Scott Kahan, MD:
We still have a long ways to go to be able to treat and support something close to a hundred million Americans that have varying degrees of obesity and weight difficulties, many of which who are searching for help, or who would be searching for help, if they knew that something out there respectful and supportive existed.

LuAnn Heinen:
That's Dr. Scott Kahan, a practicing obesity medicine specialist who leads a multidisciplinary obesity treatment center in Washington, DC. Trained as an internist, public health practitioner, and board certified in preventive medicine, he believes in holistic weight management and values the opportunity to build relationships, serving as both a family doctor and specialist for patients with obesity.

I'm LuAnn Heinen and this is the Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers. Today, Scott Kahan shares his perspective on the practice of obesity medicine amid a swirl of new drug therapies, increasing patient expectations, and the ongoing challenge of ever rising obesity prevalence, not only in adults but concerningly in children and adolescents.

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Welcome, Scott. 2023 was another year for obesity in the headlines and the buzz is continuing, even beyond the New Year, New You messaging we've come to expect in this self-improvement season. I really want to talk about your obesity medicine practice, but first let's recap what's happening in the macro environment when it comes to obesity. There's been a lot of change. Change that's impacting patients and likely how you care for them. I'm going to name a few significant developments, and if you're willing to play, give us your brief take one at a time. Okay, so number one, obesity is understood and acknowledged to be a disease to a far greater extent than ever before.

Scott Kahan, MD:
I might strike the word ‘far’ in there. I think that we have made quite a lot of progress both in the scientific community, better understanding the disease of obesity, and in the communication of that, in part to the general public, in part to primary care doctors and other health care providers. I think we've made really nice progress there, but I think it's been relatively incremental progress. I don't know that we're quite at the place where most of the public and most of the practicing health care provider community would look at obesity in the same way that they look at the disease of diabetes, for example, or the disease of hypertension. We still have quite a long ways to go, but we're making real progress.

LuAnn Heinen:
Do you think that people's minds are changing? For example, Weight Watchers has publicly apologized for its long-held stance that weight management is a lifestyle issue, not a medical one, and they're now supporting medical and pharmaceutical treatments when clinically indicated.

Scott Kahan, MD:
I think it's probably a good move for them. Perhaps it's one of many parallel moving pieces in the field, again toward thinking about obesity as more of a health condition rather than a failure of willpower or a failure of healthy lifestyle. We're moving forward, but I don't want to overstate how much progress we've made. I think perhaps it's easy to get very excited about big movement in the field because of all the big attention of late and all the social media buzz. I think in some ways those things are very good. They bring more attention to the field, they bring more opportunities to educate people and move things forward, but there's also been quite a lot of drawbacks of all that. Obesity treatment, weight management treatment, weight loss, has always been a sort of wild west, and while there's a lot more legitimacy now, there's also a lot more wild westness of

it. Just go on social media, go on TikTok and see all the things that are being talked about and all the nonsense out there and all the fad diets and now even fad prescribing recommendations at times, and I don't think we should confuse buzz for real progress. We have made a lot of progress, without question, but we've also made a lot more buzz, which isn't always necessarily a positive thing.

LuAnn Heinen:
Okay, so you kind of stole the thunder for my number two, which was a range of treatments for obesity are well-studied by now and we know what works.

Scott Kahan, MD:
Without question. A range of treatments have been well-studied for obesity and we have quite good understanding of the currently available treatments and we have quite good optimism in terms of their effectiveness and that includes behavioral counseling around dietary changes and exercise changes and so forth. We shouldn't lose sight of that. We have very good data showing that thoughtful counseling and supportive counseling around obesity management is quite helpful. We have very good data showing that those conservative approaches without medication and without surgery can be quite helpful for a lot of people. Unfortunately, not all people, only a portion of people will do really well with behavioral approaches to obesity, and that's why it's really great that we have additional scientifically proven treatments that can be helpful. That includes FDA approved pharmacotherapy for obesity medications. That includes bariatric surgery for obesity. And taken together those three broad sets of treatments have been well developed, and for a significant portion of the population, if they have access to those treatments, they can significantly improve their weight status and more importantly their overall health and wellness. I'm quite bullish about where we are in terms of the scientific developments and in terms of the currently available treatment options.

LuAnn Heinen:
Good news. Number three is a little bit of a however. BMI, which is described as the currency of how we define obesity worldwide and create health policies and indications for treatment, is under scrutiny.

Scott Kahan, MD:
I think I was the one that gave you those words exactly when we had that meeting a few months ago.

LuAnn Heinen:
I do have quotes around them.

Scott Kahan, MD:
That is a truth. BMI is the currency of how we go about addressing obesity. BMI criteria determine whether someone is eligible to get a medication for obesity. BMI criteria determine whether someone is eligible to have bariatric surgery. BMI criteria determine whether someone is eligible to get covered for intensive behavioral therapy for obesity. We can add many more aspects of how BMI is used in the area of obesity. Now, in some ways that's not a bad thing. It's good that we have some criteria, that's important, and BMI is valuable to an extent. BMI is a much better measure than just weight alone, but it also has huge limitations. Some of which are, for example, someone who is a foot taller than the next person, well BMI accounts for that, but beyond just differences in height, BMI does not account for differences in lean mass versus fat mass. BMI doesn't account for differences in body composition. BMI doesn't account for differences in one's health and one's weight-related health burdens at any given weight. It really does hold back the field in many ways. The good news here is there's been quite a lot of attention to that. There's still quite a number of ingrained aspects of health policy and health care that need to evolve beyond BMI. It has to start with better understanding and better communication of the problem, and I think we're there. Hopefully in the coming few years we're going to see some shifts to what I think will likely be something like BMI plus. I don't see any need to entirely get rid of BMI as one of the metrics of relevance, but if we can utilize BMI in parallel with other really important metrics and indicators of health, then we'll have a much better sense of who to treat, how aggressively to treat, to what ends we want to treat, rather than just a certain amount of weight loss or a certain amount of BMI reduction. That likely will have great benefits on a clinical level and it can also have really important

benefits on a policy and health economics level, because then we'll have a better chance of utilizing resources for people who have the best opportunities to see health improvements from the utilization of those resources.

LuAnn Heinen:
Well, you're foretelling number four, the last trend. The biggest driver of the current obesity swirl, and many of the headlines as you've alluded to, is GLP-1s. What's your take on their contribution?

Scott Kahan, MD:
Well, there's no question that that is the biggest contributor to the swirl, to the media attention. In some ways that's a good thing because the GLP-1 medications are generally really excellent medications for many patients, but they're not the be all end all. I do think that there is a bit of a mismatch between where all the attention should be and where it is right now. All the attention of late seems to be toward GLP-1s - the media attention, the social media attention.

LuAnn Heinen:
What about financial analysts? We've even had the *Wall Street Journal* reporting that United Airlines could save $80 million a year on jet fuel on projections for a “slimmer society” due to GLP-1s.

Scott Kahan, MD:
Exactly. I think the better way of thinking about it is that thoughtful, available, affordable medication treatment for patients who are good candidates has the potential to have a very impressive effect on clinical outcomes and potentially even on some economic outcomes. But that goes beyond GLP-1s. GLP-1s are a great development, but they're only a piece of the puzzle. As I alluded to in one of the earlier scenarios you put out, this is not and cannot be simply about medications. There are plenty of people that don't get good benefits from any of the medications. There are plenty of people that don't have access to the medications, and we have really good potential treatment options on both sides of treatment intensity from the medications, both on the side of behavioral counseling and on the side of bariatric surgery. So really important that we're thinking about this as broadly as possible and as inclusively as possible in terms of the range of scientifically proven treatment options rather than just over focusing on medications alone and certainly rather than just over focusing on GLP-1 medications alone.

LuAnn Heinen:
Are we missing any other significant drivers of the current climate? We know prevalence is very well tracked at this point and has been for the last couple of decades. The latest data I've seen are that 42% of U.S. adults have obesity, and that's projected to be 50% by 2030, with a quarter of those having severe obesity and between one in four and one in five kids 2-19 have obesity. Does that sound right?

Scott Kahan, MD:
Yes, that's consistent with the published data, although that's best-case scenario. First of all, depending on how you measure the obesity, the prevalence rates are somewhat different and often higher. For example, if we were to use the most accurate measure of obesity in a DEXA scan or an MRI scan, prevalence rates are higher. If we were to use a different definition of obesity where we're looking at where people carry their weight and how it's associated with metabolic derangement, that would give yet another outcome. And then, in particular, when we look across the population, across ethnicities, then we identify notable populations that have even more significant obesity levels, including African-American populations, particularly African-American women, including Hispanic populations. Some of these subpopulations are already over 50% prevalence rates.

LuAnn Heinen:
That leads me to your clinic, your practice. You've been practicing obesity medicine for how many years?

Scott Kahan, MD:
We're getting close to two decades, about 15 years.

LuAnn Heinen:
What gets patients to your clinic and what keeps them away, as far as you may know?

Scott Kahan, MD:
Well, in terms of getting to our clinic, a substantial number are referred by other practitioners, whether primary care doctors, endocrinologists, cardiologists, psychologists, and psychiatrists. That accounts for between 40 and 50% of patients who enter our clinic. About another 30 to 40% enter by way of referrals from current patients or sort of word of mouth. Then the remainder, approximately 20% or so, is a mix of people going online and finding us online or they hear me on a podcast or they see me on a TV interview or something like that, perhaps something that we write and put out there in a newspaper or the like. It's a combination of those.

LuAnn Heinen:
How long do you think they've been waiting to come see someone like you? Do you have any sense of that?

Scott Kahan, MD:
For a number of patients, they didn't even know that specialists in this field even exist. They may have heard of the commercial programs that are out there. They certainly have heard of a lot of fad diet type things that are out there, but many people had no idea that there is a legitimate medical field of obesity medicine, let alone the wraparound specialists that we work with, whether it's psychologists trained in obesity management, whether it's dieticians that are trained in obesity management, and other health care providers. And for other people, they have been aware of doctors and others that do this type of medicine, but sometimes they're uncomfortable seeking care, sometimes they've had poor experiences in the health care system in the past that can make it extremely uncomfortable for them to step forward and ask for help.

LuAnn Heinen:
Joe Nadglowski of the Obesity Action Coalition talks about stigma, including from his own personal experience, and the added stigma of having to ask for help. We know that experiencing white bias or stigma and then internalizing those negative stereotypes, whether they be around willpower or lack of discipline or something else, is associated with negative mental health outcomes. It sounds like that's something that you're addressing.

Scott Kahan, MD:
Well, you hit the nail on the head and it's even worse than that. There's plenty of data showing that experiencing and internalizing weight stigma, believing the stigmatizing things that are put out there at large in our society and/or that may be directly targeted at a given individual, those not only lead to negative mental health outcomes, but have been shown to lead to negative physical health outcomes as well. There are higher rates of metabolic syndrome, for example, in people who have internalized weight stigma. There's higher blood pressure, more extensive expression of stress hormones, and a range of longer-term negative outcomes, including, and this is a really interesting one that people don't realize, when people experience weight stigma, on average it leads to more weight gain, not the other way around. People often have this misconception that it's okay to be harsh with someone about their weight, because that'll jolt them into doing something about it, that'll give them the necessary motivation to finally make some changes and go on a diet or go exercise. But the data is so clear and almost incontrovertible at this point, that in fact, it's the opposite. When people experience weight bias, they tend to have more emotional eating. They tend to engage in more fad diets and extreme diets. They tend to have less motivation for exercise and they tend to gain weight, not lose weight, on average. This is a big, big issue and it's something that we in the field have been working on extremely hard for many years, and I think we've hit our stride in a lot of ways. We're making a lot of progress, but still requires quite a lot more attention. We've done a lot of work in terms of educating the general public about weight stigma in affected patients themselves to understand what that looks like and that it's not okay to be treated

badly based on your weight, based on your appearance or the like. We've done a lot of education to the general public about this being a similarly inappropriate and disgusting thing as would be prejudice and discrimination around gender or discrimination around one's race. We've done lots of work, and we continue to do lots of work, in the health care system, which is one of the more prevalent locations for experiences of weight stigma. It's a really important issue and one that we're making progress on.

LuAnn Heinen:
Are there specialized pediatric practices in obesity medicine or do you see kids and teens?

Scott Kahan, MD:
Unfortunately, there are far too few specialty practices for pediatric obesity. We are adult doctors. We don't have expertise in pediatric care. We get a lot of calls from parents and loved ones looking for help for their kids and their teens. We'll occasionally see older teens just because we don't have anywhere else to send them, but we're not specialists in pediatric care. They're exceedingly few specialists throughout the country. On the one hand, this needs to be something that's better treated in primary care, in pediatric care, but in a very careful and thoughtful and supportive way. And it needs to be something where there are opportunities for escalating care to specialty centers, whether that be for more supportive counseling and guidance, whether that be for the consideration of medication treatments when appropriate, whether that be for the possibility of bariatric surgical treatments, as you alluded to just now. Even more than with adult obesity, that's still an area of extreme unmet need.

LuAnn Heinen:
I'm speaking with Dr. Scott Kahan who practices obesity medicine. He's on faculty at the George Washington University Schools of Medicine and Public Health, as well as the Johns Hopkins Bloomberg School of Public Health, where he teaches courses on obesity, nutrition, public health and health behavior change. We'll be right back.

LuAnn Heinen:
I'd like to take a moment and share a patient's story. This is about an adult patient that I found digging around about you in a local DC area magazine. It was published a few years ago. The author of the article interviewed Grace. Grace, a high school teacher in Maryland lost 98 pounds in a year at Dr. Kahan's clinic. This is a quote from her, "he and his team are really good at opening up the conversation," she says. "They ask about what parts of your life are not well. If you're frustrated in your job and your relationships, if you have leftover issues from childhood, leftover ways of beating yourself up, those things have to be addressed in order to deal with the weight. In dealing with those issues, says the author, patients often benefit in other areas of their lives. The summer after she lost weight, grace learned to scuba dive and studied yoga in Bali. That fall, she began cycling to work and dating a fellow employee. Through it all, Dr. Kahan was "so joyfully happy for me," she said." This article goes on to talk more about you and your practice, but I don't know if you remember Grace. How does that make you feel? Did I embarrass you; are you blushing A little bit?

Scott Kahan, MD:
I'm totally embarrassed, thank you very much. It's so important to create a safe place, a safe place to engage, a safe place to open up, a safe place to ask for help and accept help, and a safe place to be able to work hard and have success, but also to fall down on your butt a little bit and know that you won't be judged. That has always been a centerpiece of what we try to do at our clinic, even more than having great treatments available, even more than looking at weight loss and diabetes improvement and all that as outcomes. At the centerpiece of how we think about this is that we have people in front of us, people that are loved and love others in their lives, people have a lot of friends, family members and otherwise that care about them and people who often haven't been able to have a safe place to explore this issue and hopefully make lots of progress on this issue. We pride ourselves on being able to offer that safe place. The article that you're quoting from, that's at least 10 years old now. Back then I think a clinic like what we offer was not quite unheard of, but few and far between. There wasn't many clinics doing what we were doing. I think today is quite different. There still aren't nearly enough, but there are many more specialists, whether from the medical perspective, whether from other areas of health care that have resources available and safe spaces available to help a wide range of people. But we still have a long ways to go to be able to treat and support something close to a hundred million Americans that have varying degrees of obesity and weight difficulties, many of which who are searching for help or who would be searching for help if they knew that something out there respectful and supportive existed.

LuAnn Heinen:
A hundred million Americans, that's a really big number. What are your patients asking of you and are their needs and expectations easier or harder to meet right now?

Scott Kahan, MD:
Easier or harder compared to what?

LuAnn Heinen:
Like what it used to be. There are so many options, there are so many treatments, but yet expectations, how do you manage expectations? Not everyone's going to lose 98 pounds, right? GLP-1s, 20% weight loss, maybe.

Scott Kahan, MD:
Yes, and it's a great point. I think the answer comes from two very different sides. On the one hand, as we've talked about quite a bit over the last half hour or so, there has been much more attention to obesity over the last 20 years and to obesity treatments, in particular, over the last few years, especially with the GLP-1s of late lots more media attention. So people are coming in now with an openness to the potential for utilizing medical treatments as well as other treatments in a way that they weren't nearly as much even just a few years ago. And that has the potential to be really positive. There's more openness to accepting potentially valuable resources and treatment options. On the other hand, because of all of the attention, the swirl I think was the word you used, and still in the context of this wild west of weight loss in social media and elsewhere, people are coming in with often wildly unrealistic expectations. These inflated, wildly overinflated expectations can make it more challenging and level setting and helping patients better understand what's possible and what's unlikely, what's realistic, is important. Part of that is level setting around the degrees of weight loss. Part of that is educating around the often huge health benefits of quite small amounts of weight loss. Most people don't need 20% weight loss to significantly improve their health indicators, to significantly improve their mobility, to significantly improve their health-related quality of life. For those that are able to get those large amounts of weight loss in safe, smart ways and their health improves significantly from it, that's wonderful and we'll likely have even better treatments still in the coming future, but far from everyone gets that degree of weight loss and relatively few people actually need that high degree of weight loss to see significant health improvements. So both of those things are happening at the same time.

LuAnn Heinen:
So, 5 to 10% of weight loss, is that how you get the better health outcomes?

Scott Kahan, MD:
We have very good data going back decades showing that as little as 2 to 3% weight loss starts to improve health indicators, triglycerides, cholesterol, these things are already improving with 2 or 3% weight loss. Blood sugar is already starting to improve with 2 or 3% weight loss. 5 to 7% weight loss, you get even more improvements in those things and further improvements beyond it. So for example, 7% weight loss, even if half is regained over the next few years, leads to a 50 to 60% reduction in the development of diabetes in people at risk. Once you get to 7 to 10% weight loss, most things are improving and many are improving substantially. So now we get to things like starting to see improved snoring and sleep apnea, starting to see improved liver function and liver fat levels, and we can go on and on. Once you get to beyond 10% weight loss, then you start to see cardiovascular benefits. In the *Look AHEAD Study*, for example, this was a large trial, NIH trial, of more than 5,000 patients who had diabetes and obesity at baseline, and they were given state-of-the-art behavioral treatment for the obesity. They lost an average of about 7% or so after the first few years, and on average, they did not have a reduction in heart attacks or adverse cardiovascular outcomes. But when you look at the people that lost at least 10% of their body weight, which is about 25% of the population, they did have an improvement in cardiovascular outcomes. So it's likely that more than 10% weight loss is going to improve the risk for stroke, the risk for heart attacks, and that's whether or not you use medications. Now, we also have data with at least two of the GLP-1s, showing that you can get further improvements in cardiovascular outcomes with weight loss and the use of GLP-1s. In some cases, the GLP-1s allow for more weight loss than behavioral approaches alone would allow for, and there may be a direct effect of the GLP-1, independent of weight loss as well. But by and large, people who lose more weight tend to see better health improvements, and when done in a thoughtful, supportive environment, outcomes tend to be improved.

LuAnn Heinen:
Do you think people who undertake a ketogenic diet find success and safely? Is that a safe success story?

Scott Kahan, MD:
I'm not necessarily against ketogenic diets. They certainly have been proved to be helpful in some populations of people with seizures, for example. I've seen quite a number of patients who have found that approach very helpful in terms of weight loss. I think the problem is the way that it's communicated and all of the buzz that had been around that, it's a little died down of late, but you go back 3, 4, 5, 6, 7 years and in the same way that we see this swirl around GLP-1s today, that's what we saw around the ketogenic diet. That it's the magic treatment for obesity, if you just go on a ketogenic diet, you'll lose all this weight, you'll never have to worry about your weight again, it'll improve your cholesterol, it'll prevent heart attacks, and so on and so on and so on. None of those things have been shown to be true, by and large. I say that even while also saying that for some people, that approach does work quite well, and I do counsel some patients in utilizing either a ketogenic approach or other low carb diet approaches at times. But to say that a ketogenic diet is going to be the cure for obesity, it is just nonsense.

LuAnn Heinen:
No magic bullet. Your point of view on GLP-1s in terms of the ability to reduce dosage, maybe after an initial weight loss, take drug breaks or stop and not experience significant regain. Any point of view on that?

Scott Kahan, MD:
First of all, we need to expand this beyond just GLP-1s. Weight medications that are effective and that are proven to be helpful for long-term use, when stopped on average, patients' weight goes back up, not necessarily all the way back up, and not necessarily everyone will see an increase in weight, but on average that's what happens and it shouldn't be surprising. These are medications intended for chronic management use, just like we would not expect someone who goes on a blood pressure medication for it to cure the blood pressure problem and when they stop it, that the blood pressure would remain at an optimal level. Or same thing with cholesterol. When we stop a cholesterol medication or a blood pressure medication, on average, all else being equal, the cholesterol or blood pressure goes back up. And that's what happens on average with weight. On the one hand, we need to be educating people that they're not magic pills, they're not short-term silver bullet treatments, but they could be, used appropriately, they very well may be really valuable pieces of

a chronic management approach to obesity. All of the attention scientifically has been toward developing the medications and developing the indications and standards of care for using them in the relative short term, six months, a year, two years, three years for weight loss. There's going to be more and more attention to what we can do to maintain that weight loss. Ideally, perhaps with less exposure to the medication, but it's unlikely that we can just use a medication, get the weight off, and then stop it and expect continuance of the benefit.

LuAnn Heinen:
What are your considerations in recommending a treatment plan or what are the most common pathways? It sounds like everyone is getting behavioral support or psychological support of some kind. What percent get pharmacotherapy?

Scott Kahan, MD:
In terms of pharmacotherapy, about 50 to 60% of our patients will utilize some degree of pharmacotherapy during the course of their treatment, and that's higher than it was a few years ago. In small part, it's higher because there are additional treatments available now and some even better treatments available now, but I think that's a smaller part of the explanation. The larger part is what we talked about earlier. There's more attention to obesity and obesity treatment of late. There's more willingness of patients, on the one hand, to be open to utilizing potentially helpful treatments, just like there's more willingness for primary care providers to consider utilizing treatments for their patients.

LuAnn Heinen:
Bariatric surgery has classically been under-utilized relative to the number of patients who qualify, really it's been a low demand. Is that still the case and when do you refer for bariatric surgery?

Scott Kahan, MD:
As far as I know, the most recent data shows only 1 to 2% of eligible patients are getting bariatric surgery and that number should certainly be higher. Some of it is low demand, so there are many patients, for example, that are not willing to do a surgery. They may be scared of surgery or they may be scared of this particular surgery. There are plenty of patients that feel like it's cheating or it's inappropriate, and that's driven, of course, by a lot of the societal stigma around this. There's also not enough providers, not enough surgeons trained in this to be able to accommodate a significantly increased number of patients getting surgery.

LuAnn Heinen:
I think the unequal access is going to be increasingly a concern. You talked earlier about the cost and according to an Aon consulting firm analysis of prescription claims from 500 employers, the use of weight loss drugs, Saxenda, Wegovy and Rybelsus, along with off-label usage of Ozempic for weight loss, increased employer health care costs by more than $300 per worker in 2023. Even while some private employers are willing to take that on, it's going to be a tough call for public employers and those in public health insurance programs like Medicaid and Medicare. If you had the proverbial magic wand, what change would you make to improve the lives and the health of people with obesity?

Scott Kahan, MD:
Oh boy, that's a tough one.

LuAnn Heinen:
I thought you'd go to the food system.

Scott Kahan, MD:
My training is initially in public health, and that's exactly how I would've answered the question 10, 15 years ago, and certainly that has to be a part of the approach here. The problem is environmental approaches, first of all, they're gargantuan things to deal with. There's so many aspects and so many industries that are ingrained in ultimately to make up our current food environment, our current physical activity environment, making substantial changes are not going to happen in years to decades. We're talking about many decades

likely. Even if I could with a magic wand make those changes start to happen, that would leave behind a hundred million people or so who currently have obesity, who currently have lived in the obesogenic environment, and to an extent whose physiologies have been shaped by that and having healthier food availability 10 years from now may not be nearly enough to help them. So just like there's no magic bullet to solving obesity, I don't think there's any magic bullet to solving the food environment. And so even if I had a magic wand that could solve one piece of this, there would still be so many other moving parts that need their magic wands. We need to shift to think about this in a more multimodal broad way, rather than either looking for the best diet or looking for the best pill or looking for the best magic wand. It's just inconsistent with the multifactorial nature of what this is.

LuAnn Heinen:
You advocate a systems approach, delivered with compassion and thoughtfulness. Thanks for showing us those qualities all through this interview. I really appreciate it.

Scott Kahan, MD:
Thank you so much for having me.

LuAnn Heinen:
I've been speaking with Dr. Scott Kahan, a physician specializing in obesity medicine. Dr. Kahan is also active in obesity policy and advocacy. He has advised the White House, multiple Surgeon Generals, the U.S. House of Representatives, national and international organizations, and federal and state agencies. He has been widely quoted in national media and delivers many invited presentations, including at TEDxManhattan and TEDMED.

I'm LuAnn Heinen, and this podcast is produced by Business Group on Health, with Connected Social Media. If you enjoyed this episode, please rate us and leave a review.