WEBVTT

1
00:00:08.340 --> 00:00:20.720
David White: Thank you, everyone, for joining us today as we unpack and explore the tremendous shifts we are seeing in the weight loss world with us to cover a range of topics. Our Dr. Jennifer Pena, and Dr. Mohit, Joshua Pere.

2
00:00:21.340 --> 00:00:30.160
David White: Dr. Pena, is a board certified Internal Medicine Physician, with over 15 years of clinical experience, specializing in digital and telehealth.

3
00:00:30.740 --> 00:00:36.680
David White: She is the co-founder and chief medical officer of measured a weight loss. Telehealth Company.

4
00:00:37.120 --> 00:00:45.170
David White: Her career includes leadership roles, such as chief clinical officer at vault, health and chief medical officer at K. Health and Nurex.

5
00:00:45.930 --> 00:00:53.160
David White: Dr. Joshua is a board certified internal medicine position. who thrives in developing digital health solutions.

6
00:00:54.000 --> 00:01:07.649
David White: As a leader in startups. He's developed numerous virtual and hybrid clinical protocols excelling in interdisciplinary collaboration Dr. Joshua puris telehealth experience. Ranges from startups to fortune. 500 companies.

7
00:01:08.010 --> 00:01:20.469
David White: Thank you. Both Jen and Mohit. Also we have 2 quick notes before we begin. Firstly, please use the Q. And a function for any questions you might have. We'll circle back to answer some at the end.

8
00:01:20.730 --> 00:01:27.430
David White: Secondarily, there's a brief survey available post, Webinar. We encourage you to fill out for a chance to win a giveaway.

9

00:01:27.740 --> 00:01:33.590
David White: Look for the survey, icon at the bottom of your screen again. Thanks for joining us in. Let's dive in.

10
00:01:35.580 --> 00:01:48.489
David White: We're starting today's discussion by acknowledging a significant shift in our approach to obesity management. The shift comes with the introduction of glp. Once these breakthroughs are transforming, how we view and treat obesity.

11
00:01:48.520 --> 00:02:02.769
David White: They're also highlighting the limitations of traditional dieting products that we have relied on for years. Amid these revelations, we hold on to an important principle. The most successful diet is the one that can be maintained over time.

12
00:02:03.300 --> 00:02:07.600
David White: This principle is backed by extensive research, including studies from Harvard.

13
00:02:07.750 --> 00:02:13.829
David White: But it's clear people need more support as obesity continues to be a serious public health issue.

14
00:02:15.430 --> 00:02:21.910
David White: In response, our government has stepped up. They've launched the comprehensive national strategy on hunger, health, and nutrition.

15
00:02:22.240 --> 00:02:29.750
David White: This initiative is aimed at helping people make better choices. We're going to dig deeper into the complexities of obesity.

16
00:02:29.960 --> 00:02:38.709
David White: We'll look at how our views have shifted from seeing obesity as an individual problem, to understanding it as a disease influenced by our surroundings.

17
00:02:38.750 --> 00:02:45.670
David White: We're going to explore the roles of virtual care technology and new pharmaceuticals in this battle against obesity?

18
00:02:46.540 --> 00:02:50.609
David White: Why is obesity such an issue? okay.

19
00:02:52.130 --> 00:03:05.470
Mohit Joshipura MD: hey? Everyone One of first. thank. I HD David and the rest of the team for having me on here. It's a real pleasure. And looking forward to this conversation and sharing the stage with with one of my very close friends and and colleagues Dr. Jennifer. Pana.

20
00:03:05.490 --> 00:03:22.090
Mohit Joshipura MD: So yeah, that's a that's a great question, David, to start off on, why is obesity a progressive and complex disease? A. And how that perspective has shifted over time? Specifically in the recent past from a person centric concept to an environment central concept.

21
00:03:22.200 --> 00:03:35.820
Mohit Joshipura MD: I think it's important to understand that for time immemorial the convenient answer to the obesity epidemic has always been that it was mostly self inflicted. you know you are obese because you don't eat right, and you don't exercise.

22
00:03:36.060 --> 00:03:42.400
Mohit Joshipura MD: and I'm not undermining or discounting the importance of lifestyle and the obesity ecosystem at all.

23
00:03:42.430 --> 00:03:45.219
Mohit Joshipura MD: But we now know for a fact that there is much more to it.

24
00:03:45.880 --> 00:04:00.049
Mohit Joshipura MD: Aside from choice. You know, there are genetic factors, environmental factors, social determinant of determinants of health factors, all of which play a key role in understanding and treating obesity in a comprehensive manner.

25
00:04:00.450 --> 00:04:09.200
Mohit Joshipura MD: We also now know that obesity has been implicated in a variety of of chronic diseases, whether it's heart disease or diabetes, or sleep. Apnea, even cancer.

26

00:04:09.370 --> 00:04:21.529
Mohit Joshipura MD: and so figuring out sustainable and cost-effective strategies. To target this in a comprehensive manner at an individual level, but also at a societal level, becomes very critical.

27
00:04:27.770 --> 00:04:33.230
David White: And, Jen, what are some of the dangers or side effects you're seeing of long-term glp use today.

28
00:04:36.750 --> 00:04:51.699
Jennifer Peña, MD, FACP: Hi, David! I echo. Dr. Go ahead just for a sentiment. Thank you. And I HD from a seems amazing webinar. And likewise I couldn't ask for sharing this stage any better than you you 2 gentlemen. So thank you.

29
00:04:51.710 --> 00:05:03.110
Jennifer Peña, MD, FACP: you know. Obviously, we're seeing a you know, a tremendous increase in the use of these ones, and a lot of the side effects inside. Different profiles are are hitting the news

30
00:05:03.160 --> 00:05:12.599
Jennifer Peña, MD, FACP: in a very sensational way. you know, these aren't new medications right. These medications have been around. And I'm talking specifically about the

31
00:05:12.690 --> 00:05:24.950
Jennifer Peña, MD, FACP: A of a fair amount of years. And and you know, we have a lot of experience in utilizing that the treatment type meetings But obviously, now you didn't utilizing them to this communication. You know.

32
00:05:24.950 --> 00:05:43.780
Jennifer Peña, MD, FACP: we're already there. and some maybe potentially so. For example, just recently, you know, we got a lot of attention to the stomach paralysis issue or gastric, which, again, we we already know as part of the side effect profile. And

33
00:05:43.820 --> 00:06:11.770
Jennifer Peña, MD, FACP: you know there's also this issue with the fact that a lot of people have a gastrophe is already under lying, or they have diabetes with gastrophes that get to get exacerbated by. But recently the American site anesthesia has made it, you know, a a recommendation to carry off with the things the up to, you know,

prevent

34
00:06:12.230 --> 00:06:18.940
Jennifer Peña, MD, FACP: But again, this is not necessarily new, but it is one of those side effects that we have to.

35
00:06:19.390 --> 00:06:21.720
Jennifer Peña, MD, FACP: also, recently, a lot of attention.

36
00:06:44.600 --> 00:06:51.980
Jennifer Peña, MD, FACP: And then there's, you know the

37
00:07:07.440 --> 00:07:08.210
David White: well.

38
00:07:08.600 --> 00:07:22.320
David White: yeah, it, you know, as as we really take a look back. We see various ways. We've track, tried to tackle obesity and and not all of them, and worked. We had the use of the amphetamine Diet Pills peak around the 1960 s. After 40 years of use that are illegal now

39
00:07:22.330 --> 00:07:31.079
David White: in the nineties. We have then, then, which thought was thought to be a miracle drug, you know, for obesity and ultimately found to have, you know, tremendous impact on on heart health.

40
00:07:31.290 --> 00:07:47.280
David White: Now we're in this era of Dlp ones. Again, we see this promise, and and to your point, we we really can't ignore the side effects or even the supply issues. you know, speaking to the supply issues close to home. One of our own colleagues wasn't able to fill her diabetes. Prescription due to the shortage.

41
00:07:47.380 --> 00:08:01.870
David White: this raises a question. are there alternatives to gop one medications today? And how can health care providers really navigate complex situations to ensure the best outcomes for their patients, it still appreciate the framework in the history of obesity care.

42
00:08:02.090 --> 00:08:08.119
David White: Can we talk about some of the alternatives, the glp ones,

and and really ensure that, you know, history doesn't repeat itself.

43
00:08:10.310 --> 00:08:16.710
Mohit Joshipura MD: yeah, I think there's there's a couple of issues at play here. One is. One is discussing the actual shortage.

44
00:08:16.940 --> 00:08:29.720
Mohit Joshipura MD: There's only currently 2 Fd. Approved glp ones for weight management. There's a wigovi and sicenta The former, you know, has some significant advantages over the latter, but we can leave that for a separate conversation

45
00:08:30.300 --> 00:08:40.170
Mohit Joshipura MD: in general demand has far out-paced supply, because we know that the medication class works both for diabetics and for weight management.

46
00:08:40.409 --> 00:08:53.450
Mohit Joshipura MD: And so there's a fair amount of off label prescribing of the other glp ones, such as such as Osmpic and in terms of the actual shortage. And and what's in the pipeline? If I had to make an estimation

47
00:08:53.640 --> 00:09:10.999
Mohit Joshipura MD: one of the new drugs you know, that has already been approved for diabetes. It's known as Monjaro. It actually is a dual glp. And G. I. P. Agonist, which you know, because of its dual mechanism of action tends to be even more efficacious than the pure Gl. P. Agonists.

48
00:09:11.000 --> 00:09:30.499
Mohit Joshipura MD: My expectation is that Onejaro, under a different brand name, will be approved for weight loss here in the next 6 to 9 months, which will again again change the ball game given. It's significant efficacy, I think Pfizer has a novel glp, one that is oral in the pipeline as well, which has space to be trials that are ongoing, which is also incredibly exciting.

49
00:09:30.690 --> 00:09:46.059
Mohit Joshipura MD: but all that being said in terms of the shortage. I don't see it being materially alleviated before early to mid 24, and so your question becomes incredibly important as to what do we do for the next 6 to 12 months?

50
00:09:46.060 --> 00:10:06.859
Mohit Joshipura MD: And so that that begs you know the the what are the non glp alternatives issue in question, and there are medications that can be used, many of which are FDA approved. We have Q. Semia, which is a scheduled for approved. I'm sorry schedule for controlled substance we have contrave, which is a combination of an antidepressant and an opioid antagonist.

51
00:10:06.920 --> 00:10:17.959
Mohit Joshipura MD: we have orless T, which is available actually in an over the counter form, and also in a separate prescription form. It acts by a inhibiting the absorption of fat through the intestines.

52
00:10:18.420 --> 00:10:24.500
Mohit Joshipura MD: All of these are Fd approved options, all of which are our non glp. One

53
00:10:24.570 --> 00:10:45.750
Mohit Joshipura MD: Some of some of us also use metformin, which is probably the most well known, you know, basic oldest anti diabetic agent. we also use metform and off label for this purpose in some cases. And so all of these medications are orally administered. All of them work to varying degrees. All of them have various advantages and disadvantages.

54
00:10:45.750 --> 00:10:59.090
Mohit Joshipura MD: but none of them clearly, I mean none of them are as potent as glp ones on. We know that And so when a clinician or a practice is deciding on how to and to whom to offer glp ones.

55
00:10:59.100 --> 00:11:01.310
Mohit Joshipura MD: These are some of the factors to consider.

56
00:11:01.450 --> 00:11:19.960
Mohit Joshipura MD: I mean, there are definitely other options, and in some cases these options might be preferred over glp ones based on certain clinical considerations. And so you know, the strategic use of these alternatives alongside. Comprehensive weight management programs can undoubtedly alleviate the shortage to some extent.

57
00:11:20.220 --> 00:11:41.379

Mohit Joshipura MD: but the reality is that the only sustainable option is catching up to manufacturing needs, and that applies both to the diabetic population and to the obesity population. You know. You can only say that diabetics are more important or less important than the obesity population for so long. I mean, that's not an argument that holds any water

58
00:11:41.380 --> 00:11:59.080
Mohit Joshipura MD: from a clinical standpoint. And and so then there's another topic which we'll discuss down the road, which is, you know, in some cases the elephant in the room which are compounded glp ones. I don't want to spend too much time delving into that right now, because I know we're going to discuss that down the road. But that's another factor that plays a key role in this question that you just asked.

59
00:12:01.640 --> 00:12:12.759
David White: what about surgery is is, you know, is that an area of focus still? Or is it off the table? In consideration of of some of these these treatment protocols? outside of perhaps pharmaceuticals.

60
00:12:15.170 --> 00:12:30.309
Jennifer Peña, MD, FACP: Happy to chime in, you know. Veryiatric surgery still remains a the same treatment for obesity, and certainly, you know, has proven long term, you know, outcomes to able to maintain that weight loss

61
00:12:30.700 --> 00:12:54.670
Jennifer Peña, MD, FACP: still more favorably than your glp wants given the the issue with the rebound that we think one of the limiting surgery is that still the indications for certain? 3 are still very, you know. for a lot of the population that's under that Bmi of 40. And so it it does make it a little bit more difficult for patients that are not quite

62
00:12:54.670 --> 00:13:17.799
Jennifer Peña, MD, FACP: at that level of obesity, and don't have that comorbidity associated with it to be able to be eligible for these procedures. And so, you know, again, chemical therapy has become much more attractive to to people because of that reason eligibility, but also because, you know, it's not surgery. And even though a lot of these procedures are minimally invasive in nature and the recovery. It's it's pretty quick nowadays.

63

00:13:17.800 --> 00:13:26.619
Jennifer Peña, MD, FACP: I mean, that's still something that we present patient and option to search for intervention versus a medication. it. Still, you know, gives people.

64
00:13:28.820 --> 00:13:36.999
David White: what about wearable technology? And how does it hold clinical relevance? And specifically, what part does wearables play in managing, you know. B. CD, today?

65
00:13:40.120 --> 00:13:45.119
Mohit Joshipura MD: Yeah, my, I mean, there's a there's quite a few wearable technologies, you know, the most you know, the most

66
00:13:45.180 --> 00:13:57.749
Mohit Joshipura MD: widely adopted. Now, is a Cg. I mean. There was a time when continuous glucose monitoring was thought of only as something that was utilized by insulin, dependent diabetics.

67
00:13:57.820 --> 00:14:11.760
Mohit Joshipura MD: and and even today, from A from a Cms standpoint, it is only approved, and those who are either insulin dependent diabetics or those who have problems with significant hypoglycemia, with with oral anti-diabetic use.

68
00:14:11.830 --> 00:14:34.580
Mohit Joshipura MD: and so. But we have a separate, you know, patient population that is becoming incredibly interested in the use of Cgs off label, and that is the fitness, added group. It is the group that is that has and wants much more metabolic insight than than you know the the common person.

69
00:14:34.580 --> 00:14:44.899
Mohit Joshipura MD: And then we we also know that, or we think that the use of Cgms in this population may help provide the kind of.

70
00:14:44.900 --> 00:15:09.269
Mohit Joshipura MD: or or help advise the kind of lifestyle tweaks that may delay in some cases may prevent the onset of certain chronic conditions. Specifically, you know, pre diabetes, hyper lipidemia, and some of these, some of these aspects. And you know, there's there's there's a few other technologies out there from a biotech standpoint. You know Lumen is one of them, you know, Jen Jen can shed some light

into that. And so this is this is definitely a space that

71
00:15:09.270 --> 00:15:27.679
Mohit Joshipura MD: that will continue to grow in the near future, and will pair itself well with some of the other interventions, such as medication, such as lifestyle to help more definitively and in a more quantitative fashion. If you will inform our choices moving forward.

72
00:15:29.200 --> 00:15:36.450
Jennifer Peña, MD, FACP: I I agree with everything that you said you. You know, when I think about location monitoring.

73
00:15:36.460 --> 00:15:50.930
Jennifer Peña, MD, FACP: you know, I'm a data drives out some type of person right? And so I I do believe that they do provide tremendous amount of debt to personalize weight loss. You know, it's a type of precision care people right? Because you're getting specific down on location.

74
00:15:50.940 --> 00:16:10.540
Jennifer Peña, MD, FACP: You know whether it is diet. you know, they pay for behavioral, you know, data. you know, activity data. And a lot of you know, information that really help you come up with a much more personalized plan. But we do have to be conscious with the data right? Because there is such a thing as too much data, or what I like to call dirty data.

75
00:16:10.650 --> 00:16:22.650
Jennifer Peña, MD, FACP: because, you know, there is a lot of wearable devices now and not all of them are necessarily validated to give you, you know. Good, good information that you

76
00:16:22.870 --> 00:16:25.689
Jennifer Peña, MD, FACP: used in a clinical setting up for

77
00:16:25.970 --> 00:16:40.710
Jennifer Peña, MD, FACP: But again, I would just say, no, no person's weight. Loss journey is the same. And so these remote devices really do help inform us as professionals about the independent patient's behaviors and specific needs and really help us.

78
00:16:41.920 --> 00:16:55.419

David White: makes sense makes sense and and kind of returning back to Mo. It's foreshadowing. you know. Recently the Fds. Issued strong warnings to consumers about the use of compound and glp ones in various States have echoed these warnings as well.

79
00:16:55.620 --> 00:17:01.109
David White: What does compounding really mean in the context of glp, one sourcing. And why the concern?

80
00:17:03.190 --> 00:17:27.809
Mohit Joshipura MD: Yeah. So I think I think there are very distinct pros and very distinct cons here, and I tend to be one of those people who, from a clinical standpoint, tends to be a centrist here. I'm neither. I'm neither too far on the anti- compounding side. And or am I too far on the pro compounding side, understanding that there are very real, you know limitations here and then, and if you want to, if you want to talk about pros, and then cons. From my standpoint, the pros are that

81
00:17:28.089 --> 00:17:46.060
Mohit Joshipura MD: you know the the the compounding is meant to alleviate the supply chain mismatch. Does it do that? Yes, it does that. It provides access to these medications or to a form of these medications in a way that the the at least in current state the branded agents are not able to keep up with.

82
00:17:46.320 --> 00:18:02.240
Mohit Joshipura MD: They also, as a result, increase access. We we talked about the the issues with the with the, you know, diabetics not having access certain obese populations not having access because the manufacturers at this point in time just can't keep up

83
00:18:02.390 --> 00:18:19.489
Mohit Joshipura MD: And and also we know that it also impacts cost in a positive way compared to these these branded agents, and so those those pros are are present. But at the same time it's very important to understand the limitations that come with compounding agents. One is that they are not FDA approved.

84
00:18:19.490 --> 00:18:33.690
Mohit Joshipura MD: you know the FDA has put out a warning to to clinicians across the board to be very, very deliberate and and diligent. With regard to their compounding prescribing practices.

85
00:18:33.690 --> 00:18:54.200
Mohit Joshipura MD: we also know that it's a matter of time before the ability of most compounding pharmacies. To produce these compounding glp compound to glp ones is going to be rescinded. you know, the the branded drugs are are understandably under a patent, and as soon as they catch up to to manufacturing needs

86
00:18:54.200 --> 00:19:09.050
Mohit Joshipura MD: the the ability to compound will be rescinded. And so that's important to understand it, which is that in a sense it's it's a pseudo band aid in a way, when that bandit will be ripped off, as I said in your your guess is as good as mine, but it it won't be for a while.

87
00:19:09.440 --> 00:19:16.839
Mohit Joshipura MD: We also know that there are certain states that have put forth warnings to to clinicians with regard to the use of

88
00:19:16.860 --> 00:19:26.300
Mohit Joshipura MD: compounding agents. These warnings are not umbrella or universal warnings, but they are nuanced. You know what what some of these States say is that

89
00:19:26.350 --> 00:19:32.559
Mohit Joshipura MD: we should not be using any compounded glp ones that are based on the salt formulation.

90
00:19:32.940 --> 00:19:38.260
Mohit Joshipura MD: They should all be using the base form of of these of these molecules.

91
00:19:38.380 --> 00:19:53.739
Mohit Joshipura MD: we also know, based on these warnings, that there is a difference between pharmaceutical grade product and research great product, and then the former is is the only one that can and should be used for for human consumption.

92
00:19:53.750 --> 00:19:59.859
Mohit Joshipura MD: and that we we also know that you know, before you know the clinician or the practice

93

00:19:59.880 --> 00:20:10.939
Mohit Joshipura MD: or the digital health entity, whoever it might be, chooses to engage in the use of compounded substances they should ensure that their compounding partner, you know, has

94
00:20:11.090 --> 00:20:32.390
Mohit Joshipura MD: conducted valid third-party testing that validates sterility of the product potency of the product etc., etc. And so all of these are are very real limitations and very real considerations to take into account before you know any any one person or entity chooses to, or chooses not to engage in the indie compounding business

95
00:20:34.200 --> 00:20:40.699
Jennifer Peña, MD, FACP: just wanted to also add really quickly that sometimes a lot of times. They're actually not deeper in the kind of office

96
00:20:41.040 --> 00:20:47.409
Jennifer Peña, MD, FACP: to be more expensive. And there is a little bit of price counting also going on there, because

97
00:20:47.500 --> 00:20:51.169
Jennifer Peña, MD, FACP: some, some what they want. You know, there are some companies.

98
00:20:51.190 --> 00:21:05.930
Jennifer Peña, MD, FACP: They're they're seeing the need. And you know, capitalizing them that we need. you know financially. So I would just urge patients that before you even consider, you know, doing that because of, you know, lack of availability.

99
00:21:06.380 --> 00:21:14.349
Jennifer Peña, MD, FACP: Make sure that you diligence. Call the pharmacies around you find that help, and certainly check with your sure, because you might actually end up paying less.

100
00:21:14.580 --> 00:21:21.210
Jennifer Peña, MD, FACP: you know, through your your coverage, then going out to

101
00:21:23.020 --> 00:21:43.690
David White: and just quickly looking at that, that salt formulation,

what should patients and providers really focus in on? In asking the question to ensure that they understand? If that specific compound is what they're receiving today, would they look to the label, or how? How would they become better informed as to what's in that compound?

102
00:21:43.980 --> 00:21:47.250
Mohit Joshipura MD: Yeah. Great question, David. You know the the

103
00:21:48.040 --> 00:22:09.570
Mohit Joshipura MD: yes. We always want our consumers, our patients, to be as well informed and as much informed as possible. But the onus here is to be quite honest on the prescriber in the compounding pharmacy, and and and and the kind of due diligence that is done between those 2 entities and and what I discussed earlier, which is, you know, ensuring that

104
00:22:09.570 --> 00:22:24.230
Mohit Joshipura MD: that base forum is being used that there is no form of sodium. There is no salt form being used in the in the compound, that it is pharma grade product and not research, great product, all of that due diligence, all of that bonus falls upon the prescriber entity

105
00:22:24.230 --> 00:22:38.639
Mohit Joshipura MD: A and their communications with their compounding pharmacy. Partner, because, at least to my knowledge, the the packaging or the label that ends up in the consumers, hands, and the patients hands may not explicitly state

106
00:22:38.640 --> 00:22:56.770
Mohit Joshipura MD: in a in at least in language that is clear enough to declare to the patient to tell them whether this is, you know, base form or soft form, or whatever it is, and so I firmly believe that that owners lies with with with us as connections and and and our companies, and and whoever we choose to engage with.

107
00:22:57.270 --> 00:22:59.520
David White: Well some deep waters that navigate there.

108
00:22:59.870 --> 00:23:00.530
Mohit Joshipura MD: Yep.

109

00:23:01.610 --> 00:23:14.950
David White: and you know it. It it brings together. You know we are in this era of diverse approaches in tackling obesity, you know. On one hand, we see organizations like weight watchers really known for their weight, loss, coaching, going all in on the use of Gop. Once.

110
00:23:15.030 --> 00:23:23.410
David White: on the other hand, we see new brands and new digital health companies really concentrating on this more holistic approach. we've talked a lot about

111
00:23:23.430 --> 00:23:31.140
David White: weight loss. But what are we really seeing outside of weight, loss, and and how obesity intersects with other areas of care?

112
00:23:32.180 --> 00:23:39.960
David White: And specifically, what are the profiles of companies in these adjacent markets and their relationship with obesity. And how are they looking at glp ones?

113
00:23:41.990 --> 00:23:50.219
Mohit Joshipura MD: Yeah. So we we're starting David to see companies that are centered around, for example, men's health or women's health.

114
00:23:50.250 --> 00:24:03.879
Mohit Joshipura MD: adding on a distinct weight management service line especially since the advent of of glp ones as a as a tool against like against obesity, against obesity management.

115
00:24:03.940 --> 00:24:26.899
Mohit Joshipura MD: and in part, this is a business decision, you know, it makes sense to do it that way. because both men and women, you know, have an increased risk of downstream complications when with with unchecked obesity. We know that. And so not only is it does it make sense from a business standpoint, but there is a clinical rationale and a pretty strong clinical rationale to to center your marketing on on both men and women. specifically

116
00:24:26.950 --> 00:24:38.329
Mohit Joshipura MD: a. And so not only do companies like Row, for example, have a very captive consumer base or user base. They can also use their very strong platform to then impact

117
00:24:38.450 --> 00:24:43.749
Mohit Joshipura MD: downstream and chronic health for their patients through these offerings

118
00:24:44.080 --> 00:24:46.940
Mohit Joshipura MD: with with women's health. It's a

119
00:24:47.150 --> 00:24:50.749
Mohit Joshipura MD: bit more of a unique nuance, because, on one hand.

120
00:24:51.380 --> 00:25:04.400
Mohit Joshipura MD: if you, if you talk about fertility and pregnancy specifically on one hand, who is trying to conceive and is obese, does have an increased risk of pregnancy complications.

121
00:25:04.460 --> 00:25:06.290
Mohit Joshipura MD: But, on the other hand.

122
00:25:06.330 --> 00:25:19.650
Mohit Joshipura MD: we now also know that induced or inorganic weight. Loss via medications is not recommended either during or immediately before pregnancy, because of the distinct risks that poses both to mom and fetus.

123
00:25:20.020 --> 00:25:31.159
Mohit Joshipura MD: And so in this case it is best to focus on on medication based weight loss during times in life when pregnancy is not a factor.

124
00:25:31.260 --> 00:25:39.040
Mohit Joshipura MD: and then and then consider, you know, more lifestyle based changes when when pregnancy is being considered.

125
00:25:45.120 --> 00:26:08.730
David White: Yeah, we, we, we especially see some of that within the fertility space. you know, having looked at various frameworks, tools, stewardship strategies, you know, what are the specifics of designing a robust digital. Out offering? And how can we ensure that these digital strategies support access adherence and positive impact and our weight loss treatments? you know, kind of more of a program design focus

126
00:26:09.880 --> 00:26:24.670
Jennifer Peña, MD, FACP: absolutely. So I mean, it goes without being said that virtual.

127
00:26:26.170 --> 00:26:44.360
Jennifer Peña, MD, FACP: So not another one of the

128
00:26:44.470 --> 00:26:47.010
Jennifer Peña, MD, FACP: your your fitness coaches your health

129
00:26:47.090 --> 00:26:58.320
Jennifer Peña, MD, FACP: It also allows us to do, you know, support groups and education in a way that is much more accessible to the patient

130
00:26:58.630 --> 00:27:04.699
Jennifer Peña, MD, FACP: and videos chat and also, especially.

131
00:27:04.730 --> 00:27:16.200
Jennifer Peña, MD, FACP: you know, access to care 20 four-seven for the patient in a way that's confidential and fragment, because we have to acknowledge that a lot of teach, instead of valuing weight issues, don't necessarily feel comfortable going to

132
00:27:16.330 --> 00:27:19.650
Jennifer Peña, MD, FACP: There's other.

133
00:27:19.670 --> 00:27:21.270
Jennifer Peña, MD, FACP: you know, that that

134
00:27:21.380 --> 00:27:39.510
Jennifer Peña, MD, FACP: things that we can add to to to these as well. things like Neil, client and leveraging artificial intelligence through the surveys where you know, you can come up with customized meal plans that are culturally sensitive, that are sensitive to

135
00:27:47.010 --> 00:28:02.289
Jennifer Peña, MD, FACP: we wanted to. you know, through the

136
00:28:02.330 --> 00:28:09.229
Jennifer Peña, MD, FACP: this way. And again, I just want to double down on your right? Because you have to remember a lot of

137
00:28:09.240 --> 00:28:19.350
Jennifer Peña, MD, FACP: you know, obesity issues. And so being able to have that

138
00:28:19.540 --> 00:28:29.329
Jennifer Peña, MD, FACP: emotional meeting with those of you that have underlying capable issues. again.

139
00:28:29.420 --> 00:28:34.809
Jennifer Peña, MD, FACP: that makes sense that makes sense.

140
00:28:38.120 --> 00:28:49.050
Mohit Joshipura MD: No, don't chime in here and say that, you know there, there's a if you want to nail down a couple of things that a digital health entity can do to deliver better obesity care today.

141
00:28:49.130 --> 00:29:02.920
Mohit Joshipura MD: there's one of 2 approaches you can take. You know, one approach is offering a comprehensive solution that includes everything that Jen just mentioned, which is, you know, medications and all the critical aspects of lifestyle that she alluded to.

142
00:29:03.050 --> 00:29:16.919
Mohit Joshipura MD: or focus and and and niche down on on one of those do it exceptionally well, and then work on partner strategies from a business standpoint, to be able to offer your consumer a more holistic and a more comprehensive solution.

143
00:29:17.320 --> 00:29:42.099
Mohit Joshipura MD: The the other thing to keep in mind is that if you are going to offer glp ones, it's important to get the testing right and to offer testing and to not ignore the importance of lab work, even though the medication label might might say that in isolation glp ones may not require any distinct you know, pre prescription or ongoing monitoring labs. It's important to understand that

144
00:29:42.120 --> 00:29:43.280

Mohit Joshipura MD: this

145
00:29:43.420 --> 00:30:05.720
Mohit Joshipura MD: you're impacting metabolic health as a whole. You are not just impacting the number on the scale, you know, as a result of that number on the scale dropping, there are a whole host of of downstream, you know, aspects that are also impacted. In most cases those are positive impacts. But it's important to know what someone's thyroid function is what someone's diabetic status is

146
00:30:05.720 --> 00:30:23.849
Mohit Joshipura MD: what someone's, you know, liver and kidney function looks like. for example, before before you, you start these medications because that impacts and informs the way you are going to manage these people on an ongoing basis. And, as Jen said, this is not a one and done type solution. It is a chronic long term intervention

147
00:30:23.940 --> 00:30:45.869
Mohit Joshipura MD: And because of that, it's also important for a company to get the marketing right, because that will be one of the differentiators. I mean, it sounds superficial, but the reality is it's important home. Are you catering to? Are you catering to a younger population or a slightly, you know, maybe potent, older and co-morbid population? you know it. But in general, no matter what approach you take.

148
00:30:46.160 --> 00:30:52.359
Mohit Joshipura MD: all of us must understand that this is a medical intervention, and it's not a cosmetic intervention.

149
00:30:52.510 --> 00:31:17.140
Mohit Joshipura MD: and I I I think again, the onus is on the the clinical community, the pharmaceutical community to kind of ensure that that message is pitched appropriately. because this is not meant to be a panacea. It's not meant to be a flash in the pan-type intervention. It is incredibly effective, and it is a watershed moment in in our fight against obesity. But by no means is that a panacea?

150
00:31:18.780 --> 00:31:38.250
Jennifer Peña, MD, FACP: I just wanted to add to that as well with that, and I hope people can hear. My I'm sorry. My mind is maybe a little bit of trouble. I'll speak so but from a business perspective also regarding the labs. but this should be the only reason, certainly not the primary reason. But we have to remember that prior

conversation

151
00:31:38.470 --> 00:32:01.309
Jennifer Peña, MD, FACP: is very much a factor in the the the management of obesity. Right now, this basic care platform. And so a lot of insurance payers and employers are requiring that there is some sort of

152
00:32:01.380 --> 00:32:30.659
Jennifer Peña, MD, FACP: we can to set that expectation with our patients at the very beginning. Because, you know, for anybody who's in this world and working these types of platforms. We all know that there is a lot of patient apprehension to getting laboratory, you know, work done before they get their prescription. but that tends to be a nice of tactics and time to where, if they don't want to do it for their wellbeing, despite what we tell them as healthcare professionals. You can also remind them that it's also like we needed it for their prior conversation.

153
00:32:31.980 --> 00:32:39.320
David White: So true. I mean, these have been great conference conversations so far Do you mind if we turn to a few questions from the audience?

154
00:32:40.740 --> 00:32:42.059
David White: Let's do it

155
00:32:43.060 --> 00:32:49.339
David White: the first one. Do you need an obesity medicine specialist to prescribe semi blue tides.

156
00:32:51.360 --> 00:33:14.219
Jennifer Peña, MD, FACP: Jen, you want to start on that one, and I can absolutely, I think, both Dr. And I. We would appreciate this question because we're phone or chert. If I had internal medicine decisions, and in less moment you've gone and tested behind my back here, and I don't know about it. I I don't believe that either of us are either fellowship, training, or ports, or divide and obesity medicine. I think this is a really important question, because.

157
00:33:14.320 --> 00:33:17.850
Jennifer Peña, MD, FACP: as we've been discussing today, obesity is a chronic condition

158
00:33:18.050 --> 00:33:41.050
Jennifer Peña, MD, FACP: and desk primary care providers, we have to be equipped to be able to take care of these patients. you know. Certainly your obesity medicine specialist or end technology colleagues are are very much, you know, important in this equation to be able to give us that subject matter expertise, especially as new drugs come out and you therapy's compound.

159
00:33:41.050 --> 00:33:54.159
Jennifer Peña, MD, FACP: But we have to be able to train ourselves and train our colleagues in primary care to be able to do this as well get gained that comfort. because, again, this is something that we have to treat as a planning condition. The good thing is that

160
00:33:54.160 --> 00:34:11.949
Jennifer Peña, MD, FACP: you know it as one of my colleagues love to say it is really difficult medicine, and it is not prescriptions that we haven't been using for a very long time. So it's just really teaching, educating ourselves and making sure that we get comfortable in taking care of our our

161
00:34:11.969 --> 00:34:12.770
Jennifer Peña, MD, FACP: see?

162
00:34:13.730 --> 00:34:34.810
Mohit Joshipura MD: Yeah, a hundred percent And and I think it's there. There's undoubtedly value in in our colleagues who have the diplomat of American Board of Obesity Medicine, because, you know, they help inform and guide the care that we ultimately provide. but but the parallel I like to draw here, Jen, is that to our mental health endeavors, which is.

163
00:34:34.810 --> 00:34:52.349
Mohit Joshipura MD: you know, in in a perfect world, you know, some people could make the argument that only psychiatrists and psychologists and and psychiatry, mental health nurse practitioners should be the one delivering, you know, up to date cutting edge, mental health care. But the the stark reality of the situation is that

164
00:34:52.520 --> 00:35:10.369
Mohit Joshipura MD: the demand is so far outpaces the supply that that is not a practical, really, not even a safe approach, because then you

have a an even even more exacerbated access problem. And so similarly here given that obesity is is in a similar state in terms of

165
00:35:10.370 --> 00:35:31.659
Mohit Joshipura MD: If it's epidemic status, we need all hands on deck, and as long as those hands are well informed up to date and responsible, and in touch with with those on the forefront of these medical technologies. I think it is okay for for those in primary care to to engage in in obesity management.

166
00:35:34.500 --> 00:35:45.119
David White: Next question is, we understand that a one C testing is required. What are their tests? If any are, are important also in consideration and in the frequency of the blood work as well.

167
00:35:50.860 --> 00:35:51.869
Jennifer Peña, MD, FACP: Oh, can you hear me?

168
00:35:52.170 --> 00:35:57.599
Jennifer Peña, MD, FACP: I I do believe somebody actually just asked that question as well in the in the chat.

169
00:35:57.630 --> 00:36:22.900
Jennifer Peña, MD, FACP: you know, this is a really good question, because there is a lot of controversy. you know around this in terms of what exactly we need to be that alluded to it a little while ago. You know what is indicated on the label versus, what do we want to do for full part of all this assessment? and so it really will depend on several factors that it depends on the medication that you're using. It depends on the patient's history.

170
00:36:22.940 --> 00:36:38.590
Jennifer Peña, MD, FACP: again, it depends on the far off requirements we just mentioned. It depends on whether you want to do a full assessment or assessment of metabolic, you know, function and so, you know, I think at a minimum, certainly assessing for diabetes

171
00:36:38.600 --> 00:36:47.640
Jennifer Peña, MD, FACP: is important. you know, getting that people with an able to see, especially for the and also a mark of real function, just to make sure that you're being safe.

172

00:36:47.660 --> 00:36:54.130
Jennifer Peña, MD, FACP: because at the end of the day it's all about making sure that you

173
00:36:54.450 --> 00:37:17.319
Jennifer Peña, MD, FACP: probably the most general answer to that question in terms of frequency. Again, it depends on all those factors. If you're treating diabetes in addition to obesity right back to you, this is going to be different. If you're having multiple agents versus just one that's going to also affect your key and some of laboratory work. So it's not a necessarily straightforward answer. You have to assess your patient.

174
00:37:18.900 --> 00:37:33.770
Mohit Joshipura MD: Yeah. And I think one of the comments made in the in the chat. I think it's Dr. Duron and Dr. Doron. It's great to see you. What if on this, on this platform you made a very good point, which is he said, that the labs can also be used as motivators and additional markers of success

175
00:37:33.800 --> 00:37:44.809
Mohit Joshipura MD: as metabolic health improves. And that's exactly correct. you know, it goes back to what we said earlier, which is that at the end of the day you are not treating the number on the scale

176
00:37:44.830 --> 00:37:48.029
Mohit Joshipura MD: you are treating metabolic health.

177
00:37:48.060 --> 00:38:07.779
Mohit Joshipura MD: This is not a cosmetic endeavor. It is a medical endeavor and and an understanding underlying metabolic health risk factors, whether it's cholesterol or or or diabetes, or thyroid, or or you know, blood chemistry. All of that impacts and informs how we treat you as a patient on a long term sustained basis

178
00:38:08.810 --> 00:38:12.590
Jennifer Peña, MD, FACP: absolutely. And and I say to remember also that

179
00:38:12.720 --> 00:38:29.880
Jennifer Peña, MD, FACP: if you're going to test, the more you test, the more data you have, and you have to make sure that you know what you're going to do that with that information. you know, this happens

to us a lot in the we like to get a lot of assessments. But then, to most point, if you get a I believe in vacation.

180
00:38:29.910 --> 00:38:33.689
Jennifer Peña, MD, FACP: and you're not equipped to treat it. What are you going to do with that patient?

181
00:38:33.760 --> 00:38:36.860
Jennifer Peña, MD, FACP: So ensure that if you're going to order the lab

182
00:38:37.290 --> 00:38:40.340
Jennifer Peña, MD, FACP: that you know we are going to do that patient they need for their care.

183
00:38:40.810 --> 00:38:42.589
Mohit Joshipura MD: That's all right. And Jen here.

184
00:38:42.790 --> 00:38:54.040
Mohit Joshipura MD: Jen, here's the other point that comes to mind, which is that if you, if you think about eligibility for Lp ones. they are clearly, those who are Bmi 30 plus as it stands right now, are clearly

185
00:38:54.520 --> 00:38:57.749
Mohit Joshipura MD: based on, based on the label and based on the research we have

186
00:38:57.810 --> 00:39:09.369
Mohit Joshipura MD: the Bmi. 27 to 29.9. Those who fall in the moderate to significant overweight category are also eligible. As long as they have some level of co- morbidity.

187
00:39:09.390 --> 00:39:20.270
Mohit Joshipura MD: Sometimes, when you talk to a patient. they may not know that they have high cholesterol, they may not know that they have an A one c. Of 5.8, which renders them as a pre diabetic

188
00:39:20.330 --> 00:39:37.480
Mohit Joshipura MD: all of these factors, if you get them on paper and actually draw the labs and have objective data to work with, you might

actually augment the eligibility of that patient or set of patients for glp once, and so you might, by by doing a simple intervention like blood work.

189
00:39:37.480 --> 00:39:53.989
Mohit Joshipura MD: you might alter the the the downstream course of care for either a single patient or an entire set of patients, and so, even from an eligibility standpoint, especially in the overweight group that is not obese labs hold a a significant, significant value.

190
00:39:57.070 --> 00:40:08.790
David White: What it is speaking to lab, you know, what is the link to cortisol testing when it when it comes into context of obesity management and and and health around. the weight loss.

191
00:40:10.020 --> 00:40:24.250
Jennifer Peña, MD, FACP: Yeah, I I just I just got with the payer over this question. So this off. But you know, obviously, court is all for those practitioners, you know, in the audience, you know this is a a a measure of met, you know.

192
00:40:24.250 --> 00:40:45.300
Jennifer Peña, MD, FACP: metapolic right? Part of your metabolic assessment does similarly say to your thyroid panel, but it's the most of us here, you know. We're health care professionals, not for as all as a pickle that it's it's difficult to do in the right way at times. Sometimes it's because the patients don't do it the right way, or they don't do it at the right time, and you know I don't. We go into the nuance of it.

193
00:40:45.400 --> 00:40:56.070
Jennifer Peña, MD, FACP: but But it is again part of that more holistic approach to cardiac. You know, a lot of these prior conversations

194
00:40:56.280 --> 00:40:59.360
Jennifer Peña, MD, FACP: are being called up. If there isn't some sort of

195
00:40:59.500 --> 00:41:08.420
Jennifer Peña, MD, FACP: underlying, you know a chat for any underlying that might be predisposing the patient to be sitting again at some sort of

196
00:41:08.570 --> 00:41:13.460
Jennifer Peña, MD, FACP: That quote is all in balance and so sometimes we do have to add those to

197
00:41:13.480 --> 00:41:14.860
Jennifer Peña, MD, FACP: for a

198
00:41:16.970 --> 00:41:30.299
Mohit Joshipura MD: yeah, I mean cortisol. There's a bunch of other hormones. Jen's absolutely right, you know. There's cortisol. There's a bunch of other hormones that have been implicated in in in the obesity ecosystem. And this is what we were discussing earlier, which is that it is not just about

199
00:41:30.380 --> 00:41:37.079
Mohit Joshipura MD: about what you do, while that is certainly a critical part of this whole of of this whole ecosystem

200
00:41:37.130 --> 00:42:00.240
Mohit Joshipura MD: genetics play a role, you know. there's a melano cordon based receptor that has been implicated in in obesity. There's a lot of research going on in that space. There's Leptin, there's Ghrelin, there's Cortisol all of these hormones again, we don't have to get into the the scientific nuances. But all of these hormones play a very distinct role in in stress and appetite and hunger

201
00:42:00.240 --> 00:42:07.739
Mohit Joshipura MD: and satiety, and all of these things that impact how much you eat, how full you feel, how quickly you feel full.

202
00:42:07.740 --> 00:42:13.620
Mohit Joshipura MD: And eventually, you know, play a role in what you see on that scale. And so it's a, it's a, it's a

203
00:42:13.620 --> 00:42:19.329
Mohit Joshipura MD: a multi-pronged problem that requires a multi faceted solution

204
00:42:22.870 --> 00:42:28.660
David White: moving to our last question, are patients required to be

informed they are receiving off-labeled drugs?

205
00:42:38.440 --> 00:42:40.669
Mohit Joshipura MD: Go ahead. Yeah.

206
00:42:40.860 --> 00:42:54.969
Mohit Joshipura MD: Oh, yeah, I'm I'm happy to chime in and then obviously let gender the same. Yeah. 100 again, that is, we have a, we have a clinical and an ethical and moral responsibility to inform these patients about what we are prescribing them.

207
00:42:55.330 --> 00:43:04.579
Mohit Joshipura MD: why we are prescribing it, and why, even though it might be off-label, we feel like in their particular case, the benefit outweighs the risk.

208
00:43:04.830 --> 00:43:16.950
Mohit Joshipura MD: And so, you know, I I. As I said, I tend to be a centrist on this issue specifically with regard to off label prescribing of branded glp ones. Because there you get into the question of.

209
00:43:17.110 --> 00:43:35.389
Mohit Joshipura MD: do diabetics need it more? Do do you know obese patients need it more specifically in our in our shortage situation. And then with the compounds you, you you get into, what's their own set of of considerations. And so All of these factors must be considered. But at the end of the day

210
00:43:35.570 --> 00:43:58.110
Mohit Joshipura MD: a clinicians responsibility remains, first and foremost, to to do no harm to to consider risks and benefits and at the end of the day make an individualized decision where benefits outweigh risk, and and in many cases that might mean the prescription of a of an off-label substance. And that's and that's okay. But but yes, we must. We must tell them that explicitly.

211
00:43:59.290 --> 00:44:02.239
Jennifer Peña, MD, FACP: absolutely. And again from a business perspective.

212
00:44:02.300 --> 00:44:13.280

Jennifer Peña, MD, FACP: I say, say you, at the very beginning make it very well known to your patient that part of their treatment regimen by food of label medication?

213
00:44:13.300 --> 00:44:17.890
Jennifer Peña, MD, FACP: and that because of that it may or may not be covered by their insurance.

214
00:44:17.990 --> 00:44:25.230
Jennifer Peña, MD, FACP: I think you know, if you set that expectation from the very beginning. It also helps alleviate and sort of patient frustration.

215
00:44:25.360 --> 00:44:30.770
Jennifer Peña, MD, FACP: When you get to the level of having to issue the prescription, and then maybe not.

216
00:44:30.950 --> 00:44:42.469
Jennifer Peña, MD, FACP: because it is still outlable, and some papers are still on necessarily being, and it's generous in terms of approving. the use of some of these prescriptions for obesity management. I think again, that

217
00:44:42.490 --> 00:44:43.770
Jennifer Peña, MD, FACP: giving them that information.

218
00:44:44.370 --> 00:44:46.609
Jennifer Peña, MD, FACP: bye. really helps you.

219
00:44:48.660 --> 00:44:51.099
David White: No, thank you, thank you so much. And

220
00:44:51.150 --> 00:45:17.489
David White: I think, moving into some of our our closing discussion here. so many, so many areas that we touched upon today and and really excited to have been able to cover so many topics. really, I think some of the takeaways, you know, navigating weight loss in the current environment really requires a multifaceted approach. you know, medicines have their roles, but it doesn't seem like they're the silver bullet. We we also will continue to see shortages

221

00:45:17.580 --> 00:45:33.319
David White: into 2,024. I think, specifically for clinicians. it's important for us to remember that we are impacting the metabolic function of the patients as a whole, and not just the number on the scale as as well as brought to the conversation.

222
00:45:33.540 --> 00:45:44.460
David White: and I think, Jen, important as you call that we really need to consider who the patient is, and and are they trying to conceive? Are they going through manipulus? And and how is their mental health.

223
00:45:44.640 --> 00:46:08.420
David White: and you know, stepping back and looking at how these digital health companies are coming to the market to serve? there is enough demand from consumers to get innovative in weight loss. these solutions really, I think, should be focused on on niche and and marketed to the communities. this will allow them to differentiate, differentiate themselves, but also really align with the patients that they're trying to serve.

224
00:46:08.450 --> 00:46:23.390
David White: And I and to everyone's point, we really can't undermine the importance of a nuanced nutritional supportive program. including customized meal plans on the back end to to help everyone on these different types of journeys. And

225
00:46:23.630 --> 00:46:53.610
David White: and you know, testing is critical to empowering patients to take control of their metabolic health. and I, I think you know again, we've covered so much, and we really would truly like to express our sincere gratitude to all of our panel members for participating in this enlightening discussion. Your insights and ever expertise have been invaluable. Now, I'd like to invite you to share how the audience can stay connected with you. Is there a preferred method or platforms? where they can reach out and follow your work?

226
00:46:58.220 --> 00:46:59.209
Mohit Joshipura MD: Jen, go ahead.

227
00:47:00.470 --> 00:47:12.290
Jennifer Peña, MD, FACP: Thank you again. David. Thank you. Ihd and thank you for sharing this panel. This is wonderful, and thank you for all the attendees as well. for for me.

228
00:47:12.320 --> 00:47:18.819
Jennifer Peña, MD, FACP: follow me on Linkedin. certainly feel free to reach out, and we will be. We will be adding the link here.

229
00:47:18.960 --> 00:47:20.149
Jennifer Peña, MD, FACP: to the chat.

230
00:47:20.820 --> 00:47:43.079
Mohit Joshipura MD: Yep, Sam, same. you know I'm very grateful to have been a part of this. I I I tend to often, you know, receive more than I did. Well, I I learn a lot from these discussions. it. It's an absolute pleasure to interface with you, David and and Jen, as always, and and same for me for those you know that that would like to be in touch. Linkedin is something I'm very active on.

231
00:47:43.080 --> 00:48:02.070
Mohit Joshipura MD: not only as a professional network. But also in this particular space I I follow. And I'm connected with a bunch of experts in the space. That is something I'm deeply passionate about, and and it also serves as a as a resource and a learning tool for me. So I'd say yes, like 10 would be the best avenue to connect.

232
00:48:05.410 --> 00:48:13.829
David White: Thank you again, everyone for joining us today and enjoy the rest of your day and look forward to future conversations on a variety of topics. Thanks everyone.