Addressing the Chronic Disease of Obesity

Applications from the GSA KAER Toolkit on the Management of Obesity in Older Adults

Momentum Discussions Podcast from The Gerontological Society of America

Aired November 9, 2023 at GSA 2023 in Tampa

Guests:
Kathryn N. Porter Starr, PhD, MS, RDN
Associate Professor, Duke University School of Medicine
Research Health Scientist, Durham VA Medical Center

John A. Batsis, MD, FACP, FTOS, AGSF, FGSA
Associate Professor
Division of Geriatric Medicine, School of Medicine
Department of Nutrition, The Gillings School of Global Public Health
The University of North Carolina at Chapel Hill

Host:
Jennifer Pettis, MS, RN, CNE
Director of Strategic Alliances
The Gerontological Society of America

Announcer:
The Gerontological Society of America, meaningful lives as we age.

Jen Pettis:
Welcome to this GSA Momentum Discussion podcast episode, Addressing the Chronic Disease of Obesity. Momentum Discussions highlight topics experiencing great momentum in the field of gerontology. We're grateful to Novo Nordisk for their support of the GSA KAER Toolkit for the Management of Obesity in Older Adults and today's podcast. My name is Jen Pettis and I'm the Director of Strategic Alliances at the Gerontological Society of America. I'm delighted to serve as a host for today's Momentum Discussion podcast being recorded from the podcast booth at GSA 2023 in Tampa, Florida.

Jen Pettis:
Joining me for this podcast is Dr. John A. Batsis, a geriatrician and an associate professor in the Division of Geriatric Medicine in the School of Medicine and the Department of Nutrition in the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill. Also joining me is Dr. Kathryn Porter Starr, a registered dietician and an associate professor at Duke University School of Medicine, as well as a research health scientist at the Durham VA Medical Center. As I mentioned, we're recording this podcast at GSA 2023. Drs. Batsis and Starr, thank you for taking time out of your busy schedule to participate in GSA's Annual Scientific Meeting here in Tampa, for all your contributions to our GSA KAER Toolkit for Obesity, and for sharing your insights with me during this time together.

Dr. Kathryn Starr:
It's such an honor to be here and thank you for having us.

Dr. John Batsis:
Really a pleasure, Jen, and thank you again for the opportunity to chat with you and our GSA membership.

Jen Pettis:
Let's start by talking a bit about perceptions around obesity. Dr. Batsis, how well is obesity understood as a chronic disease by different audiences? For example, can you address the understanding of obesity as a chronic disease among healthcare professionals, in the public in general, and with older adults? How do these perceptions perhaps vary by racial or ethnic groups or other characteristics?

Dr. John Batsis:
I think this is a great introduction to the topic of obesity and weight in older adults. Obesity was designated as a chronic disease by the American Medical Association several years ago. The challenge here is whether it really has been implemented and accepted as part of being a chronic disease by healthcare practitioners. That's the big question that we need to ask ourselves. It really needs to be viewed along the lines of hypertension, diabetes, high cholesterol, and other comorbidities. We need to consider it as a chronic disease, not as a failure of behavioral management among patients across the entire lifespan. It's about biology. Everybody is an individual and, with each chronic disease, it's a biological basis of what triggers the onset of the disease.

I think there's been a challenge amongst healthcare providers. A major component has been a lack of education in their training. Different healthcare practitioners and physicians have different degrees of medical school training in what obesity is, its causes, and how to treat it. In the past when I went through training, we didn’t receive a lot of nutrition-related education. Thankfully, things are changing, and a first good step is obesity being recognized as a chronic disease. Additionally, we have board certification in obesity medicine, which is really enhancing the importance of obesity as a disease that needs to be managed accordingly. The challenge with the public is a good one to talk about. We have negative stigma and a lot of biases towards persons with obesity in our society.

We really need to be thinking about it differently. Patients and people with obesity are not just lazy. They're not just in a position where they failed or have an inability to change their diet or exercise. A lot of folks do try. We really need to be thinking about how we target everyone individually. Everybody is different, and a one-size-fits-all strategy doesn’t address this major epidemic. Individual strategies are critically needed.

Dr. John Batsis:
Lastly, we know that there are a significant number of racial and ethnic disparities in obesity care. A major component of this has to do with access to care. I know we're likely going to talk about that a little bit later, but importantly, social determinants of care and recognizing that everybody has different backgrounds and areas of privilege compared to areas of non-privileged rural or urban areas. These are just some small examples, but these all impact the differences in the heterogeneity that we see in older adults' obesity in general. It's complex, and I think that's really a major take home point. There isn't one solution. It's really a multifactorial based solution.

Jen Pettis:
Thanks for that introduction. Great information. Dr. Starr, how is obesity linked to other chronic health conditions and risks for functional decline and decreased independence in older adults?

Dr. Kathryn Starr:
That's a great question, and I just want to say it's such an exciting opportunity to be here with Dr. Batsis and the synergy gets me so excited about this topic area and the movement that we're heading towards in trying to address all the things that he mentioned. As we're thinking about obesity as a disease, it's important for us to think about the biological components of obesity and other chronic health conditions and inflammation. Chronic low-grade inflammation is a major contributor to those associations with obesity, cardiovascular disease, insulin resistance, type 2 diabetes, and numerous other chronic health conditions. Thinking about the quality of the muscle as we're aging, coupled with the physiological changes that come with age, anabolic resistance is a concern. We know that we are going to see a decline in muscle mass and muscle quality and function as we get older.

It's naturally occurring. However, when we have an inflammatory component mixed in with the natural aging process, we know that it's going to contribute to a decline in function. Add to that excess adiposity, consider muscle quality and the ability for the body to function and the muscles to function. There is going to be an impairment in us being able to do the activities of daily living and things that we love to do. As we're thinking about the correlations and associations with obesity and other chronic health conditions and that functional decline, I think coming back to what the physiology is that's happening in the body when we're thinking about excess adiposity, which is important. We're moving into this conversation about treating obesity as a disease, I think that really helps paint the picture that it's not about willpower. It's not about someone's just not trying hard enough or they're not willing to put in the effort or time. Let's think about it as a disease state. Let's think about how we can treat that with multiple modalities and understand that yes, there is a behavioral component to this, but that's one component that we must include in that conversation. I think that multiple chronic condition state is really another great area where we can kind of home in as we're continuing this conversation around obesity and obesity as a disease state.

Dr. John Batsis:
I really want to hit home what Katie just shared. It's about biology and we've only in the last 10 to 15 years, have really gotten a great understanding of the biological basis of obesity itself as a disease. Once we understand that, then we can target biology. Some of the newer medications, some of the strategies are really affecting underlying biology. You're hitting the underlying issue with adjunctive types of therapies.

Jen Pettis:
Dr. Batsis, you mentioned earlier about different racial and ethnic groups, and I wonder if you can tell us a bit about prevalence of obesity in older adults between some different groups. There is a significant issue in health disparities between urban and rural populations. Could you comment on that as well as ethnic and racial differences?

Dr. John Batsis:
First and foremost, we need to be thinking about how we define obesity. Particularly in older adults, that really is a major challenge. In clinical care, we frequently use body mass index (BMI). We know that as one ages their height changes, as well as body composition, as Katie mentioned, and in terms of the loss of muscle mass and muscle strength with age. This really changes that ratio of weight over height in meters squared. Body mass index is not a great indicator for adiposity in older adults. We know that its diagnostic accuracy diminishes and reduces with age. Waist circumference is probably a better indicator. Using both is probably even better as an indicator. I just want to mention a couple of caveats. Our healthcare system is not able to measure body fat on everybody, at least at this stage.

Most estimates are using body mass index for good or for bad. It's just the way it is from a population-based standpoint. When we look at the most recent data, and again, depending on the survey that's used, for instance, the National Health and Nutrition Examination Survey, both in males and females using body mass index of over 30 kilograms per meter squared, the prevalence rate is approximately 42% to 43%. 70% of our population, both older and younger and middle age or younger adults over the age of 18, are classified as having obesity or being in the overweight category. This is a true public health epidemic. Irrespective of the challenges that we've had over the last couple of years with COVID-19, some of the long-term estimates have shown that our life expectancy is starting to be affected.

When you do a deeper dive and notice different populations at risk, a lot of developing countries are now assuming a lot of industrialization. We see a lot of their rates increasing in urban versus rural settings, which is where we see disparities. A lot of that has to do with healthcare access challenges. Disadvantaged communities include tribal communities. They have poor access to care, fewer resources than others, and their rates of obesity are much higher alongside other chronic conditions. Every population has different targets in terms of potential causative reasons. Someone in rural North Carolina versus in rural Florida, one rural is one rural is one rural. You can adapt that according to every type of demographic. There are a lot of similarities, but there are a lot of differences, and we really need to be understanding some of these health equity issues.

Jen Pettis:
Dr. Starr, this seems like it might be a simple question, but I suspect it's not, and that is, why is it so important to intently address obesity in older adults?

Dr. Kathryn Starr:
We know that our older adults are very heterogeneous. When we are working with our older adult patient population, we have the saying, "when you've seen one older adult, you've seen one older adult." It's not just the physiological changes, it's the social determinants of health that are included in the factors that promote obesity. It's the education, it's the racial differences, it's the ethnic differences, it's the trauma potentially from childhood that's not been dealt with.

Dr. Kathryn Starr:
There's just so many components included in how we're thinking about obesity and how we're thinking about the treatment of obesity. Consider how society views food. Food is social, food is love, food is gathering, food is celebration, and food can be sadness. There's also this other relationship that we have when we're thinking about the relationship we have with food too, and that is you. We must put that into the model.

When we're thinking about the biology of aging, the social determinants of health, giving education about proper intake and what your energy needs are, how you're treating this with another chronic health condition, and then how we're dealing with some of the psychological components, this cannot be tackled by one person. The PCP cannot be the one person who's helping to treat and manage and work on this obesity treatment management while maintaining our patient-centered approach with the individual. I think that unfortunately our healthcare system is not necessarily built for that interprofessional approach to care for obesity. We have seen this interprofessional approach work in bariatric surgery models, and we've seen it work in cancer models. We've seen it work in other chronic health condition models. I know that we can make this work.

We must tackle this; this is an epidemic. We're talking 70% of the population is in that overweight category. It's just going to continue to become a problem that we must address. It's not just a quick fix. It's not just a new medication. We really do have to tackle this from all these angles, which is why it must be with intent. The other major component is meeting our older adults where they are and bringing them into this conversation. We need to be their partner alongside them in this process, rather than imposing a treatment plan on them. We need to discuss what is the plan that we're going to be working on together? What is the interprofessional plan and how do we continue that continuity of care? It's not a 15-minute visit; it can't be, right? I think we're trying to treat it as a 15-minute visit, and that's why we're not really seeing a lot of movement here in obesity management and treatment.

Dr. John Batsis:
I think that's exactly the fundamental issue. You just nailed it right there, Katie. You can't do this in 15 minutes. Older adults come to the primary care clinician with their list of 6 or 7 items during a 15, 20, even, let's give it 30-minute visit. They're not going to get to number 6 or 7, which is often where weight and weight-related health promotion comes. They are more worried about their knee pain, they're more worried about their shortness of breath, their waking up and being exhausted, which may all fundamentally be part of the obesity itself, but it's lower on their list and it's lower on the provider's priority list.

From a patient standpoint we need to meet the patient where they are, and from a primary care standpoint, there is an infrastructure challenge. I think a huge infrastructure challenge, which regrettably or not comes full circle to reimbursement, because that's what our system is all about. We predominantly have a fee-for-service rather than value-based care. We haven't even touched upon the surface of community-based resources here. It's like a hub and spoke model where the PCP can potentially be the coordinator, but you really need a team. I think we need to really emphasize, highlight, bold face, and underline that.

Jen Pettis:
The assessment piece is that older adults themselves need to be included as part of that inter-professional team or interdisciplinary team, as they begin to support this individual on their weight loss journey. What are some key tenets of that assessment that PCPs and others need to take into consideration, Dr. Starr?

Dr. Kathryn Starr:
The geriatricians and the gerontologists in the room are always going to come back to what matters most to the patient. That's fundamental in what we're taught and in how we work with older adults. However, that is not fundamental across the board. The patient must be at the forefront, as we said, and really thinking about what does matter most to them. What about mobility? What are the four Ms? Or what are the 5 Ms, including multi complexity, mind, medication. We need to consider how they impact the older adult and how they also cross over into obesity treatment and management. There is a component for each of those. If we think about what matters most from an obesity treatment standpoint, we're thinking about mobility for obesity treatment standpoint, multi complexity, right?

We're the cognitive component here and everything we're working on in cognition is part of a crossover within obesity treatment, but we haven't quite made that leap. From an assessment standpoint, putting the patient first and making sure that we're all on the same page, our goals make sense, and we're following along and following suit with where the individual older adult is. One of the conversations that happened yesterday was that you can't take somebody from pre-contemplation to behavior change in a day. There are baby steps in having those conversations. From an assessment standpoint, we know we need to be thinking about weight and body composition.

We need to be thinking about sarcopenia and how we're measuring the loss of muscle function, loss of muscle strength, and whether that's speed, whether that's hand grip strength, or whether that's chair stands. We need some form of a functional component in there so we can truly capture what is their functional status, what is happening. I think that's key. We're not doing that across the board. One of the other things that I think is also paramount to this is making sure that we know where the person's at in this process. This is not just a quick fix. This is going to take time, and this is going to take some work, but it takes work from the entire team. I love what John was saying about creating this hub system where we have these resources out there where if we identify during an assessment that is access to food, we can get them out to a community-based organization.

But there needs to be cross-communication between the PCP, the registered dietician, as well as the community-based organization, and social worker. It's important to know that when a social work consultation is put in because we see that there's food insecurity, we can confirm that they received the meal. Is the dietician able to help with the medically tailored meals? If they have multiple chronic health conditions and were just put on the wait list for Meals on Wheels, the PCP cannot be the one that's following up on all of this. From an assessment standpoint, what is the patient's functional status? How are they moving? How does that quality muscle mass look? As we're thinking about treatment options, are there some community-based organization resources that we can refer people out to? Are we identifying those social determinants of health that we need to? From the treatment component, if we're prescribing diet and exercise, do they have the resources to do this?

Dr. Kathryn Starr:
If they do not, where are those resources? How do we get those resources and how do we have those conversations? Assessment is crucial. I think when we're thinking about assessment, we often have those blinders on and we're just thinking, BMI, body composition, waist circumference, and it's so much more than that. We've already covered all those things. My thoughts around this idea are about having this comprehensive assessment, which can't be done in 15 minutes. It's going to have to be across disciplines, across professions, and coordination of that care and communication of care.

Dr. John Batsis:
This comprehensive assessment really needs to incorporate core geriatric principles. That includes thinking about geriatric syndromes as well as the social behavioral components. A comprehensive geriatric assessment can't be done in 15 minutes. How are you going to be able to do all this all at once?

Dr. Kathryn Starr:
I love that because I think if we're looking at obesity assessment, obesity care, we need to be going back to that model of the geriatric assessment and thinking about how are we aligning that with the geriatric assessment and how are we crossing over with that? Very few people have geriatricians. We need more geriatricians.

Dr. John Batsis:
We also need more folks trained in geriatrics or with geriatric skills. Neither the United States nor elsewhere is going to be able to develop more geriatricians or geriatric care providers. Therefore, we need an understanding and focus of adapting our existing infrastructure. Our annual wellness visit is a great opportunity to incorporate some of the core geriatric assessments and functional assessments that are important in managing persons with obesity.

Jen Pettis:
We have just a few minutes remaining, and I want to spend those talking about treatment plans. We've talked about assessment, Dr. Starr, would you address dietary and physical activity interventions? One thing that comes to mind here, and I'd love to hear your thoughts on what we need to do differently is when an older adult has pain in their knees and needs that knee replacement and the orthopedist tells them that they must first lose 20 pounds. How does someone like you help them meet that goal safely and effectively with these interventions?

Dr. Kathryn Starr:
It's such a great question, and we see this all the time. We see this a lot where we have an individual who is really in a lot of pain, however, they're an individual with obesity, and the surgeon is just not willing to take them to the operating room until they've lost weight. What I see happening in my clinical setting is I get the individual who has then really reduced their dietary intake and really focused on trying to get to a specific BMI level. They know they need this so that they can move. We are seeing this loss of weight, but it's loss of muscle mass and its loss of function. By the time I'm getting them in there, they're not even able to get up out of a chair. We need to improve the communication part of this. We must make sure if we're telling someone that they must lose weight to get a treatment, they are given the resources and guidance and consulting.

Dr. Kathryn Starr:
One of the key things that I do in my clinic, and what I have done with my orthopedic surgeons is really talk to them about, “Hey, I understand that this is the requirement that we have for surgery. I get that. How can we work together?” If we have somebody, they're now putting in a consultation for a registered dietician so that we can see the patient and help them with that weight loss safely. We help them with that weight loss in a way in which we make sure that they're getting enough adequate protein, they're getting enough micro and macronutrients, and that we're doing that in a safe environment so that when they do lose that weight, they're going to be able to go into the operating room and they're going to be able to get back to that functional baseline status more quickly.

One of the key concerns is making sure that we're not just telling people they need to lose weight, or they need to move more. We must be more purposeful with our comments because older adults are listening to what is being told to them, especially if pain is on the line. They're going to do something to get out of pain. We see this across the board. From a lifestyle intervention perspective, there are several things that we must think about. As a result of the that John and I do, I constantly focus on muscle and physiology because it just helps me really capture that ability to think about what's happening to the muscle, and what's happening to the individual itself. We need to focus on what we need to do so that they can have that movement and keep that mobility so they can keep that functional status so they can keep their independence.

I want to make sure that we're thinking about muscle with weight loss and one of our focuses is not just promote movement, but purposeful movement. It's about doing strength training so that we can truly help keep that muscle mass as strong as possible, especially when we're thinking about weight loss. Regardless of weight loss, we really do need to be thinking about strength training. Unfortunately, only around 20% of older adults are doing any form of strength training exercises. From a nutritional and dietary standpoint, we're really thinking about making sure that they're meeting micro and macronutrient intake, but also making sure they're getting in that protein intake and doing anabolic resistance to building muscle mass. Resistance training is important for stimulating muscle protein synthesis is something that we consider when we're thinking about older adults and protein intake, especially when we're thinking about weight loss. Finally, we do need that aerobic exercise. It's a combination of all three of these making sure that we have a purposeful diet that includes high quality protein and making sure that we're thinking about not only aerobic exercise, but also resistance training so we can really maximize muscle health and help these individuals lose weight in a way that they can keep that muscle mass, as much as they possibly can.

Jen Pettis:
You mentioned a few minutes ago about potential trauma someone might have experienced in the past and other things that might be contributing to their obesity or their overweight. Can you comment a bit on psychological and behavioral services for an older adult when they're on this journey?

Dr. Kathryn Starr:
Absolutely. When we consider substance abuse disorders, and we go to the literature around addiction and substance abuse, the psychologist is one of the key players in that, because this is something that we should find the root cause of to start the healing process. A lot of times the psychologist is not a part of the weight loss journey or the weight management journey, and it should be because we have ties to food.

Dr. Kathryn Starr:
If we've had some trauma, or if we're using food as a way to fill something inside of ourselves, we really have to work on that regardless of what treatment we do. If we're not fixing that internally, there's going to be another void that has to be filled and it's going to be filled with something else.

Having the psychiatrist on board is such a crucial component. I think they're frequently missing on the team when we're putting together who is on the team for obesity treatment and management. They really do need to be a part of that conversation so that we can really help. One of the great models is the VA Move Program. It includes an exercise physiologist, a registered dietician, and a psychologist. All three of those working together to really help change behavior, educate, and work through some of the components that might be dealing with trauma or psychological connections that we're utilizing food to fill a gap.

Jen Pettis:
Dr. Batsis, the last question is for you. What are the roles of pharmacological and surgical interventions in care for older adults?

Dr. John Batsis:
I was waiting for that question, Jen, and it's not a short answer unfortunately, but I'll try to summarize it. We have all been exposed to a plethora of new anti-obesity medications, particularly the GLP-1 agonists. Another one was approved just earlier this week. I think there's a lot of promise with these medications. The clinical trials have really demonstrated significant amount of weight loss in these populations. As with any clinical trials though, you really want to dissect the studies, you want to see what, where, and with whom were these clinical trials done, in terms of what was the patient population and what were the characteristics of those patients? Most of these trials are not related to older adults. Very few trials have had a significant number of older adults in their cohorts. There are some, but the majority are not.

That's first and foremost. Why is that important? Circling back to our earlier conversation, the biology of an older adult is very different than the biology of a 20, 30, 40 or 50-year-old. We need to be very mindful of that. That’s not to say not to use them, but that's not to say we should completely use them in everybody. They should be considered as adjunctive therapies to lifestyle therapies of improving dietary quality and aerobic and resistant exercise. The reason for that is the weight loss that is observed with these GLP-1s is particularly high. It's almost on par with what you see with bariatric surgery. We know from the bariatric surgery literature, when you lose weight, you're losing both fat and muscle. This comes back to the issue of weight loss induced sarcopenia. We haven't even talked about the effect on bone, but that's a discussion for another day.

How do we mitigate that and who are the appropriate candidates? I would love to say I have good evidence for you, Jen, and our listening GSA members, but we don't have good evidence here. There are minimal studies of looking at body composition changes in older adults because of these medications. We know that weight loss on its own without aerobic and resistant exercises leads to disproportionate reduction in muscle mass and strain. Individuals who are on these medications should probably be well positioned to undergo a structured exercise routine, whether they should be initiating that at the time of the medication or not is unknown. The hope is that they have been engaging in changes in their diet and exercise. They have that foundation, and then you're adding on top of that the GLP-1, so you're not starting an exercise routine de novo. I think that's what I'm afraid of in this population.

Dr. John Batsis:
From a surgical standpoint, there's been more literature in older adults, with a lot of methodological challenges in the literature. How do you define older adults? Is it age? Is it functional status? The big centers, there are bariatric surgery centers of excellence. Type of surgery is important. Open versus laparoscopic, importance of cognition and social support all play into factor. You're hearing a lot of the same themes, comprehensive geriatric assessment in the evaluation of our patients.

Jen Pettis:
Well, thank you both. This was a great discussion. Thank you for joining us here at GSA 2023 in our podcast booth. We are so lucky to have you guys as GSA members and such close collaborators, and we really appreciate your support of our obesity work. Thank you both.

Dr. John Batsis:
Thank you again for the opportunity.

Dr. Kathryn Starr:
Thank you, Jen. This was great.

Announcer:
The Gerontological Society of America was founded in 1945 to cultivate excellence in interdisciplinary aging research and education to advance innovations in practice and policy. For more information about GSA, visit geron.org.