Nutritional Needs of Older Adults with Obesity

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

Momentum Discussions Podcast from The Gerontological Society of America

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Pettis:

Welcome to a GSA Momentum Discussion podcast, addressing the unique nutritional needs of older adults with obesity and overweight. Momentum discussions highlight topics experiencing great momentum in the field of gerontology. We are grateful to Novo Nordisk for their support of the GSA Toolkit for the Management of Obesity in Older Adults and today's program. My name is Jen Pettis, and I'm the Director of Strategic Alliances at the Gerontological Society of America, and I'm delighted to serve as a moderator for today's momentum discussion.

Please join me in welcoming today's discussant and one of our expert reviewers for the Toolkit for the Management of Obesity in Older Adults, Dr. Kathryn N. Porter Starr. Dr. Starr is a dietitian and an Assistant Professor of Medicine in Geriatrics at Duke University School of Medicine. She is also a Research Health Scientist at the Durham VA Healthcare System in Durham, North Carolina. Dr. Starr, thank you for taking the time out of your busy schedule to share your insights around this important topic.

Dr. Starr:

Thank you so much for having me. I'm really excited to be here to talk about the nutritional needs of older adults with overweight and obesity.

Pettis:

Great, thank you. Let's jump right in. To start with, I'd like to ask you to share some of the unique challenges that older adults with obesity and overweight face.

Dr. Starr:

One of the first things that I want to emphasize are the physiological and metabolic changes that occur with all older adults, not just older adults with overweight and obesity. We all lose muscle mass as we get older. After about the age of 40 years, healthy adults lose approximately 8% of muscle every 10 years, and this can accelerate, such that we see a reduction of 15% per decade after the age of 70 years. This is important as we think about the impact not only on our older adults, but also our older adults with obesity. I want to emphasize this because when we add obesity to muscle loss, it has a big impact on function and functional changes. Additionally, it impacts the muscle quality itself, so that we see more fat within the muscle, the muscle does not contract as well, and the muscle does not function as well.

From my experience working with older adults and talking to them about their goals, one of the most important and common goals is the desire to stay independent. And when we think about the needs of our older adults and what their goals of care are, it's important to understand what impacts the ability to meet that goal of independence. Physical function is one of those factors that impacts independence.

So how does nutrition play a role in the loss of muscle mass and muscle strength? Nutrition plays a role related to anabolic resistance that emerges as we get older. And what is anabolic resistance? It is resistance to building muscle mass or stimulating muscle protein synthesis.

We have learned that older adults need an increased amount of protein, and we're finding that it may be beneficial for older adults to consume protein more consistently throughout the day. Reaching around a 30-gram threshold three times a day may help promote and stimulate muscle protein synthesis. We also know that leucine is the key factor to help stimulate muscle protein synthesis. We find leucine in our animal proteins and our high-quality proteins.

Taking a step back to think about some of the unique challenges that our older adults face, particularly our older adults with obesity, they're facing this impact on their muscle and the quality and the health of their muscle, which is going to have a detrimental impact or could have a detrimental impact on their independence.

They're also facing this unique experience where their energy needs are going down, but certain nutrient needs are going up. We know that we need more vitamin D and calcium as we get older, and we also need more protein. Understand the physiology and those changes that occur can help us understand how best to treat and manage obesity from a weight loss standpoint. I also want to emphasize that I have worked with older adults who come to me that say, "my doctor told me I needed to lose weight, and so I just reduced my intake." Well, because our nutritional needs are different as we get older, older adults need to be thinking about the actual nutrients they are getting and not just reduce overall intake.

I really want to caution our healthcare providers that it's important to work with a registered dietician when we are recommending weight loss for our older adults to make sure that they're getting all their necessary macro- and micronutrients. Dieticians can help maximize muscle mass as much as possible

and have them slowly lose weight while preserving muscle. And older adults should always include strength training because that helps preserve muscle. Sarcopenia is really the condition of loss of muscle mass, muscle function, and muscle strength that occurs with aging. And when we combine that with obesity, we start to see even more complex conditions that can have impacts on our older adults.

Pettis:

So, Dr. Starr, why is sarcopenia in an older adult with obesity particularly concerning?

Dr. Starr:

That's a great question. Sarcopenia leads to reduced mobility, which results in reduced energy expenditure, and this can ultimately lead to positive energy balance and weight gain. And as obesity develops, it increases inflammation and insulin resistance, as does sarcopenia. With this combination, we see an exaggerated impact of inflammation, insulin resistance, and that intermuscular adipose tissue, or fat, within that muscle. So that muscle becomes harder to contract—the muscle doesn't work as efficiently as it should. It is also important to note that, in addition to causing serious functional limitations, sarcopenic obesity is strongly linked with negative outcomes in both the hospital setting and in the community setting. We see more frequent hospitalizations, negative post-operative outcomes, and an increased risk of falls fractures. It's also related to increased mortality. So again, thinking about the whole impact—not only on independence from the goal setting of their patients—but also to the impact on the healthcare system, sarcopenic obesity is something that we should be focusing on with our patients.

Pettis:

So far, we've talked a lot about individual issues or person-centered issues. I'm wondering whether there are socioeconomic, environmental, or other external issues that a care team also needs to consider when they're supporting an older adult with obesity or overweight?

Dr. Starr:

Absolutely. I really feel that our social, environmental, and economic risk factors often go unrecognized. We're typically focused on the physiological and metabolic conditions of our patients, and we're not necessarily diving into the social and environmental risk factors that many of our patients may be experiencing, especially our older adults. And therefore, I always advocate for our interprofessional teams and working with a team approach when caring for our older patients. One of the first things I want to emphasize is social isolation. We know that our older adults experience more social isolation than any other population. And in my experience, it's even more common with veterans. We also know that social isolation may limit the foods that are consumed.

So, we may see someone who has obesity, but is not actually getting all the nutrients that they need because they're eating alone and they're eating prepackaged meals.

Transportation is another big issue that we don't always talk about and ask about. Do people have transportation to and from a grocery store? Do they have the ability to get groceries? Do they have the ability to be able to prepare food? Sometimes it's not necessarily financial constraints, it's a physical inability to prepare your own food that can lead to food insecurity. There is a lot of work that has looked at the relationship between food insecurity and obesity, and it sounds paradoxical, but it is common. We see this in our older adult population, where they choose lower quality foods, foods that are more energy dense, not nutrient dense, which leads to increased calories, but not high-quality foods, not foods that allow them to meet their true macro- and micronutrient requirements for a healthy diet.

Pettis:
Are you concerned about the potential for malnutrition in older adults with obesity and overweight?

Dr. Starr:

Absolutely. Malnutrition is common in older adults with obesity and overweight. Just like the social and environmental and economic risk factors, malnutrition often goes undiagnosed and unrecognized in this population because we continue to focus on the excess weight. We think it would be okay if they lost some weight. And that's really a terrible approach when we're looking at our older patients. I always make sure that our patients are assessed for nutritional risk regardless of their weight or their BMI status. And that is because of exactly what we just discussed. Just because someone has excess adiposity, it doesn't mean that their diet is high quality. It doesn't mean that they're getting all the nutrients that they need. And it doesn't mean that they have that they don't have sarcopenic obesity.

There's a lot to think about regarding the impact of overweight and obesity on nutritional status in older adults. When these patients are hospitalized, it is important not to overlook their nutritional status. If a patient has excess adiposity along with low lean muscle mass, and this individual gets sick and is hospitalized, there will be an impact on their ability to return to their baseline functional status. And ultimately when they get out of the hospital, that's when we start to see the impacts such as decline in function, and inability to regain independence, and a need for caregiver providers.

As healthcare providers, we need to focus on maintaining the muscle mass as best as we can. We work with our physical therapy, occupational therapy, and nutrition teams to make sure the patient receives adequate protein and gets out of bed as much as possible.

I really want to make sure that we are thinking about patients from the whole person perspective and understanding that malnutrition can occur in older adults with obesity. Healthcare providers need to make sure that we are using that lens when we're looking at our patients who are hospitalized or preparing for surgery, including patients with obesity or overweight, because they could be at risk for malnutrition or could be malnourished.

Pettis:

I have one final question for you today, Dr. Starr. We've talked about some of the important care considerations for healthcare teams supporting older adults with obesity and overweight. My last question is about starting a conversation about weight management older adults. What can care team members do to effectively start that conversation?

Dr. Starr:

One of the first things to consider is that healthcare providers have weight biases that are barriers to obesity treatment. When weight stigma is experienced by patients in the healthcare setting, it can lead to avoidance of future care and reduce adherence to prescribed services or treatments. And we also see lower trust in communication with our healthcare professionals, which contributes to reduced quality of care and increased health disparities. Therefore, the recognition of obesity as a disease is essential for addressing weight bias in the healthcare setting, and beyond.

One way we can do this is to use person-first language, where the patient or the person is mentioned first, followed by the disease or health condition. So, rather than saying "obese patient," we should say "a patient with obesity," like we do for other diseases and health conditions. Second, we need to approach obesity with compassion and respect, and ensure that we address social support. What is the patient going to need to be able to be successful?

Additionally, we need to provide hope for our patients, just like we would do with any other health condition. Evidence shows that framing a health condition positively can help increase patient engagement and support behavior change and creates trust in the healthcare providers.

When starting the conversation, our first approach is making sure that we are addressing and treating our patients with respect and compassion, which will allow us to help our patient and partner with our patient in ways that can facilitate weight management treatment. Finally, weight management works best when we have an interprofessional team approach with the right team members, including a dietician and a social worker.

Pettis:

Thank you so much. This was a wonderful conversation. I'd like to summarize a few key points.

First, obesity is a disease that requires the support of a healthcare team supporting just like we would support any other disease or any other condition. We also discussed the need for person-first language and person-centered care, which could mean an interdisciplinary or interprofessional team surrounding the older adult to address individual-level factors, including factors such as access to food and the social supports around dining with people or addressing social isolation. I also heard the importance of addressing weight bias amongst ourselves as a healthcare community and working with our colleagues to do that as well. And I heard a real strong message about the importance of screening everyone for nutritional deficiencies and not assuming someone who is overweight automatically has their nutritional needs met. What are some other key points I didn't mention?

Dr. Starr:

I think another key point is the need to keep the goals of the patient at the forefront of our care. We also need to make sure that patients are brought into the conversation. Rather than telling someone that they need to lose weight, we talk with them about what they would like to do and explore whether they have the support that they need. Do they have financial constraints? Are they able to get the food that they need? Can they prepare the food? We must really dive in and understand what factors underlie the health condition. And I think that approach will really help us have more meaningful conversations on how we can help our patients really achieve their goals.

Pettis:

This has been a great discussion. Thank you so much for joining us. And thank you so much for all the great work you're doing for veterans as well as for other older adults who are experiencing obesity.

Dr. Starr:

Thank you.