PRACTICE MANAGEMENT Toolbox

Building a Weight Loss Program in GI Practice

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Introduction

Obesity has emerged as a major public health challenge, leading to immense unmet clinical need for effective and minimally invasive weight loss options. Gastroenterologists are in a unique position to fulfill this demand and service a significant proportion of obesity management market. Several steps need to be taken to build a weight loss program in a GI practice.

Key components of a weight loss program in GI practice include the following:

1. Medical Treatment Options
2. Nutritional and Behavioral Modification
3. Endoscopic Weight Loss Procedures

Medical Management with Drug Therapy

The target patient population for anti-obesity drugs includes patients who have Obesity (BMI ≥ 30 kg/m²) or overweight (BMI ≥27 kg/m²) with one or more obesity related comorbidities. The major challenge is navigating insurance barriers. It is beneficial to create templates for letters of necessity. Use supporting documentation for comorbidities such as prediabetes/diabetes, fatty liver, or obesity secondary to a medication. It is helpful to evaluate HbA1c, liver function tests, and a FibroScan or shear wave elastography (SWE). Oftentimes uncoupling the medications is required if insurance denies FDA approved combination agents. For example, a prescriber can prescribe separately off label (phenterimine and topiramate) rather than the combined medication Qsymia which is FDA approved. This can also apply to Contrave which is the

combined medication for naltrexone and bupropion hydrochloride. You may require partnering with a local pharmacy dispensing weight loss drugs. Consider continuing weight loss medications for at least 1 year after achieving desired weight loss to avoid rebound weight gain after medicine discontinuation.

A comprehensive review of medical weight loss drugs is beyond the scope of this article. However, the following is the list of medications commonly used in a medical weight loss program.

1. Incretin based therapies. These are the first line agents for medical weight loss. These include GLP-1 agonists: liraglutide (Saxenda), semaglutide (Wegovy); and GLP-1 plus GIP agonists: tirzepatide (Zepbound). Tirzepatide is the most efficacious medication for weight loss. Semaglutide has shown improvement in cardiovascular outcomes.

2. Phentermine. Approved for short-term weight loss for 3 months. It can be extended long time by using low dose. Need monitoring for blood pressure and heart rate.

3. Qsymia (phentermine/topiramate). This is the most effective non-incretin-based medication. Caution is advised among women of childbearing age.

4. Contrave (bupropion/naltrexone). It is a reasonable option among smokers and patients who suffer from depression. Caution among patients with chronic opioid use and seizure disorder.

Optimizing Nutritional and Behavioral Modification

1. Implement prescription meal replacement programs such as Optifast. May use in-house pharmacy to dispense the product.

2. Incorporate nutritionist consultations either in person or through telehealth.

3. Provide Individualized behavioral modification support by medical assistants in practice or through online apps. Training resources for staff include:

a. AFPA (American Fitness Professionals and Associates): www.afpafitness.com

b. NESTA (National Exercise & Sports Trainers Association): www.nestacertified.com

c. Cornell University: Wellness Coaching Certificate: ecornell.cornell.edu

Endoscopic Weight Loss Procedures

Endoscopic weight loss interventions are indicated for patients who fail dietary and medical management. Future treatments may see endoscopic procedures combined with medication therapy. Patient selection is a key factor. Ideal candidates have a BMI of 30–40 kg/m², have not achieved adequate weight loss through other means, and are not candidates or do not wish to undergo surgery. A comprehensive review of endobariatric options is beyond the scope of this article.

Common endoscopic interventions in GI weight loss programs include the following:

1. **Gastric Balloons -** Intragastric balloons (IGB) are saline, or gas filled devices that induce satiety by slowing gastric emptying. In the United States (US), these are approved for temporary placement for 6-12 months. The expected total body weight loss (TBWL) is around 10-12% at 6 months. Most common adverse events include nausea and vomiting. It can lead to dehydration and require intensive post-procedure monitoring to prevent hospitalization and early device removal. The procedure is completely reversible, and long-term outcomes depend on dietary compliance. These devices can also be used as a bridge therapy for surgery in severely obese patients to reduce operative difficulties and improve surgical outcomes.

   Three FDA approved IGBs are available in the US. These include Orbera®, Obalon®,and Spatz3®. These balloons vary in delivery and removal mechanisms. Orbera® has been the longest commercially available and most used IGB in the US. The manufacturer organizes several training camps to provide certifications to interested physicians and helps set up their program.

2. **Endoscopic Sleeve Gastroplasty (ESG) -** ESG involves gastric wall plication to create an endoluminal equivalent of surgical sleeve gastrectomy using the FDA-approved OverStitch device™ (Apollo Endosurgery). TBWL averages 15-17% at 12 months and may be maintained at 2 years. In addition, it has favorable metabolic effects on lipid profile, glycemic control, and liver enzymes. The severe adverse event rate is about 2%. However, there is a significant learning curve for any endoscopist to gain proficiency in this procedure.

3. **Endoscopic Revision of Roux-en-Y Gastric Bypass (RYGB) or Sleeve Gastrectomy -** Weight regain is seen in about one third of the patients after traditional bariatric surgeries due to the dilatation of gastric pouch/remnant and gastro-jejunal (GJ) stoma.

OverStitch™ system can perform Trans-oral outlet reduction (TORe) or Trans-oral outlet reduction with Gastroplasty (TORe-G) reducing the size of GJ stoma and gastric pouch. TBWL at 12 months is about 10% but procedures are usually well tolerated and low risk as compared to revisional surgeries. Similarly, revision endosleeve (R-EndoSleeve) can be performed after a failed sleeve gastrectomy achieving about 15% TBWL.

Refer to ACG resources for technical details and outcomes on these procedures.

How to set up a weight loss program in your GI practice

1. Develop a detailed budget and a proforma financial statement to secure funding and practice alignment.

2. Assess clinical feasibility by evaluating local availability of medical and endoscopic expertise.

3. Determine staffing needs (e.g., nutritionist, nurse, medical assistant, care coordinator).

4. Carefully identify sites for endoscopic procedures either hospital based or ambulatory surgery center (ASC). The site affects costs and program sustainability.

5. Evaluate existing infrastructure at each site. Most standalone endoscopy centers are not appropriate for such advanced procedures. However, multispeciality ASCs are generally well equipped with surgical and anesthesia services required to handle such patients safely. Multispecialty ASCs are better equipped, though upgrades (e.g., APC, endoscopic accessories) may be necessary.

6. Negotiate facility fee contracts with either hospitals or ASCs.

7. Secure pricing agreements with manufacturers for recurring devices like balloons, suturing systems, and endoscopic accessories.

8. Obtain anesthesia coverage and evaluate its associated related costs.

9. Evaluate training needs and certifications for physicians, allied staff, and technicians. Industry resources can be utilized to accomplish such training requirements. Consider obtaining certification from the American Board of Obesity Medicine.

10. Acquire additional professional liability insurance. While there is no uniform national trend in premiums, report all non-standard endoscopic procedures.

11. Consider developing a separate website focusing on wellness and weight loss.
12. Develop an online marketing strategy and consider associated advertising costs.
13. Build a cash pay model and determine the pricing of individual endoscopic procedures and their concurrent medical management. This depends on the costs incurred in individual settings and services offered, like 6-12 months post procedure medical care.
14. Consider having strong nursing or Advanced Practice Providers (APPs) for preop and postop care to improve outcomes and patient experience.
15. Partner with psychologists, endocrinologists, and bariatric surgeons to provide comprehensive care.

Measure success and scale up:

Several key indicators can be considered to monitor the success of the program and subsequent scaling up the operations.

Key indicators of success include:

1. Weight loss metrics (total body weight loss, excess body weight loss) at 6 and 12 months.
2. Closely monitor adverse event rates to assess the safety profile.
3. Assess patient satisfaction through surveys.
4. Long-term outcomes, including weight maintenance and improvement in comorbidities (e.g., diabetes, fatty liver).

Strategies to scale up your program include:

1. Aggressive community-focused marketing.
2. Committed and motivated leadership.
3. Networking with local endocrinology and bariatric surgical practices.
4. Building a multidisciplinary team (bariatric endoscopist, hepatologist, obesity medicine specialist, endocrinologist, nutritionist, exercise physiologist) to offer personalized comprehensive care.

A comprehensive weight loss program can be developed within a GI practice by focusing on dietary interventions, medical management, and endoscopic procedures. A combination of approaches is more effective than any single strategy. While a successful program ideally incorporates all three, practices can begin by adopting individual components based on available resources and expertise.

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