AMS Workgroup
Obesity, Mental Health, and Addiction

GAPS/BARRIERS

I. Lack of awareness/denial that Obesity, Addiction and Mental health disorders are chronic diseases and evidence-based treatment is available. The failure to recognize these conditions as chronic disease results in stigma in the community as well as the health care system.

II. Limited Access to treatment for these conditions
   - Lack of adequately trained specialist workforce.
   - Certain populations are especially affected, including youth, minorities, maternal, LGBTQ, rural areas.
   - Social determinants are a major factor – transportation, economic, employment.
   - Uninsured-Underinsured.

III. Poor communication between primary care and specialist providers.

IV. Lack of Training of primary care clinicians to assess and manage these disorders in their practices.
   - Lack of consistent screening for Obesity, MH or SUD.

V. Inconsistent, limited and sometimes complete lack of coverage for screening, prevention and evidence-based treatments.
   - Preventive strategies and screening.
   - Nutritional counseling and obesity surgery.
   - Intensive behavioral therapy, inpatient and outpatient treatment and medications for all these disorders.

OPPORTUNITIES/SOLUTIONS

I. Education to combat stigma and change policy.
- Community (identify existing education resources such as NAMI, AFSP, etc.
- Op-ed’s, Newspaper/TV articles, PSA’s.
- Funding entities to increase our voice and reach.
- Health insurance decision makers, public and private.
- Political leaders and legislators.

II. Education to combat stigma, increase knowledge, diagnostic and management skills.
- All undergraduate and graduate education.
- Medical school, residency and fellowship education.
- Current primary care clinicians.
  - Comfort and confidence in screening.
  - Comfort and confidence in management of appropriate patients in primary care.
  - Pro-actively identify and communicate with specialty resources.

III. Encourage standard of care in all well-child and adult annual visits to include screening for mental health, obesity and substance use issues with appropriate insurance coverage.

IV. Increase communication between primary care and specialists (clarify misunderstandings related to HIPAA as a reason for non-communication).

V. Build network and relationships with community resources.

VI. Expand workforce to include nutritionists, trauma-based therapists, peer recovery specialists, community health workers, alcohol & drug abuse counselors, etc.

VII. Increase use of telemedicine and mobile health.

VIII. Identify what the true financial barriers are to treatment for obesity, MH, SUD, including options for people without insurance.