Healthy Aging
a dietetic practice group of the
Academy of Nutrition and Dietetics

The Spectrum

A Peer-Reviewed Publication

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Nutrition Needs for the Older Adult with a History of Metabolic Surgery (Part 1)

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Please note: *In order to receive the CPEU credits, you must read both parts of the article. It should have been approved for 1 CPEU credit. Part 2 of the article will be released in the spring edition of the newsletter.*

Approved for CPE Credit

LEARNING OBJECTIVES

At the conclusion of reading this article, participants will be able to:

- Describe the documented outcomes of metabolic and bariatric surgery in older adults.
- List and describe comorbidities associated with metabolic and bariatric surgery in older adults.
- Implement successful strategies, processes, and procedures to maximize outcomes of metabolic and bariatric surgery in older adults.

INTRODUCTION

Metabolic and bariatric surgery (MBS) has been performed successfully on older adults, showing significant benefits such as reduction in weight and remission in comorbidities, with only a small increase in postoperative complications compared to the younger adult population.[1,2] Total MBS rates have grown from an estimated 158,000 surgeries in 2011 to 262,893 surgeries in 2021[3], with the number of surgeries only decreasing from the previous year in 2020[3] coinciding with the COVID-19 pandemic.[4] Approximately 10% of MBS were performed on patients 60 years and older from 2009-2013.[5] Because of steady increases in obesity, a growing aging population, no age limit requirement for MBS, and evidence supporting the potential benefit of surgery for some older patients, registered dietitian nutritionists (RDNs) working with older adults must be knowledgeable on medical nutrition therapy for older patients with a history of MBS. This article shares information about current nutrition-related recommendations for patients 60 years and older with a history of metabolic surgery. We also indicate where age-specific recommendations are lacking.

BACKGROUND

Obesity is a risk factor for cardiovascular disease, nonalcoholic fatty liver disease, cancer, chronic kidney disease, Type 2 diabetes (T2D), obstructive sleep apnea, osteoarthritis, metabolic syndrome, and urinary stress incontinence. Studies show that MBS is associated with improvement and sometimes remission in these and other obesity-related comorbidities in both the overall population[6-18] and in older adults that received MBS.[25-31,2]

Obesity Prevalence in the Older Adult Population

According to 2017-2018 NHANES data, 42.8% of adults aged 60 and older in the United States met the criteria for obesity, and 9.6% were classified as severely obese.[32] These statistics are comparable to the overall adult population, with 42.4% obesity and 9.2% severe obesity in adults aged 20 and older.[32,33] Obesity (BMI ≥30 kg/m^2) and severe obesity (BMI at or above 40.0 kg/m^2) rates on average have increased yearly.[12,33] This results in the potential for an increase in frailty, impaired mobility, decreased quality of life and increased risk of all-cause mortality, already concerns in the older adult population.

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Metabolic Bariatric Surgery Defined

Weight loss surgery is termed "metabolic and bariatric surgery" (MBS) because of the impact these surgeries have on both weight and metabolic dysfunction.[1] MBS involves surgical modification of the gastrointestinal tract (GI) in order to treat obesity and obesity-related diseases, and is now considered the most effective obesity treatment for all BMI classes.[1] Studies have shown surgery may be beneficial when non-surgical attempts at treating obesity and obesity-related comorbidities are not effective.[1,24,34-35] This evidence applies even in patients with class I obesity (BMI 30-34.9). For example, current guidelines recommend that MBS should be considered in patients with T2D with a BMI of 30-34.9 when hyperglycemia is not controlled with medications.[36-38]

The main MBS types will be referred to by their common abbreviations throughout this paper:

- Roux-en-Y Gastric Bypass (RYGB),
- Sleeve Gastrectomy (SG),
- Laparoscopic Adjust Gastric Banding (LAGB),
- Biliopancreatic Diversion with Duodenal Switch (BPD/DS)

MBS GENERAL BENEFITS VERSUS RISK IN ADULTS AND OLDER ADULTS

Studies support the effectiveness and safety of MBS in the older adult population, although more research is needed.

Complication Rates in Adults and Older Adults

In the overall adult population, MBS may reduce risk of premature death by 30-50% compared to a 0.1-0.5% risk of perioperative mortality and a 2-6% risk of any major complications after MBS.[38] For this population, the risk of adverse reactions from MBS is comparable to many other common surgeries, including the appendectomy, cholecystectomy, hysterectomy, and knee arthroplasty. In the older adult population, studies show comparable risk[27,31] or slightly increased risk[25] of complications after MBS. However, while some studies do show statistically slightly higher rates of postoperative complications[25] and lower rates of weight loss in the over 60 patient population, they still conclude MBS is a safe and effective treatment for some older adults.[29-30] Further, earlier treatment of T2D and metabolic disease through MBS may also reduce or eliminate the need for future surgeries with higher risk profiles required later to treat complications of obesity and T2D.[13,38-39]

Reduction in Comorbidities in Adults and Older Adults

In the general adult population, studies show high comorbidity remission rates after MBS among patients with obesity-related chronic diseases[6,10,14,19,23,35,37,40]: 96% for obstructive sleep apnea, 92% for T2D, 76% for dyslipidemia, 75% for hypertension, and 58% for cardiovascular disease.[12-13]

In the older adult population, studies also show improvement in comorbidities, although rates vary by study and surgery type. Some reasons for this variability compared to the general adult population may be smaller study size and length, as well as participant age, length of time with comorbidity/comorbidities, severity of comorbidity/comorbidities, and type of surgery performed. Additionally, large scale studies are needed for the older adult population. Notable study results follow.

- In a study following 451 adults aged 65 years and older for 3 years, 8.86% of patients had perioperative complications, 49.67% of patients had improvement in comorbidities and patients overall had a mean excess body weight loss of 70.76%.[25]
- A retrospective review looking at patients who had either the SG or RYGB compared 83 patients over the age of 60 to the general adult population aged 22-59. The study found no significant difference in the complications between the two groups and also no statistically significant difference in percent excess body weight loss (%EWL) at 12 months.[67]
- Similarly, a retrospective study comparing 57 patients over 60 years of age to 195 patients under 60 years who underwent SG also noted comparable rates of overall postoperative complication in both groups. The study results showed benefits in the older adult population, with improvement in all comorbidities including T2D (older 38.6% vs 27.3% younger 34.9% vs 23.9%, $p < 0.05$), hypertension (older 82.5% vs 38.1%, younger 52.6% vs 29.2%, $p < 0.05$), and hyperlipidemia (older 75.4% vs 42.9%, younger 35.9% vs 21.1%, $p < 0.05$).[68]
- A case-control study matching 89 patients over 60 with 89 patients aged 18-40 who had received a SG also showed comparable complication rates and significant improvement in comorbidities in both groups of patients: hypertension (improvement in 73.1% older vs 69.2% younger), T2D (improvement in 40% older vs 31.1% younger).[31]

The studies above demonstrate comparable or only slightly higher complication rates from MBS in the older adult population compared to patients under the age of 60, while showing significant excess weight loss

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and improvement in comorbidities. Of note, although studies show significant remission in T2D in older adults after MBS, the current standard of treatment for adults 65 years and older with T2D is not surgery.[16,36,41]

Risks of MBS

Long-term risks of MBS for adults of all ages include nutrient deficiencies, and routine monitoring for micronutrient deficiency and altered nutritional status is recommended. Depending on the type of MBS, additional long-term risks include anemia, dumping syndrome, osteoporosis, and severe postoperative hypoglycemia. Because MBS may increase risk for substance abuse, worsening or new depression and/or anxiety disorders, and suicidal ideation, patients require screening by mental health professionals. These conditions must be adequately treated prior to approval for surgery.[12]

More studies are needed to assess the risks versus benefits in the older adult population. Large-scale, long-term research studying the impact of MBS on older adults is lacking and the number of patients over the age of 60 receiving MBS is low compared to the overall adult population receiving the surgery.

QUALIFICATIONS FOR BARIATRIC SURGERY IN ADULTS AND CONSIDERATIONS FOR OLDER ADULTS

The American Society for Metabolic and Bariatric Surgery (ASMBS) lists the following as qualifying factors for bariatric surgery (BMI criterion must be adjusted for ethnicity)[1,42]:

1. Patients with a BMI ≥ 35, regardless of the presence/absence of comorbidities related to obesity.
2. Patients with a BMI of 30-34.9 who are not able to lose substantial weight, sustain weight loss or achieve significant comorbidity improvement without surgical treatment.
3. Patients with BMI ≥30-34.9 with T2D.

While there is no age limit to MBS, the ASMBS acknowledges slightly higher rates of postoperative complications in older adults.[1,2] In addition to age, other factors must be considered when evaluating a patient for surgery, including frailty, smoking status, end organ function, and cognitive ability.[1] Higher odds of 30-day adverse events after bariatric surgery were linked to frailty status in a study of 21,426 adults ≥ age 60 receiving bariatric surgeries.[43]

MBS DIET PROGRESSION

Preoperative Diet Progression

To improve the surgeon's ability to perform the surgery, weight loss prior to MBS may be indicated to decrease visceral adipose tissue[44] and reduce liver size in patients with fatty liver or enlarged liver.[12,44,45] Weight loss prior to surgery may also help the patient meet pre-surgery glucose goals in patients with T2D.[12] Currently a range of diets are practiced prior to surgery, including a very-low-calorie diet, low-calorie diet, ketogenic diet/very-low-calorie ketogenic diet,[44,45] as well as a low-carbohydrate diet. The night prior to surgery, carbohydrate loading is also being studied as a potential surgical protocol to reduce length of stay by decreasing protein catabolism.[12,46] Unfortunately, studies are inconclusive in determining the best dietary option for preoperative weight loss the months or weeks prior to surgery, and standardized guidelines are unavailable for either a pre-operative diet or recommendations for preoperative weight loss.[44,45]

Postoperative Diet Progression

Recommendations on postoperative diet progression for the initial months after surgery are not standardized across organizations. UpToDate, ASMBS, ERAS Society, and the Academy of Nutrition and Dietetics all have their own variation of the postoperative bariatric surgery diet and related recommendations.[12] There is no research to support use of one set of recommendations over another.[46]

The postoperative diet listed in the Academy of Nutrition and Dietetics' *Pocket Guide to Bariatric Surgery* divides the diet stages into 0-3 month and 3-12 months:[46]

- **0-3 months:**

- **Clear Liquids**: Started on postoperative day 0 and 1, clear liquids should be low in sugar and calories and should not include caffeine, alcohol, or carbonation. The patient should slowly increase portion size from sips as tolerated. Because some patients have noted discomfort when using straws initially after surgery, straws should be used with caution and are not recommended for patients who report gastrointestinal discomfort.
- **Full Liquids**: The patient may begin full liquids on postoperative day 0 and 1 and should continue for 10-14 days. Patients should aim for liquids with no added sugar or fewer than 20 grams sugar per serving to decrease risk of dumping syndrome. Patients should include liquids with 25-30 grams protein per serving from a variety of different protein sources and should consume a protein shake or meal replacement drink every 3-4 hours to allow for adequate protein intake while limiting grazing.
- **Semisolid**: As tolerated, the patient may add egg whites, oatmeal, farina, low-fat ricotta, low-fat cot-

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tage cheese, Greek yogurt without chunks/seeds, soft banana, sugar free pudding, etc. Patients may advance to soft foods as tolerated.

- **Soft**: Patients may incorporate soft, moist foods, but should avoid fruits and vegetables that are stringy, have thick or fibrous skins, seeds, or membranes. Bread, rice, and pasta may not be tolerated and so may be delayed until later diet stages.
- **Regular Textures**: As portion size increases and tolerance to foods improve, patients may advance slowly to regular textures as tolerated. The following foods may not be tolerated or cause obstruction, and so may need to be avoided: untoasted bread, rice, pasta, meat or poultry that is dry or fibrous, fruits containing skins or membranes, and vegetables that are stringy.

■ **3 to 12 months:**

As tolerated, patients should aim to follow a healthy, maintenance diet focused on whole foods that are dense in nutrients while limiting highly processed food options.

General Recommendations:

■ Alcohol consumption is discouraged after MBS, due to concern for altered tolerance, increased risk of ulcers, increased calorie consumption, and potential for "addiction transfer."[12,46]

■ After a RYGB, patients should avoid concentrated sweets to limit symptoms of dumping syndrome.[12,46]

■ Patients are encouraged to eat slowly, take small bites, chew well (20-40 chews per bite), and practice mindful eating.[12,46]

■ The RDN should educate the patient on how to follow a structured eating plan to avoid grazing while also ensuring adequate nutrient intake.[12,46] Encourage the patient to distribute protein intake throughout the day.[15]

■ The patient and medical team must monitor for postbariatric hypoglycemia (PBH), which usually occurs >1 year after surgery.[12,46,47]

■ The RDN should monitor the patient's ability to prepare meals, clarify the patient's food sources (e.g. prepared by the patient, family, home health aide, obtained from Meals on Wheels or eaten at a senior center), and assess the knowledge and motivation of the patient.

■ The RDN should assess the patient for ability to be safely physically active[46] and adjust recommendations accordingly.

MACRONUTRIENT AND FLUID NEEDS OF ADULTS AFTER MBS

Nutrient recommendations following MBS are available for adults, but recommendations specific to the older adult following MBS are not available. (See table on page 5).

CONSIDERATIONS FOR OLDER ADULTS

■ **GI Changes**: The older adult population has increased rates of xerostomia, poor dentition/periodontal disease, altered taste, decreased sense of smell, increased risk of gastroesophageal reflux disease (GERD), altered stomach acidity, possible delayed gastric emptying, decreased glucose tolerance, altered insulin secretion and resistance, and increased constipation.[15] Dysphagia also increases with aging, as well as presbysphagia – alterations in normal swallowing function in older adults.[15] The RDN should assess the patient for a history of these issues, identify current problems that may alter intake, and work with the patient to adjust diet accordingly.

■ **Skin**: Increased fragility of skin and loss of skin thickness and moisture increases the risk for delayed wound healing and formation of decubitus ulcers.[15] Additionally, the skin of older adults has decreased ability to manufacture vitamin D in response to sunlight.[15]

■ **Hydration**: Decreased thirst sensation in the older adult patient may increase risk of dehydration.[15(p75)] Common postoperative issues in MBS patients, including nausea, vomiting, diarrhea, poor tolerance to oral intake and poor overall oral intake, may also contribute to dehydration. Patients should be encouraged to monitor the adequacy of their own fluid intake to reduce the risk of dehydration.[12,46]

■ **Medications**: The patient's medications must be considered, as some common medications in patients over the age of 60 may impair absorption, result in side effects (xerostomia, anorexia, taste changes, appetite loss, dysphagia, constipation, diarrhea), deplete nutrients like vitamin B-6, vitamin B-12, or folic acid, or have drug-nutrient interactions.[15] For example, pain medication will likely contribute to constipation that may impair tolerance to oral intake, decrease appetite, and alter absorption of nutrients.[15]

■ **Taste/Smell**: Regardless of surgery, older adults are at risk for age-related altered taste/or smell.[15(p7,84)] Other factors contributing to an altered sense of smell or olfactory loss include chronic disease, medications, cigarette smoking, upper respiratory illness, and history of stroke or epilepsy.[15] Taste sensitivity may decrease in older adults, while periodontal disease, xerostomia, changes in saliva, medications, and cigarette smoking may alter sense of taste. Olfactory or taste dysfunction in older adults may impact the patient's appetite and food choices.[15]

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MACRONUTRIENT/ OTHER	RECOMMENDATION	COMMENTS
Protein	Recommendations for the adult patient who has received MBS vary by organization, and range from: ■ 46 g/day women, 56 g/day men or 10-35% of caloric intake[12] ■ 0.8-1.2 g/kg body weight per day for weight maintenance and 1.2 g/kg body weight during active weight loss (BPD/DS surgery - may increase up to 1.5-2 g/kg).[12] ■ Minimum of 60 grams per day or up to 1.5 grams per kg ideal body weight[46] ■ The RDA for older adults is 1 gram/kg, but after surgery adjustment may need to be made to preserve fat-free mass during weight loss. ■ Maintenance of 35% of calories from protein	Protein recommendations should be individualized and adjustments made based on activity level of the patient, increased needs due to wound healing, symptoms causing malabsorption, renal status, dialysis,[46] as well as whether or not the patient is malnourished.
Fat	During the long term maintenance stage following MBS, daily calorie intake may consist of 20-35% from fat,[12] as tolerated.	Early after surgery, fat intake may be lower due to intolerance.[12]
Carbohydrate	*The UpToDate: Postoperative Nutritional Management* guide recommends early post op for adult patients begin with 50 gm/day; increase as diet advances to 130 gm/day.[12] Recommendations for grams of carbohydrate are not provided through the Academy of Nutrition and Dietetics *Pocket Guide to Bariatric Surgery* or the 2008 ASMBS Allied Health Nutritional Guidelines.	
Fluids	The patient should maintain adequate hydration (usually 1.5 L/d or 48-64 ounces/day)[12,46] and will need to be monitored for tolerance to avoid over/under hydration. While there is not adequate evidence to support routine avoidance of fluids 30 minutes before meals, in the early stages of diet advancement, the patient should be encouraged to avoid drinking with meals and for 30 minutes after the meal. [46]	As with all patients, fluid recommendations should be individualized to the patient, with adjustments made in patients with heart failure, kidney failure, or excessive vomiting, diarrhea, high output enterocutaneous fistula, or increase in edema.[15,46]

■ **Body Composition**: Body composition changes as people age, with progressive skeletal muscle loss and higher proportion of fat.[15,72] The RDN should monitor for age-related loss of muscle mass and quality (sarcopenia including sarcopenic obesity)[15] as well as assess for other causes of unintentional muscle loss, weight loss, decline in strength, and/or increase in frailty that may require evaluation and intervention for malnutrition or nutrient deficiency. Inadequate protein intake may delay healing or cause hair or muscle loss.[15]

Of note, while BMI is often used in clinical practice as a low-cost tool to estimate body fat, it does not adjust for the changes in body composition of older adults or for loss of height. Additionally, studies suggest that a different goal BMI range may be beneficial for older adults, with a moderate BMI potentially reducing risk of

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mortality in this population, but more studies are needed.[48] Current BMI recommendations for older adults are are the same as recommendations for the general adult population.

SUMMARY

Nutrient adequacy and tolerance to diet is altered in the older adult population with a history of MBS due to a combination of factors, which may include altered GI absorption and metabolism, common medications, increased risk of xerostomia, poor dentition/periodontal disease, altered taste, decreased sense of smell, increased risk of GERD, altered stomach acidity, possible delayed gastric emptying, decreased glucose tolerance, alteredinsulin secretion and resistance, and increased constipation.[12,15,46] The RDN can support the success of older adult patients by considering their unique medical history, medications, tolerance to diet, adequacy of macronutrient and micronutrient intake, symptoms, lab results, lifestyle, and weight changes in order to create a personalized dietary plan that meets the patient's needs and goals.

CLINICAL IMPLICATIONS

Older adults with a history of bariatric surgery are at risk for nutrient deficiencies, and the RDN must monitor for:

- poor wound healing due to inadequate energy intake, inadequate protein intake, micronutrient deficiencies, uncontrolled diabetes, or other related issues[15,46]
- intolerance to the diet progression
- adequacy (or excess) of weight loss
- adequacy, but not excess of energy and protein
- constipation or diarrhea due to MBS, medications, dietary intolerance, inadequate fluid intake (constipation), or age-related changes in the GI tract

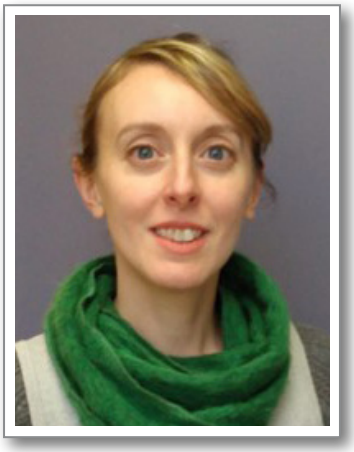
The RDN must offer nutrition-related counseling to support appropriate weight changes and balanced diet as needed.

CONCLUSION

The number of people 60 years and older with a history of MBS continues to grow, and RDNs working with older adults must familiarize themselves with the unique needs of this population. ■

References

Click here to see the references for this article.



About the Author

Katie Defoe-Raymond, MS, RDN, CSG, LDN is a Registered Dietitian at WestMass ElderCare, an Area Agency on Aging. Her role includes working closely with the caterer to ensure that the meals through the Meals on Wheels program meet quality, food safety, and nutrition standards for older adults. She also provides nutrition and food safety education and works with the nutrition counseling program for older adults. She has worked as an inpatient RDN for 10 years, including working with patients in the Geriatric Psychiatric unit. She has also worked in community nutrition as the past Nutrition Coordinator of The Food Bank of Western Massachusetts, in private practice, and had her own private practice in a surgical office specializing in bariatric surgery. She received her Bachelor of Science in Human Nutrition and her Dietetic Internship through the University of Massachusetts Amherst, and her Masters of Science in Nutrition through the University of New Haven. Katie is a Board Certified Specialist in Gerontological Nutrition. She has held several positions on the Western Area Massachusetts Dietetic Association Board. When not working, she enjoys running, hiking, and traveling with her two boys.

CPEU CREDIT

This article has been approved for 1 hour of CPEU credit, available through May 31, 2024.

Click here to take the quiz and answer the Critical Thinking Evaluation Tool questions.

The Commission on Dietetic Registration has expanded the CPEU limits for activity type 175 (Recorded Pre-approved CPE) from 45 to 50 for the RD/RDN and 30 to 33 for the DTR/NDTR for all current 5-year cycles (2017-22, 2018-23, 2019-24, 2020-25, 2021-26, 2021/22-2027) effective immediately.

Interested in Working with the HA DPG?

Seeking Volunteers for Committee Positions

Looking to become more involved in the dietetics profession?
Do you have a passion for older adult nutrition and wellness?

The Healthy Aging Dietetic Practice Group (HA DPG) is looking for volunteers to work with executive-committee directors on various committees. Committees include: communications, sponsorship, membership, and professional development.

- **The Communications Committee** publishes *The Spectrum* newsletter, manages our Facebook and Twitter accounts, and supports the HA DPG website. If you like to write or love social media, this committee might be a great fit for you!
- **The Sponsorship Committee** works on networking and building relationships with organizations to help support HA DPG activities by fundraising and soliciting sponsorship. Sponsorship is all about relationships. If you have good professional relationships with corporations that work in the nutrition and wellness industry, this committee is perfect for you.
- **The Membership Committee** focuses on building and maintaining a unified, engaged, and diverse membership. This includes soliciting current members on ways to increase HA DPG member benefits, writing *The Spectrum* newsletter articles that spotlight current members, and brainstorming new ways to increase current membership. If you enjoy RDN outreach and networking, this committee is looking for you!
- **The Professional Development Committee** plans and coordinates continuing-education opportunities for our DPG. We have multiple webinars each year that require assistance in soliciting topics and speakers, plus organization. If you like to plan, organize, and educate, this is a great opportunity to use those skills.

Candidates are appointed to these committees; they are not part of our DPG's annual elections. Each committee has a director responsible for guiding and leading the team, and each appointed committee member will focus on a specific area as outlined by the director of that committee. The time commitment varies between committees, but it should be about an hour or two a month.

Let us know if you're interested by clicking here. We are sure you will find volunteering for the HA DPG a very rewarding and fun experience.

Author Opportunities

Healthy Aging is seeking newsletter article authors!

Here are a few topics of interest:

- Compilation of state senior nutrition programs
- Continuing-care retirement communities
- Integrative medicine and nutraceuticals
- Medications and related nutritional concerns
- Physical activity for preventing age-related diseases
- Nutrition at end-of-life and hospice care
- International Dysphagia Diet Standardization Initiative
- Nutritional needs of older adults status post bariatric surgery
- Weight management guidelines for adults age 70+
- Mental health and nutrition
- LGBTQ care, older adults, and nutrition
- Malnutrition versus frailty in community-dwelling older adults
- Older adults and substance use/addiction
- A topic of your choice

We highly recommend to review our guidelines on submitting articles and all other submission details. You'll find a list of previous articles in *The Spectrum* here. Link here for the author release.

If you would like to learn more about submitting an article to *The Spectrum*, or would like to suggest a topic for a future article, please contact Kellie Kirschbaum, *The Spectrum*'s Editor in Chief.

Legislative and Advocacy Updates:
Impact of Government Shutdowns

Kat Bechdol, MS, RDN, CSG, LD; Healthy Aging Policy and Advocacy Leader

Over the past decade it feels like we have had constant threats of government shutdowns. Although it feels like a constant threat, an actual government shutdown has only officially occurred three times in the past decade.[1] Most of us who do not work for the federal government are not greatly impacted when this happens; and therefore, we don't spend a lot of time worrying about it. I've known for years how government shutdowns impact essential workers who are forced to work without pay, as my sister has worked for the Department of Homeland Security for over a decade. Every time this happens, we hear of stories of workers who can't afford daycare, groceries, gas, and yet are still expected to show up every single day and work. Eventually these essential workers will receive their back pay. Considering 60% of Americans live paycheck to paycheck, this delay in payment can be detrimental.[2] It wasn't until the last round of government shutdown threats that I began to pay attention to how they impact those who don't work for the federal government. It's not just essential and non-essential government employees who are impacted but also the recipients of government programs.

Many people think of our social programs like Woman, Infant, Children (WIC) or Supplemental Nutrition Assistance Program (SNAP), as programs that continue to operate no matter what. What they fail to realize is that in states where those programs are completely funded by federal dollars, recipients may not get the support they need. This past September, the White House released a statement explaining that "[d]uring [a] … shutdown, women and children who count on WIC would soon start being turned away at grocery store counters, with a federal contingency fund drying up after just a few days and many states left with limited WIC funds to operate the program."[3] For those who meet the criteria to receive these supplemental benefits, they are a lifeline of support for themselves and their families. This doesn't just impact young families, it also impacts older families who receive benefits through the Older Americans Act (OAA), like Meals on Wheels. In states whose state dollars fund these programs, they have a lifeline that allows them to continue providing benefits to their residents as long as their funds sustain them. This is just another example of what advocacy can help us achieve for the individuals we serve.

Older Americans are not just taking care of themselves; they may be caring for others who live or rely on them such as younger family members (like their grandkids), their pets, or other disabled adults. When politicians callously use the threat of a government shutdown remember that these individuals rely on programs funded by the federal government. We are getting ready to enter another election year, which will bring with it attack ads, negativity, and turmoil.
I encourage all of our members to do the research that is needed to know the individuals who will be representing them. Know how they used times, like government shutdowns, to push through unpopular bills. Know if they refused to support bills that would help push forward our profession and care for the individuals we serve. Do not blindly go into an election and hope for the best or sit it out because you believe you are privileged enough for it to not impact you. Every single one of us is impacted by the decisions our government representatives make, and it is our responsibility to go into elections with eyes wide open, and research done to know what we are voting for.

As always, the Academy has action items open for bills and proposed legislation they support. As a member of the Legislative and Public Policy Committee (LPPC) for the Academy, I want to encourage everyone to receive action alerts and answer the call. The legislation the Academy supports would benefit all dietitians and all individuals living in our country. Current legislation we are promoting includes expanding Medicare medical nutrition therapy (MNT) Coverage, advancing the Farm Bill, and funding critical health and nutrition programs. Please do your part and go to the Action Center and pledge your support. As always, don't hesitate to contact me if you have any questions or concerns, we always love to hear from you! ■

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Legislative Update

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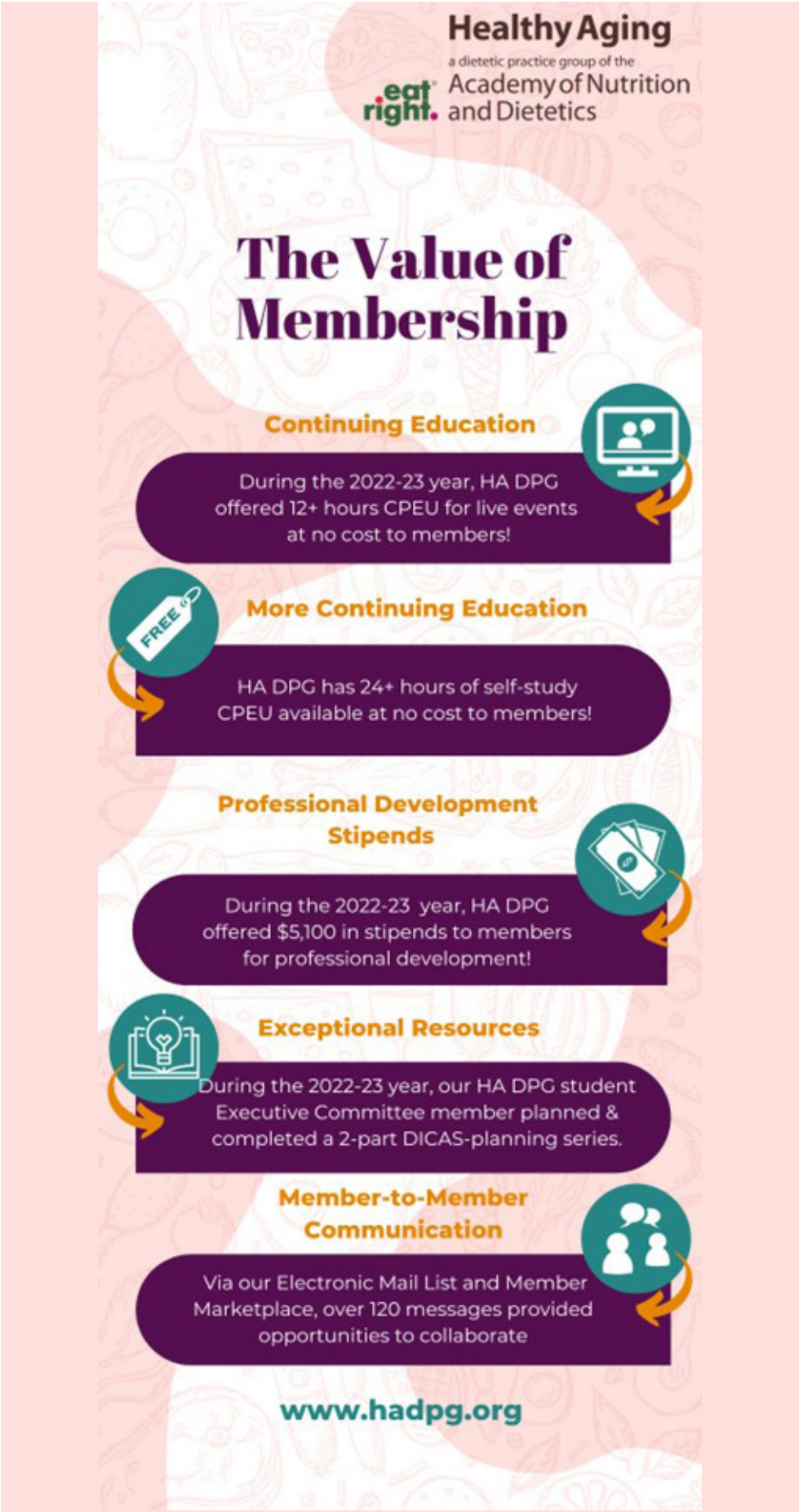


House of Delegates Update:

A Lot Has Been Going On In The HOD Over The Last Few Months!

Maureen Janowsky, RD, CSG, LDN, FAND

DEVELOPING COLLABORATIVE-READY PRACTITIONERS

One of the Critical Issues introduced to the HOD in the 2021-2022 program year was Developing Collaborative-Ready Practitioners. The task force assigned to address this topic worked with the Honors Committee for the creation of a new award related to interprofessional practice. I am happy to share The House Leadership Team (HLT) and staff were recently notified by the Honors Committee that they and the rest of the Board of Directors have approved a two-year pilot of an Outstanding Interprofessional Practice award to judge interest in the award and fine-tune qualifications and scoring criteria. The nomination period will begin on November 1 and end March 1, along with the other national awards. Look for more information from the Academy soon.

CRITICAL ISSUES REVIEW

In August, the HOD reviewed all the critical issues that had been submitted in the last quarter. All but one of the issues are already being addressed by either the HOD or another Academy organizational unit. The new item submitted was artificial intelligence and how it will impact our profession in the future. The delegates broke into small groups to discuss. The feedback was submitted to the HLT for review. The decision was made to include artificial intelligence as a critical issue.

Topic	Current Status
Membership	Current HOD critical issue
Visibility of nutrition and dietetics technician, registered (NDTR)	Current HOD critical issue
Student enrollment	Current HOD critical issue
IDEA (Inclusion, Diversity, Equity and Access)	Council on Future Practice is addressing
Advocacy and communications	Forwarded to Policy Initiatives & Advocacy and Communications
Payment and reimbursement issues	Forwarded to Policy Initiatives & Advocacy
Changes with Commission on Dietetic Registration (CDR)	Forwarded to CDR to address
Artificial intelligence	Identified as a new critical issue

continued on page 11

MARK YOUR CALENDAR: UPCOMING CONFERENCES & EVENTS

Click here for a list of upcoming conferences, workshops, webinars, and other events related to healthy aging.

House of Delegates Update

continued from page 10

As shared during a September eblast, the HLT identified areas of improvement on how the HOD functions related to composition. To create consistency in term length as well as ensure representation of constituency groups, the HLT recommended changing the Delegates at Large composition. The original recommended changes were:

- Phase out the Under 30 Delegate-at-Large to be replaced by the Early Practitioner Delegate-at-Large.
- Transition the NDTR, Retired and the Early Practitioner Delegate-at-Large from elected to appointed positions.
- Adjust the Student Delegate-at-Large from a one-year to a two-year term and the CDR Delegate-at-Large to a three-year term.

Feedback was gathered from Healthy Aging constituents (see below) and submitted to the HLT.

- 86.2% were generally in favor of the proposed changes.
- 6.9% were not in favor.
- 3.4% had no opinion regarding the proposed changes.
- 3.4% were in favor with an exception.

The HLT reviewed the feedback from all the delegates and made the following revisions to their recommendations (noted in the table below):

Position	Current Delegate-at-Large Structure	Proposed Changes (as of 10/12/23)
Retired	3-year term, Elected by Membership	No changes
30 and Under	3-year term, Elected by Membership	Transitioned to an Early Practitioner - credentialed 5 years or less
Student	1-year term, Appointed by President-Elect and Speaker-Elect	Appoint for a 2-year term
NDTR	3-year term, Elected by Membership	No changes
NDEP	3-year term Elected by NDEP members	No changes
ACEND	3-year term, Appointed by ACEND, non-voting	No changes
CDR	1-year term, Appointed by CDR, non-voting	Appoint for a 2-year term, non-voting

These changes are based on the following rationale:

1. Phase out the Under 30 Delegate-at-Large to be replaced by Early Practitioner Delegate-at-Large. Rationale: Currently this Delegate-at-Large has no formal network within their constituency to ensure they are representing the groups' views. If the constituency was tied to years in practice rather than age, Academy staff could support engagement efforts without compromising member privacy.
2. Adjust the Student and CDR Delegate-at-Large positions to two-year terms.

   Rationale: Due to the fast nature of the work of the HODs, one-year terms are not effective in ensuring the highest level of involvement even though they align with other student volunteer term lengths. A second year as student and CDR representatives will help with the continuity of outreach and representation, as well as allow for more thorough training and support for each incoming Delegate-at-Large.

Next steps include deliberation until Nov 1st. The House of Delegates will vote on the changes from November 2nd to November 8th. Look for the results in the next newsletter or reach out to me if you'd like to know earlier.

Please let me know if you have any questions. Also, if you're interested in volunteering to provide feedback to me, please contact me at maureen.janowski@compass-usa.com. ■

HA DPG Members at FNCE® 2023

HA DPG members had a great time at FNCE® 2023 in Denver, Colorado!

HA Executive Committee. From Left to Right: Top Row: Kim Duhon, Chair-elect; Katherine Conrad, Nominating Committee; Kellie Kirschbaum, Newsletter Editor in Chief; Mary Ellen Camire, Membership Chair; Aaron Smith, Nominating Chair at Large; Jacob Mey, Sponsorship Chair. Front: Lynnsey Bogash, Past Chair; Emily Schilling, Current Chair.

Kim Duhon and Mary Ellen Camire at DPG Showcase.

HA DPG Past Chair, Lynnsey Bogash; Chair, Emily Schilling; and Chair-elect, Kim Duhon.

HA DPG Members at FNCE® 2023

HA DPG members had a great time at FNCE® 2023 in Denver, Colorado!

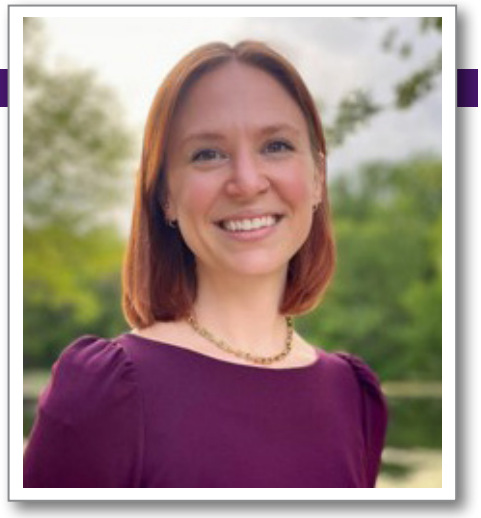
HA Member Reception. Left to Right: Aaron Smith, Kellie Kirschbaum, Jacob Mey, Katherine Conrad.

Maureen Janowski with Members from Healthy Aging Member Reception at FNCE® 2023.

Kellie Kirschbaum and Katherine Conrad greeting our Healthy Aging Members at the HA Member Reception.

Chair's Message

Emily Schilling, RD, LDN, CDCES



Hello Healthy Aging members!

It was such a pleasure connecting with so many of you at FNCE® in Denver! While in Denver, the Healthy Aging executive committee had the opportunity to meet face-to-face. We discussed our member satisfaction survey results and brainstormed for the future of the DPG. Here are a few highlights from the meeting:

MEMBER SATISFACTION SURVEY

Thanks to all of you who completed our member satisfaction survey. The executive committee uses this feedback to better meet your needs!

1. Healthy Aging members ranked *The Spectrum* newsletter, self-study CPEU articles, and educational webinars as our most **valuable member benefits**.
2. Many Healthy Aging members are not aware of the many other great benefits HA has to offer, including:
   a. Podcasts
   b. Stipends &
   c. Social media

Check out the new Healthy Aging website and our social media pages to take advantage of all of our member benefits!

LOOKING FORWARD

To this point, Healthy Aging has primarily focused on chronic disease management in older adults. However, we want to acknowledge the growing interest in longevity and the fact that we are ALL aging every day. With this in mind, Healthy Aging plans to start including more educational resources aimed at prevention – what steps can you and your patients take now to age more healthfully?

We noted specific areas of interest in aging as it relates to hormones, skin health, cognition preservation, bone and muscle mass maintenance, sexual health, physical activity, and sleep. If any of these categories are your area of expertise, let us know! We'd love to learn more and share with members. You can reach out to me here.

That's all for now!
Emily

Healthy Aging Podcasts

Healthy Aging is pleased to present a series of podcasts, hosted and produced by HA DPG Executive Committee member, Jacob Mey, PhD, RD.

In this podcast series, Jacob interviews a variety of RDNs and other professionals on new research, evidenced-based practice, issues in long-term care, and many other topics related to healthy aging.

Need Continuing-Education Credits?

HA DPG offers a variety of CPEU and learning opportunities:

- Free self-study webinars
- Free continuing-education articles published in *The Spectrum*
- Free podcasts
- Self-study virtual conferences for purchase
- CSG Flashcards and Skill Review Study Videos for purchase

Why Join Healthy Aging DPG?

Healthy Aging Dietetic Practice Group offers a wide array of member benefits!

Click any of the following links to learn more.

- Newsletters (including access to all archived newsletters)
- Professional development stipends (FNCE®, our Virtual Workshop and to support studying for/completing the CDR CSG credentialing process)
- The electronic mailing list (EML–formerly known as the listserv)
- "Live" and recorded webinars on timely topics
- Podcasts–including a CPEU offering
- Our CSG study resources, including the CSG Help Desk, flashcards and resources

Become a Member!

Tell Us What You Think!

We want to make *The Spectrum* as useful to you as possible. Please send us your feedback!

Click this graphic to let us know your comments, suggestions, and questions.

Healthy Aging
Dietetic Practice Group

Our Mission

Empowering and supporting members to be food and nutrition leaders promoting life-long wellness.

Our Vision

Optimizing longevity and wellness in aging through food and nutrition.

HA EXECUTIVE COMMITTEE 2023–2024

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