

Seven Strategies for Success



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Seven Strategies for Success

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The dialogue continues for GSA members in the GSA Obesity and Aging Interest Group.

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Introduction

The United States and many other countries face an epidemic of obesity and overweight.

Obesity is now recognized as a chronic disease requiring lifelong therapy to correct abnormalities in a complex interplay of genetics, gastrointestinal and pancreatic hormones, gut-brain signaling, the environment, and socioeconomic factors. Older adults are particularly vulnerable to the negative consequences of overweight and obesity. In older adults whose muscle mass and strength are declining even though their overall body size may be static or increasing, attempts to lose weight can exacerbate this decline and thereby compromise their ability to perform tasks people need to do every day, such as picking up and carrying objects, walking across the room, or rising from a chair.

The Gerontological Society of America (GSA) recognizes the need to amplify current concepts of obesity as a chronic disease with negative effects on healthy aging. Through research published in its journals and presentations at its professional meetings, GSA has served as a forum describing the scope of the epidemic of overweight and obesity among older adults and addressing the challenges faced by older adults with these conditions. Realizing that more than a passive role was needed, GSA made the commitment to enhance

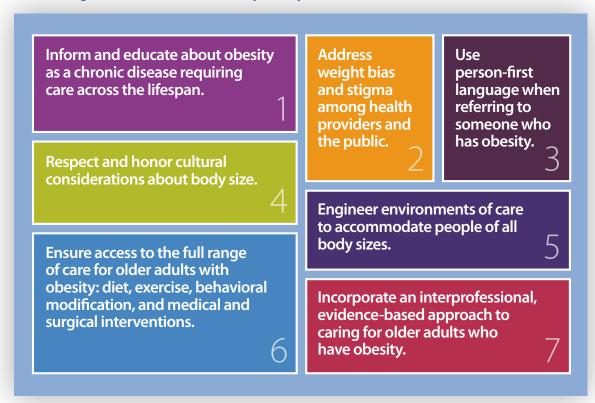
care by communicating with clinicians; seeking reimbursement for treatment of obesity through advocacy with policymakers; and educating health care providers, the public, and older adults specifically regarding the availability of and science behind new therapies and approaches to care.

The resolve of GSA to address the obesity crisis led to the hosting of a roundtable of experts in this field on June 8, 2023, in Washington, DC. A group of researchers, clinicians, and advocates were asked to address key guestions about obesity as a disease

of body weight regulation and how outdated paradigms and perceptions about obesity can be improved among health professionals, policy-makers, and the public. That meeting produced valuable information on key aspects of obesity care across the lifespan and particularly in clinical care for older adults

In this report, the roundtable's insights are presented. These insights are discussed in the framework of seven strategies, listed in Box 1, to address barriers to quality obesity care for older adults.

Box 1. Strategies to Address Barriers to Quality Obesity Care for Older Adults



Inform and educate about obesity as a chronic disease requiring care across the lifespan.







While many of the complications of obesity may not appear until later in life, today's sedentary lifestyles and excessive portions of high-calorie, highly processed foods have resulted in larger body sizes beginning in childhood. Obesity's health consequences are already evident during childhood and adolescence, including high blood pressure, high cholesterol, type 2 diabetes, breathing problems such as asthma and sleep apnea, and joint problems.^{1,2}

As people age with either overweight or obesity, these complications continue to emerge or multiply, and other chronic medical problems set in. Diabetes, cardiovascular disease, cancer, and dysfunction of other body systems are more common in people with overweight and obesity. These illnesses are likely to lead to fewer years of healthy living, increased risk of disability, risk of institutionalization, and shorter lifespans overall.³

Obesity rates for adults 65 years of age and older, defined by body mass index (BMI), have nearly doubled over the last few decades, increasing from 22% in 1988 to 42% in 2020. This increase has brought much-needed awareness to older adults and their unique needs when it comes to discussions around treatment options for overweight and obesity. The good news for today's older adults with overweight and obesity is that clinical medicine has finally recognized obesity as a chronic disease that, like others, requires multimodal management across the lifespan.

Starting with the recognition of obesity as a chronic disease in 1998 by the National Institutes of Health and through funding of obesity research, the causes of overweight and obesity have been identified, and a multitude of effective clinical interventions are available. Current evidence shows that eating and caloric intake in humans is controlled through a complicated system of gastrointestinal and pancreatic hormones and signals from certain parts of the brain. Rather than a trait that people can control through eating less and exercising more, weight is biologically regulated similar to blood pressure or blood glucose. Obesity, in fact, is a disease of weight regulation and parallels what is observed with hypertension (a disease of blood pressure regulation) or diabetes (a disease of glucose regulation). To manage obesity over the long term, treatment is needed that counteracts imbalances that lead to excessive weight gain.3

Over the past decade, numerous organizations including the American Medical Association and American Gastroenterological Association—have joined The Obesity Society and the American Association of Clinical Endocrinology by recognizing obesity as a complex chronic disease with a pathophysiologic basis. Medications now on the U.S. market are highly effective for weight loss. This recognition of obesity as a disease is important because it acknowledges that this is a medical condition that can be prevented (primary), treated to prevent worsening and development of complications (secondary), and treated if complications develop to prevent progressive disease and manage the complications (tertiary). Thinking about obesity as a disease also helps to avoid the stigma, discrimination, and bias that have been associated with the condition.5







Address weight bias and stigma among health providers and the public.

Individuals with obesity and overweight experience weight bias and stigma that further complicate their lives. In adults with overweight and obesity, an estimated 40% experienced implicit and/or explicit bias due to their weight.⁶ Exposure to overweight and obesity-related weight bias is associated with increased prevalence of morbidity, psychological distress, eating disorders, social isolation, and exercise and health care avoidance. Further, in a longitudinal study of 13,692 older adults, weight discrimination was associated with a 60% increased risk of mortality.⁷

While increased body size is viewed positively in some cultures, overweight and obesity are viewed frequently as a result of personal choices and lack of willpower. This leads to bias against people with this condition, microaggressions in everyday life, and discrimination in the workplace and other settings. Misinformation extends to the clinical setting, where health professionals are only recently learning about important advances in this field or know how to provide obesity care, and payment for effective treatments is generally denied if the patient "just" has obesity.

Unfortunately, weight-biased attitudes, including the belief that individuals have obesity because they are lazy, incapable of change, uneducated, or lack motivation, are common among health care providers.8 Health care providers who hold these biases may consciously or unconsciously spend less time with the patient, withhold or delay treatment options, show less respect, and/or associate all other health problems with overweight or obesity. Patients with overweight and obesity who experience these attitudes and behaviors are more likely to avoid clinical care and appointments that require being weighed or exposing the body; they are also less likely to trust and have open and honest communication with health care providers.9 There is an urgent need for health care providers and health care organizations to confront these biases by recognizing that obesity is a multifaceted disease with specific and treatable causes and not a failure of the individual, a character flaw, or a lack of willpower.



Roundtable participant Diane Ty reflected on the similarities between ageism and sizeism in that both "isms" often seem socially acceptable in the United States. She shared that individuals with obesity often internalize issues with their weight (e.g., feel that having obesity is their own fault) similar to how older adults internalize feelings about their age (e.g., feel that they are too old to engage in a particular activity). Several roundtable participants highlighted the intersectionality of sizeism and ageism leading to increased stigma and bias in health care and other sectors.

To provide empathic care to people of all body sizes, health care providers and staff members must first address their own biases and misconceptions about weight. These implicit biases are difficult for people to recognize and address. They can be detected and better understood using tools such as the Implicit Associations Test for Weight Bias, which is available through the Strategies to Overcome and Prevent (STOP) Obesity Alliance website.¹⁰

Resources are available to educate all staff in the medical office, including materials from GSA, as listed at the end of this report. All medical office or clinic staff—receptionists, medical assistants, and health professionals—should learn appropriate ways of talking with patients about weight and understand the disease processes that lead to chronic weight gain and maintenance of body size at unhealthy levels.

Use person-first language when referring to someone who has obesity.

Person-first language uses destigmatized, empathic terms that keep the individual at the center of the discussion. Its use is critically important in an open discussion of body size with people who have overweight and obesity.

All who care for individuals with obesity and overweight should avoid saying "obese people" and "they are obese." Instead, use "people with obesity or overweight" in the same manner as referring to patients or people who may have hypertension, diabetes, or any other clinical condition. The transition to person-first language is a difficult but vital process and may require taking some time to become normalized. However, making such a transition is very important to patients. There is value in self-correcting, particularly in public settings, to model appropriate language, even among health care professionals.



Rather than focusing solely on pounds and BMI, physicians and the interprofessional health care team should talk about what goals the older adult has and what it would mean to achieve those goals. The ultimate goal for most older adults is to engage in a healthy lifestyle, manage or prevent the development of chronic health conditions, and maintain their independence and function. Some older adults have a goal of lowering their blood pressure; others wish to decrease their knee pain. Irrespectively, the common avenue to achieve the goal is often weight reduction.

Health care providers and staff should have responses ready for common roadblocks that stop patients from addressing overweight and obesity. Appropriate and helpful responses to common patient statements are shown in Figure 1.¹¹⁻¹⁴

Figure 1. Top 10 Myths About Weight Loss and Sample Responses

It's just calories in/calories out. Anyone can lose weight by eating less or exercising more.

While weight loss does require a calorie deficit and counting calories is one way of achieving that, it is just as important to focus on the quality of foods eaten and use other interventions that can alter the complex web of hormonal and physiological systems that control the impulse to eat and how much energy the body dissipates through usual activities of life.

Cutting out carbohydrates or fat makes you lose weight.

The Dietary Guidelines for Americans 2020–2025 recommends a healthy eating plan that emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products, includes protein sources, is low in saturated and trans fats and added sugars, and stays within the person's daily caloric needs. Eliminating any major component of a healthy diet is not healthy.

Cut out breakfast.

This is one of the worst things a person can do while trying to lose weight. As opposed to helping, studies have shown skipping breakfast is associated with overweight and obesity—and the association is greater than with alcohol consumption or levels of inactivity.

It is possible to focus weight loss on one part of the body.

Exercises can be used to tone particular areas of the body where people want to lose weight, but the caloric restriction needed for weight loss affect all parts of the body.

"Elimination" diets work best for losing weight.

People need to use methods in losing weight that are sustainable and that they are able to maintain for the rest of their lives. Removing specific foods from one's diet may (or may not) be effective for weight management, but if the person doesn't want to live without the eliminated food forever, fad diets are not recommended.

Never snack!

When healthy foods such as fruits are chosen, snacks can help get people on diets from meal to meal without hunger or symptoms of hypoglycemia. Like eliminating treats, omitting all snacking is also not an intervention most people can maintain over the long term.

Eating certain foods—such as pineapple, ginger, garlic, chili peppers, onions, asparagus, or avocados—will speed up the body's metabolism and help burn fats.

No foods have been found to burn fats. People need to eat a healthy diet; if it includes these foods, that's fine, but it won't increase weight loss.

You have to go hungry.

To establish a long-term, healthy eating pattern, people actually should not go hungry. A good rule to follow is to never skip a meal and to use healthy snacks if hunger occurs between meals.

Artificial sweeteners help people lose weight.

People who drink lots of sugar-laden teas or carbonated beverages can avoid those calories by using artificial sweeteners, but most evidence shows that use of these products is actually associated with a higher body mass index and greater cardiometabolic risks.

Eliminating gluten helps with weight loss.

This is not true, and gluten-free diets are frequently low in fiber. That causes people to feel less full after meals and thereby eat more.

Source: References 11-14.

Respect and honor cultural considerations about body size.

Not all cultures view extra pounds negatively. For instance, roundtable participant Dr. Javier F. Sevilla Mártir imparted that in the Hispanic community, people with obesity are called prettier, healthier, wealthier, or even gorgeous. Gender stereotypes come into play, with excess weight on men viewed as an indication of wealth and the care provided by spouses. As a result of cultural influences and a variety of other issues, older adults may be hesitant to lose weight. Therefore, the focus of weight management conversations may be more successful if the focus is on getting healthier, not on getting a thinner figure.

During a GSA Momentum Discussions Podcast episode, Rodolfo J. Galindo, MD, Associate Professor of Medicine, University of Miami Miller School of Medicine, discussed the importance of considering a key dynamic in Hispanic families. He noted that mothers or grandmothers in the Hispanic culture are the matriarchs, and that, culturally, they run the family. Dr. Galindo explained that "they prepare food for everybody, and they enjoy bringing everybody together by eating what they have made with a lot of effort and love. So, implementing a healthier diet must be done within the family's cultural dynamic." He went on to discuss the importance of helping them understand how to incorporate healthier choices while respecting the importance of the role of the matriarch within the family.

Interprofessional teams must also respect cultural considerations around physical activity. Religion or religious practices may impact levels of physical activity. For example, including prayer in a dance program in a particular culture may motivate participation. In other cultures, exercise in public by females may be prohibited, strenuous exercise may be viewed as unfeminine, or cultural expectations around dress for women may inhibit their ability to exercise. Issues such as access to technology and economic resources are also vital considerations when interprofessional teams recommend physical activity.¹⁵

Additionally, there are racial and ethnic considerations around using BMI (calculated as weight in kilograms divided by height in meters squared), a measure originally developed to determine an average-sized European man rather than to identify someone with overweight or obesity.¹⁶ BMI, commonly used as a proxy for weight status and incorporated into product labeling of medications approved by the U.S. Food and Drug Administration and managed care prior authorization algorithms, fails to provide a direct measure of fat mass, which instigates the adverse effects of the disease. For instance, BMIs of 23.0 to 24.9 are considered healthy for most people; BMIs should be 23 or less in certain racial/ethnic groups with smaller body frames, primarily those of Asian descent. 17-21 Similarly, researchers identified racial and ethnic differences in BMI and adiposity relationships; compared with non-Hispanic White adults of the same age and the same BMI, non-Hispanic Black adults had less adipose tissue whereas Mexican American adults had more adipose tissue.²² Inconsistencies across races and ethnicities are also seen in the correlation of waist circumference to BMI.²¹ Since BMI has been central to the assessment of obesity for several decades, most clinicians rely on this measure to determine when action is needed and to talk with patients about the need for interventions. It is measured routinely in clinical practice in contrast to other validated anthropometric measures that may have better diagnostic accuracy and predict adverse outcomes in a more refined manner.

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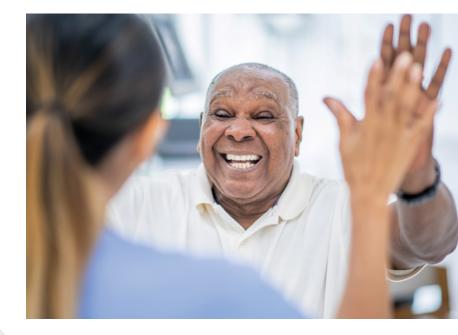
Engineer environments of care to accommodate people of all body sizes.

Older adults with overweight or obesity too often receive limited to no guidance from health professionals about weight and weight loss. Body size is a very sensitive area that is even more delicate when the bias and stigma associated with overweight and obesity have been lifelong experiences.

The messages of "you don't belong here" can begin the moment patients walk into a medical office or other clinical setting. The sizes of furniture in the waiting room, the language the staff uses, and the intake process should be enhanced to prepare the patient for a conversation about body size in the examination area.

In the waiting room, chairs appropriate for people with larger body sizes should be available. Staff need to know what language to use when talking with patients about weight-related topics. Questions can be asked about the terms the patient prefers when discussing excess weight; some are comfortable with *overweight* or *obesity*, while others may want to discuss *body size*. Educational videos and presentations can be available on monitors in the patient waiting room; appropriate images and content of magazines and other printed materials also should be available in the waiting area.

Staff should be trained to ask patients for permission to obtain their body weight during the intake process. Weights should be measured in a private area—the hallway or a common area where other people are present may add to a patient's anxiety. Accommodations should be made for patients who want to face away from the display and for those unable to rise or stand on their own for weighing. Appropriately sized cuffs should be used when measuring blood pressure. Care teams should ensure the availability of appropriately sized gowns and other body coverings.²³





Ensure access to the full range of care for older adults with obesity: diet, exercise, behavioral modification, and medical and surgical interventions.

Individuals who want to get to a smaller body size have a full range of effective, evidence-based options: dietary modifications, exercise strategies, lifestyle engagement, antiobesity medications, and/or bariatric surgery. The values and goals of the older adult related to weight management must be considered when determining which modalities to utilize in addressing overweight and obesity. For most older adults, treating overweight and obesity can add years to their lifespan and, importantly, add quality to those years. Patients must be actively involved in setting a goal for their treatment process and ultimately must be committed to their plan to be successful.

The process of the health care provider and patient setting mutual goals and deciding together on interventions is called shared clinical decision-making. Clinicians should describe the available options along with the relevant advantages or disadvantages and work with the patient to consider the options and determine which strategies that individual can commit to and incorporate into daily life.

Current guidelines recognize that patients presenting with obesity-related conditions such as cardiovascular disease or diabetes and those with obesity are best treated initially with medications in addition to the traditional dietary and exercise changes. For all individuals with a BMI of 40 or greater and those with BMIs of 35 to 40 with comorbidities, referrals to bariatric surgery at the beginning of the treatment journey are indicated, particularly since an appointment with a qualified surgeon may not be available for weeks or months. 11-15

Modern concepts of therapeutic management of overweight and obesity are driven by basic research into the mechanisms used by the brain, pancreas, and gastrointestinal system to signal the need to eat and when to stop. Medications can mimic or interrupt signals causing abnormal satiation ("hungry brain"), abnormal hedonic eating ("emotional hunger"), abnormal satiety ("hungry stomach"), and low energy expenditure ("slow burn").²⁴

By recognizing these abnormalities as the real causes of overweight and obesity, health professionals and medical organizations now know that this is a chronic disease requiring lifelong treatment. As with hypertension and dyslipidemia, long-term management of overweight and obesity is needed to reach and remain at the patient's chosen body size.

Rather than focusing on a specific weight or BMI as the goal of weight loss, the health care provider and the patient can talk about percentage reductions in body size. The provider can explain how each percentage point lost can help control diabetes, blood pressure, lipids, liver disease, and kidney disease. Progression from prediabetes to diabetes is also slowed or stopped by loss of as little as 5% or 7% of body weight.^{25, 26}

Whatever goal is chosen, the SMART process can be applied by making goals *specific, measurable, attainable, relevant,* and *time-based.* After the patient and health care provider agree on a plan, the interprofessional team and patient work

together to implement the behavioral and lifestyle changes, such as the following:

- Adhering to a healthy diet.
- Incorporating aerobic and resistance exercise into a daily routine.
- Using medications properly and safely.
- Working with a psychologist to identify new skills and ways of thinking about health choices.
- If needed, referring the patient to a qualified surgeon to determine whether bariatric surgery is an appropriate treatment.



Follow-up visits with a relevant interprofessional team member should be scheduled every three months to track the patient's progress and add new interventions if needed. Since most older adults with overweight and obesity have additional diseases, team members may include registered dietitians, nutritionists, pharmacists, physical and/or occupational therapists, and other qualified practitioners with experience in geriatrics.

Diet and Exercise

Diet and exercise are the two primary lifestyle factors that are addressed in treating overweight and obesity. As with other interventions for overweight and obesity, a lifelong commitment is needed to maintain the desired body size. Choosing the right regimen for older adults can be challenging when a person's concomitant cardiovascular, musculoskeletal, and respiratory conditions are considered. Involving the complete interprofessional team is imperative, particularly registered dietitians, nutritionists, exercise physiologists, and in some cases, physical and/or occupational therapists.

Body size can often be reduced by 5% or 10% with caloric restriction with or without antiobesity medications, but maintaining the target weight often requires meeting the physical activity guidelines recommended by the Centers for Disease Control and Prevention for most older adults: at least 150 minutes of moderate-intensity aerobic activity such as brisk walking or 75 minutes of vigorous activity per week, at least two days per week of resistance exercise that targets all major muscle groups, and activities to improve balance such as standing on one foot.²⁷



Certain key nutrients must be prioritized when dieting for weight loss. As individuals get older, the ability to stimulate muscle protein synthesis is blunted. To combat anabolic resistance, older adults should consume 1.0 to 1.2 grams of protein per kilogram of body weight per day.²⁸ Additionally, older adults undergoing weight loss are at risk of losing 25% or more of lean muscle mass.²⁹ Therefore, meeting protein and resistance training recommendations during weight loss is crucial for the maintenance of muscle mass and physical function.

The body's need for calcium and vitamin D also increases with age, ranging from 1,000 to 1,200 milligrams per day of calcium and 600 to 800 international units per day of vitamin D. Good sources of calcium and vitamin D include fortified dairy and other beverages and foods; salmon and sardines; and vegetables such as spinach, collard greens, bok choy, mushrooms, and taro root.³⁰

Fiber is another priority nutrient. The recommended daily allowance of fiber is 21 grams for women and 30 grams for men 50 years of age and older. However, many adults fail to meet these recommendations. Fiber is essential for gut motility and maintenance of gastrointestinal health and aids in managing blood glucose control and absorption of cholesterol. Further, consuming a diet rich in fiber has been associated with a reduced risk of type 2 diabetes, colorectal cancer, and cardiovascular disease. Foods high in fiber include whole grains, fruits, vegetables, legumes, nuts, and seeds. When possible, nutrients should be obtained through foods before turning to a supplement.³⁰

For many individuals on a weight loss journey, loss of protein-rich skeletal muscle tissue is common. Sarcopenia is an age-related phenomenon that results in loss of muscle mass, strength, and function. Muscle mass decreases approximately 3% to 8% per decade after 30 years of age and this rate of decline is even higher after 60 years of age. Sarcopenia is exacerbated by activity-limiting conditions or sedentary lifestyle, hormonal changes, poor nutrition, and/or altered neurologic or vascular activity. Sarcopenia can also affect people with a high BMI, in a condition called sarcopenic obesity. People with obesity and sarcopenia have a greater risk for complications than with obesity or sarcopenia alone.³¹



While it is difficult for older adults who commonly have diseases that limit their ability to participate in aerobic and resistance exercise, an on-site, high-intensity, comprehensive lifestyle program that lasts six months or more benefits participants. Such programs are associated with the maintenance of weight loss over time.³² People who are not able to access such programs can set up similar programs in the home or take advantage of programs delivered using video-based technology. Home programs can incorporate periods of exercise several times per day. This approach is useful for individuals with cognitive disorders, time limitations, and/or physical limitations. Older adults in rural areas have lost weight and improved physical function using technologybased obesity interventions.33

Medications

Several new medications and combinations of older agents have changed the landscape for people with overweight and obesity. These agents are helping older adults and others achieve the requisite net energy loss when used as adjuncts to diet and exercise. Once weight loss is achieved, medications, exercise, and diet must be continued to prevent regaining weight.

Some older drugs have adverse effects that limit their use. These medications may not be ideal for older adults who are taking other medications and have pre-existing medical comorbidities.



Newer medications that were originally developed and approved for the management of type 2 diabetes build on the advances in understanding the role of glucagon-like peptide-1 (GLP-1) hormone in weight management. Liraglutide and semaglutide are GLP-1 receptor agonists. Tirzepatide is a dual-action agent, stimulating the GLP-1 receptor and acting as a glucose-dependent insulinotropic polypeptide agonist. These agents have produced percentage reductions in weight beyond levels expected with orlistat and phentermine (Figure 2).^{32, 34-37}

Medication therapy may be appropriate at the beginning of treatment in people with BMIs of 30 or greater and those with BMIs of 27 to 30 who also have weight-related comorbidities such as hypertension or diabetes. The drugs may also be indicated in patients whose BMIs are between 25 and 27 after the first three months of treatment if diet and exercise do not produce weight loss of 5% or more. The action points for weight management are lower for people of Asian descent. Waist circumference can also affect clinical decisions.

Once an antiobesity medication is initiated, the patient must be monitored for effectiveness and side effects; the patient should be educated to contact the prescriber as needed during the first three months of use. A reassessment is in order if the patient has not lost 5% or more of baseline weight by three months. Adherence to the medication should be considered, along with intolerance, cost, and other reasons the patient may not be taking the medication as directed. If these factors are not present or the patient continues not to lose weight, the medication should be stopped due to a lack of efficacy and initiation of another medication should be considered.

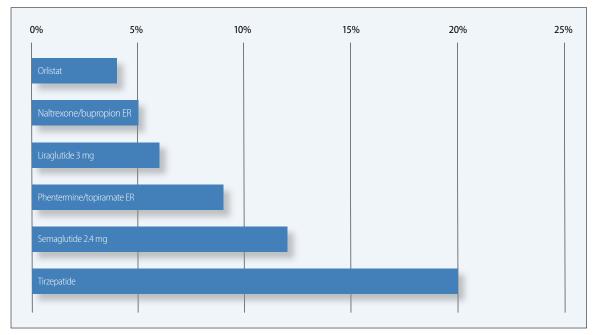


Figure 2. Percentage Weight Loss in All Adults With Antiobesity Medications

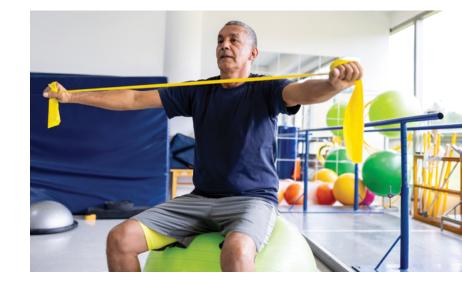
Note: This diagram presents typical weight loss with antiobesity medications. Weight loss differs between people with and without type 2 diabetes. These data are for all adults and are not specific to older adults or those with or without diabetes.

Abbreviation: ER = extended release.

Source: References 32, 34-37, and product labeling available online at Drugs@FDA.

The combinations of older drugs introduced in recent years are extended-release formulations of phentermine/topiramate and naltrexone/bupropion. Phentermine/topiramate is effective for weight loss but has similar adverse effects and concerns as when phentermine is used alone. Topiramate is an anticonvulsant agent, and patients must taper this drug combination over one week to minimize breakthrough seizures during discontinuance.³²

When these newer antiobesity medications are used to promote weight loss, the importance of nutritional and exercise interventions must be emphasized. Sarcopenia is a real risk when weight is lost without adequate protein intake and resistance exercise for maintaining muscle mass.³¹





Bariatric Surgery

When weight loss with diet, exercise, and medications is not sufficient to meet clinical and patient goals, bariatric surgery may be appropriate. The decision to proceed with bariatric surgery is not a trivial one, as patients must have an interprofessional assessment that includes an evaluation by the surgical team, psychologist, dietitian, and other allied health staff. Patients must be psychologically prepared and fully committed to following a regimen of exercise and special diets for the rest of their lives.³⁸

Bariatric surgery can be considered in patients with BMIs of 40 or greater or 35 to 40 when they have comorbidities. Because bariatric surgery can be curative for persons with type 2 diabetes sometimes within three days—the procedure can also be considered in those with a BMI as low as 30. Other postsurgical improvements are seen in weight (up to 35% weight loss), cardiovascular function, liver health, and many other systems of the body. Bone health is adversely affected by vitamin D deficiencies and increases in parathyroid hormone levels of 40% or more.31 Following bariatric surgery, individuals can tolerate only a limited amount of food at a time, putting them at risk for nutrient deficiencies. Additionally, depending on the procedure, absorption of vitamin B₁₂ may be impaired and increase the risk for vitamin B₁₂ deficiency. Education on supplements and proper nutrients is essential to avoid micronutrient deficiencies.

As with pharmacotherapy, the need for dietary, exercise, and lifestyle interventions delivered by an interprofessional team continues after bariatric surgery. Notably, given the complex care needed after bariatric surgery, an interprofessional team must be involved to address the unique health, nutrition, exercise and lifestyle, and pharmacotherapy needs of these patients.

Incorporate an interprofessional, evidence-based approach to caring for older adults who have obesity.

In older adults with overweight and obesity, the benefits of weight loss, in general, are less than in younger people. Because of this circumstance, structured lifestyle interventions with dietary modifications and exercise should be implemented with clear clinical goals such as prevention of type 2 diabetes, reductions in blood pressure, and/or improvements in mobility and conditions such as osteoarthritis that limit physical function.

Older adults should be cared for by an interprofessional team during the weight loss process to ensure that the clinical goals are achieved without compromising overall health or other conditions. Patients may need long-term contact with registered dietitians, exercise physiologists, physical and/or occupational therapists, social workers, pharmacists, and other involved members of the health care team.

The efforts of the interprofessional team are best applied within a structured program, preferably one shown effective in clinical trials. The ultimate goal is precision nutrition and precision medicine in which each person receives the exact diet, exercise program, medications, and other interventions that are best for that individual. Until this goal is achievable, professional guidance using a team approach can ensure optimal care.









Conclusion

More so now than ever before, people are entering older adulthood with another serious, progressive chronic disease to manage: the disease of obesity. While contemporary methods of treating this chronic disease exist, a variety of issues—including stigma and bias, lack of insurance coverage of the full continuum of care, and the lack of widespread recognition of obesity as a disease requiring treatment across the lifespan—continue to limit many older adults' ability to access quality obesity care. GSA convened the June 2023 roundtable to examine the barriers and identify solutions to address them.

Participants in the GSA roundtable identified the need to overcome outdated perceptions of obesity and overweight, communicate appropriately with older adults about their body size, and address cultural differences in obesity care. They also raised the importance of providing care in conjunction with treating common comorbidities faced by older adults, acknowledging that obesity is often at the root of these comorbidities. They emphasized the need for collaboration among the interprofessional team to care for older adults with obesity and the need for team members to assist older adults to overcome barriers to implementation of lifestyle changes, including diet and exercise; incorporate medical and surgical interventions, as appropriate; and align the needs of older adults with community resources. Based on the roundtable findings, GSA calls on individuals, health care systems, and society to implement the seven strategies identified in this report and bring obesity management to the forefront of care for older adults.

Resources

Related Resources From GSA

- GSA KAER Toolkit for the Management of Obesity in Older Adults
- Insights & Implications in Gerontology: The Chronic Disease of Obesity
- Obesity in Older Adults: Succeeding in a Complex Clinical Situation
- The Gerontological Society of America KAER Toolkit for Brain Health
- Malnutrition Resources and Infographics
- Sleep Health
- GSA Momentum Discussion Podcasts on Overweight and Obesity
- GSA Journals—The Journals of Gerontology Series A and Series B, The Gerontologist, Innovation in Aging, Public Policy & Aging Report

Other Resources

Academy of Nutrition and Dietetics

- Dietary Intake and Physical Activity Measurement Tool (Academy members only)
- Section on Weight Management
- What Resources Are Available to Assist in Assessing Body Weight in Older Adults? (Academy members only)

American Academy of Physician Associates

- Obesity Intake Form
- Obesity Management in Primary Care Certificate Program: Practice Management and Leadership Training for PAs and NPs

American Association of Clinical Endocrinology

Nutrition and Obesity

American Association of Nurse Practitioners

- National Obesity Care Week: Increasing Access to Care
- Obesity Specialty Practice Group

American College of Occupational and Environmental Medicine

- Books and resources on obesity in the workplace; impact on employee costs and absenteeism
- Obesity in the Workplace: Impact, Outcomes, and Recommendations

American College of Physicians

• Obesity Management Learning Series

American Council on Exercise

- Senior Fitness Specialist Certification Program
- Take 5 With Dr. Amy Bantham: Move to Live More
- Fully Vaccinated? Here Are Some Guidelines for Returning to Physical Activity
- Linking Physical Activity, Therapies and Mindfulness for Healing

American Gastroenterological Association

- Obesity Awareness Highlights—Pharmacotherapy and New Initiatives
- Obesity and How It Affects GI Patients
- · White Paper AGA: POWER—Practice Guide on Obesity and Weight Management, Education, and Resources

American Medical Group Association

- Obesity Care Model Collaborative (Association members only)
- Obesity Care Model Collaborative: Resource Guide (open access)

American Psychological Association

- Obesity webpage
- Links to relevant books such as Dieting, Overweight, and Obesity

American Society for Metabolic and Bariatric Surgery

 General information on older adults, including articles on "older adults" in the Society's journal, Surgery for Obesity and Related Diseases

American Society for Nutrition

• Rethinking the problem of long-term weight management

Black Women's Health Imperative

• Diabetes and Prediabetes

Centers for Disease Control and Prevention

• Adding Physical Activity as an Older Adult

ConscienHealth

Affiliates and Advocates (networking and research)

Health.gov (website coordinated by the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion)

- Move Your Way Community Resources—Materials for Older Adults
- · Physical Activity Guidelines for Americans Midcourse Report: Implementation Strategies for Older Adults

MedTech Coalition for Metabolic Health

- Supports view of obesity as a multifactorial chronic disease requiring a comprehensive approach
 to prevent and treat
- Founding members are seca, KORR Medical Technologies, and LEVL

National Alliance of Healthcare Purchaser Coalitions

· Obesity Initiative; actions for employers about obesity; benefit design consideration regarding bariatric surgery

National Institute of Diabetes and Digestive and Kidney Diseases

- Stay Fit as You Mature and Health Tips for Adults
- Strategic Plan for NIH Obesity Research
- NIDDK-sponsored clinical trials on overweight and obesity
- Definition and Facts for Adult Overweight and Obesity
- Treatment for Overweight and Obesity

National Institute on Aging

- Maintaining a Healthy Weight
- The obesity-linked gene
- Overcoming Roadblocks to Healthy Eating
- Healthy Meal Planning: Tips for Older Adults
- Summaries of studies showing relationships between obesity and conditions such as dementia, sleep, loneliness/social isolation in older people
- Four types of exercise for improving health and physical ability in older adults: endurance, strength, balance, flexibility

Obesity Action Coalition

- Position Statements on a comprehensive medical approach to obesity prevention and treatment, coverage by health insurance as standard benefit, and discrimination and care issues
- #StopWeightBias Campaign
- Overview of Advocacy in Obesity

The Obesity Society

Position Statements

Trust for America's Health

• The State of Obesity 2020: Better Policies for a Healthier America

WW

- Weight Watchers Reimagined
- Programs on food, activity, sleep, mindset, personal assessment, and behavior change

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