestyle change programs into benefits.
- Making regular check-ups, HbA1c testing, glucometers and retinopathy screenings exempt from high deductibles or co-payments.
- Covering preventive and diabetes-related podiatry services.
- Making insulin and other glucose-lowering medications exempt from deductibles and cost sharing, or setting a low, fixed-dollar co-payment rather than one that varies with list price. Do the same for AOMs.
- Ensuring that rebates or discounts for medications employees pay for are passed on to them at the point of sale.
- Ensuring affordable access to FDA-approved devices for managing diabetes.
- Providing coverage for bariatric surgery—and post-surgical maintenance care—when recommended.

Value-based insurance design and racial health equity

Value-based insurance design (V-BID) is based on the principle of lowering or removing financial barriers to essential, high-value clinical services, including preventive visits, certain diagnostic tests and specific medications for the management of chronic diseases. This approach contrasts to "one-size-fits-all" cost-sharing that has been traditionally incorporated into high-deductible health plans. Increasing evidence shows that this approach can discour-

67 https://www.healthaffairs.org/do/10.1377/hblog20210902.136368/full/

age people from seeking preventive care and screenings, care for management of chronic illnesses, and medications needed to manage those illnesses.[68] V-BID has the potential to mitigate cost-related non-adherence to medications[69] and avoidance of preventive and disease management, thus enhancing health outcomes.[70]

V-BID can also help promote more equitable access to essential services. V-BID strategies combined with other efforts aimed at improving racial health equity could enhance health outcomes among people of color—in this case, those with obesity and diabetes. A modeling study undertaken by David D. Kim, PhD., for example, found that increased uptake of bariatric surgery could generate substantial clinical value to patients, payers, and society, including greater benefits to minority and sicker individuals.[71]

You can find many resources on the V-BID Center's website at: *https://vbidcenter.org/*. The EBRI Issue Brief*, Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Plans*, is available at: *https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_542_hsaemployersur-14oct21.pdf?sfvrsn=73563b2f_6* may also be helpful.

Holistic health and well-being

Social determinants of health (SDOH) — the conditions in which people live, learn, work and play—have a significant impact on health outcomes and play a major role in health disparities among people of color. Behavioral risk factors for disease—like lack of exercise, smoking, misuse of alcohol and drugs, and frequent consumption of sugary and fatty foods—have ties to SDOH. Employers need to approach improving overall employee health and well-being and preventing diseases like obesity and diabetes holistically and should include programs and actions to address SDOH within employee populations. (*For more information on SDOH and their impact on health outcomes, see the NEBGH guide,* Social Determinants of Health: What Employers Can Do *at https://nebgh.org/initiative/social-determinants-of-health/*)

5. Ensure Access to Racially Sensitive Mental Health Support

Depression and anxiety are not uncommon among people dealing with obesity and type 2 diabetes, and many healthcare experts believe treatment for these mental health conditions are an essential component of successful disease care.[72] For BIPOC populations, the risks of depression and anxiety that accompany these diseases may be higher given the stress of exposure to racism. Some have used the term "racial battle fatigue"[73] to describe the mental health effects of living with racialized microaggressions.

68 https://academic.oup.com/tbm/article-abstract/8/3/375/5001932

69 https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1633

70 https://www.healthaffairs.org/do/10.1377/forefront.20210902.136368/full/

71 https://www.healthaffairs.org/do/10.1377/forefront.20210902.136368/full/

72 https://pubmed.ncbi.nlm.nih.gov/25643685/

73 https://archive.thinkprogress.org/black-people-arent-making-things-up-the-science-behind-racial-battle-fatigue-9726fcebc938/

Offering racially sensitive and culturally relevant mental health resources to your employees is not only good for their overall well-being but can also enhance their ability to manage health conditions like obesity and diabetes. Studies have shown that patients are more satisfied with communication and have greater trust when they see racially or socially compatible clinicians.[74, 75] Finding diverse providers within health plan networks can be difficult, but plans are aware of this and working to expand their networks. Mental-health-specific vendors such as Alma, Lyra and Spring Health specifically promote their diverse provider base. Included Health, which covers mental health as well as primary and specialty care—a selling point given employers' focus on DE&I—also promotes its diverse provider base.

A list of some potentially helpful resources employers may not be familiar with is in the Appendix *on page 28.*

6. Evaluate Healthcare Vendors on DE&I Practices and Hold Them Accountable

Providing employees with benefits and services that reflect their needs and preferences is an important component of creating a work environment that supports employees of color. Contracting with health plans and other vendors that understand the unique needs of diverse employee populations and are willing to be evaluated based on achieving successful engagement of them is one way benefits leaders can intentionally build more equitable benefits and programs.

Ask questions to assess adherence to DE&I practices

Here are some questions you can ask to assess adherence to DE&I practices by your health plan and other vendors:[76]

- Can you provide data by race and/or ethnicity? Can you provide it regularly or only on request?
- What methods are you using to attract diverse talent and clients?
- How do you lead by example in DE&I?
- How does your organization's work align with and support our DE&I strategy?
- How do you engage users in evaluating how well your offerings meet their needs? How do you ensure that feedback reflects diverse users?
- What is your strategy for understanding those you're not reaching?
- Do you use qualitative and quantitative methods to measure the success of your offerings?
- If your offerings involve machine learning and artificial intelligence, to what extent have you looked at inherent bias in your algorithms?

74 https://journalofethics.ama-assn.org/article/disentangling-evidence-and-preference-patient-clinician-concordance-discussions/2019-06

75 https://www.psychiatryadvisor.com/home/topics/mood-disorders/the-perception-of-physician-cultural-competency-and-mental-health-outcomes/

76 https://www.resourcesolutions.com/latest-news/delivering-on-diversity.html

Request that your health plan provides claims data you want to see regularly, disaggregated by race and ethnicity. Employers can also assess their plan's cultural competence by reviewing their HEDIS and CAHPS scores.[77] HEDIS includes measures of culturally competent services and translation abilities and in 2022, HEDIS requires that health plans stratify and report on five select measures including HbA1c control for patients with diabetes, by race and ethnicity, to better identify disparities.[78] The other four measures are colorectal cancer screening, controlling high blood pressure, prenatal and postpartum care, and child and adolescent well care visits. CAHPS includes indicators of consumer experience and satisfaction.

You can also ask your health plan to seek the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care[79] if they don't already have it. NCQA's program creates a roadmap for culturally competent care delivery and awards the distinction to organizations that meet or exceed standards in providing culturally and linguistically appropriate services (CLAS). NCQA evaluates how well an organization complies with standards for:

- Collecting race/ethnicity and language data
- Providing language assistance
- Cultural responsiveness
- Quality improvement of CLAS
- Reduction of health care disparities

Keep pressing for diverse provider networks

A number of studies highlight the benefits of having healthcare providers who look like their patients. One study found that Black patients assigned to Black doctors were 18% more likely to follow their preventive care recommendations compared to those assigned to non-Black doctors.[80] Increasing the racial and ethnic diversity of network providers is critical to improving health outcomes and ensuring that BIPOC individuals feel safe, heard and understood during each healthcare encounter. New companies such as Health In Her HUE and HUED provide lists of physicians of color that can be resources for employees as well as plans.

Some large employers are taking an extra step to offer tailored concierge and healthcare navigation services for different racial and ethnic employee populations.[81] These services can engage employees of color in accessing healthcare providers sensitive to their needs and preferences.

77 https://www.healthaffairs.org/do/10.1377/hblog20201217.850341/full/

78 https://www.ncqa.org/about-ncqa/health-equity/data-and-measurement/

79 https://www.ncqa.org/programs/health-plans/multicultural-health-care-mhc/

80 https://www.nber.org/papers/w24787

81 https://www.cnbc.com/2021/09/21/large-employers-launch-telemedicine-program-to-tackle-black-health-.html

7. Advocate and Invest

Employers can advance racial health equity by advocating for and investing in change efforts, in addition to implementing their own practices and policies to support racial health equity.

Understand the Treat and Reduce Obesity Act

The U.S. Treat and Reduce Obesity Act (TROA) aims to reduce obesity in older Americans by enhancing Medicare beneficiaries' access to intensive behavioral therapy providers and allowing coverage for FDA-approved AOMs. This bipartisan bill has been on the legislative docket since 2014 (and was reintroduced in 2021) but has yet to become law. Employers' voices would be helpful in advocating for this legislation.

Self-insured employers can improve outcomes for employees with obesity by matching their benefits with those suggested in TROA.

Invest in the expansion of diversity in healthcare

One contributing factor to poorer health outcomes among BIPOC populations is their unmet need for culturally competent care — they are often treated differently because of their race or ethnicity.[82] Exacerbating that challenge is the lack of diversity in healthcare. For example, only 5.8% of physicians are Hispanic,[83] compared with nearly 20% of the U.S. population, and only 4% are Black, compared with 13% of the U.S. population.[84] Fewer than 10% of physicians throughout the United States are from an underrepresented minority group, including African American/Black, Native American, Alaska Native or Hispanic.[85] Recruiting more BIPOC individuals in all areas of healthcare can significantly increase people of colors' degree of comfort in seeking care and their receptiveness to treatment recommendations. It would also diminish bias in care. Studies have shown that patients prefer to receive health care from doctors who they can relate to and understand, and with whom they share similar backgrounds. They also have better health outcomes in such cases.[86]

Large employers have opportunities to invest in provider pipeline programs as well as a variety of organizations such as the Association of Black Women Physicians, the National Black Nurses Association and the National Hispanic Medical Association.[87] Such support could improve the diversity of those who care for your employees.

82 https://healthblog.uofmhealth.org/lifestyle/health-inequality-actually-a-black-and-white-issue-research-says

83 https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018

84 https://www.nytimes.com/2018/08/20/health/black-men-doctors.html

85 https://www.ama-assn.org/press-center/press-releases/new-policy-aimed-increasing-diversity-physician-workforce

86 https://www.ama-assn.org/delivering-care/health-equity/what-s-needed-improve-physician-diversity-pipeline-programs

87 https://amsny.org/initiatives/diversity-in-medicine/diversity-programs/other-pipeline-programs/

Invest in communities where your employees live

Organizations that prioritize employee health, address health inequities and invest in their communities can expect to reap cost benefits and savings in the form of reduced healthcare costs, greater productivity, increased employee retention, enhanced morale, and reduced absenteeism.[88] From funding scholarships in specific communities to sponsoring neighborhood revival campaigns to partnering with local churches for fundraisers, many large organizations are getting more creative about where they are investing their time and resources.[89] You can collaborate with your DE&I leadership and leverage ERGs to understand where to start investing in the communities where your BIPOC employees live.

When it comes to preventing obesity, diabetes and other illnesses in communities of color, partnering with trusted entities such as churches and organizations such as YMCAs and neighborhood associations can be effective. Investments can take the form of sponsoring educational programs and supporting initiatives like expanding the availability of fresh fruits and vegetables through farmers' markets, starting yoga classes and safe outdoor walking clubs, and providing incentives for participating in regular screening programs.

88 https://hbswk.hbs.edu/item/why-business-should-invest-in-community-health

89 https://people.com/human-interest/people-100-companies-that-care-2021/

Appendix

Actions to Take: Achieving Racial Equity in Obesity and Diabetes Prevention, Treatment and Outcomes

Use this checklist to identify and prioritize actions to take. Track your progress in working toward racial health equity when it comes to addressing obesity and diabetes among your employees.

- ☐ **Address Racial Disparities in Health Outcomes through DE&I Efforts**
  - ☐ **Partner with DE&I leadership**
  - ☐ **Leverage Employer Resource Groups**
  - ☐ **Identify Inequities in Benefits and Programs**
    - ☐ Analyze your data
    - ☐ Talk to your employees

- ☐ **Design Benefits that Support Best Practices in Obesity and Diabetes Care**
  - ☐ **Address the underuse of effective obesity treatments...diabetes treatments too**
  - ☐ **Think about families**

- ☐ **Improve Health and Benefits Literacy**
  - ☐ **Educate employees about obesity as a disease**
  - ☐ **Make sure benefits information is accessible and understandable**

- ☐ **Reduce Financial Barriers to Care for Obesity and Diabetes**
  - ☐ **Value-based insurance design and racial health equity**
  - ☐ **Holistic health and well-being**

- ☐ **Ensure Access to Racially Sensitive Mental Health Support**

- ☐ **Evaluate Healthcare Vendors on DE&I Practices and Hold Them Accountable**
  - ☐ **Ask questions to assess adherence to DE&I practices**
  - ☐ **Keep pressing for diverse provider networks**

- ☐ **Advocate and Invest**
  - ☐ **Understand the Treat and Reduce Obesity Act**
  - ☐ **Invest in the expansion of diversity in healthcare**
  - ☐ **Invest in communities where your employees live**

Resources

Weight Bias Resources

1. https://www.obesityaction.org/action-through-advocacy/weight-bias/people-first-language/

2. https://www.obesityaction.org/action-through-advocacy/weight-bias/weight-bias-guides/

3. https://uconnruddcenter.org/research/weight-bias-stigma/

4. https://www.obesityaction.org/resources/combating-weight-bias-why-we-need-to-take-action/

5. https://implicit.harvard.edu/implicit/selectatest.html

6. https://stopweightbias.com/

7. https://www.itsbiggerthan.com/

Culturally Sensitive Health and Wellness Resources

Resource name	Type of service	Target population	Description	Cost
Therapy for Black Girls https://therapyforblackgirls.com/	Mental health support	Black women	Prioritizes making mental health topics accessible and relevant for Black girls and women. Website hosts blog posts, videos, a "find a therapist" function and a podcast.	$9.99/month
Therapy for Latinx https://www.therapyforlatinx.com/	Mental health support	Latinx people	Launched to address the mental health needs of the Latinx community and modeled after Therapy for Black Girls. Provides resources like book recommendations, crisis hotlines and mental health screenings. Offers the opportunity to be matched with a therapist from a nationwide database.	n/a
Open Path Collective https://openpathcollective.org/	Database	People who lack health insurance or adequate mental health benefits	Website seeks to bridge the gap between the need for therapy and the ability to pay for it.	One-time membership fee of $59
Black Emotional and Mental Health Collective https://beam.community/	Resource hub	Black people	Community of activists across health professions who promote healing and mental and emotional health in the Black community. Hosts virtual community-building events and healing-centered trainings, and provides grants for wellness-related innovation and educational resources.	n/a
Safe Black Space https://www.safeblackspace.org/	Community Resource	People of African descent	Community of activists of African ancestry in Sacramento, Calif., who use healing circles to support each other through shared experiences of racism and trauma. Provides resources for people in other locations to host their own circles.	n/a
Spora Health https://sporahealth.com/	Mobile app, primary care	People of color	Seeks to provide a holistic approach to primary care using telemedicine and a mobile app that takes into account a patient's lived experience.	$9.99/month
Hurdle Health https://www.hurdle.health/	Mobile app, therapy	People of color and minority groups	Provides culturally intentional teletherapy based on lived experiences, particularly focusing on minority populations.	Pay as you go: $129/session Gold membership (2 sessions/month): $97.50/session Platinum membership (4 sessions/month): $87.25/session
Liberate https://liberate.com/	Digital health platform	Providers and patients	Aims to increase patient engagement to improve. outcomes. Uses videos, infographics, slides and audio to educate patient on conditions and medications, and can be integrated across all major EMR platforms.	n/a

About NEBGH

Northeast Business Group on Health (NEBGH) is an employer-led, multi-stakeholder coalition that empowers members to drive excellence in health and achieve the highest value in healthcare delivery and the consumer experience. Our employer/purchaser members cover 6 million lives in the U.S. and 10 million globally. We help members manage costs, obtain more value from the benefits and services they purchase, and improve the health and well-being of employees. We promote the purchasing power employers represent in efforts aimed at improving healthcare quality, value and transparency.

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