OHCA Dining & Nutritional Service Conference

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GLP-1R Agonists and Older Adults

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Agenda

- Obesity in older adults
- Weight loss medications
  - GLP-1R Agonists
- Dietary Considerations
- Clinical experiences with patients prescribed GLP-1R Agonists

Objectives

- Considerations for planned weight loss in older adults.
- Understand mechanism of GLP-1R Agonists medications.
- Provide dietary guidance and education to patients prescribed GLP-1R Agonists.
- Clinical application in practice.

Review of What We Know

Obesity is a chronic disease of excess adiposity or body fat, which results from excessive accumulation of fat that is more than the body's skeletal and physical standards.

Obesity is recognized as a chronic and inflammatory disease.

Obesity is defined by healthcare professionals by BMI (Body Mass Index), since it is an inexpensive, quick, and fairly reliable measure of body fatness.

Lancet Diabetes and Endocrinology Commission met monthly from June 2022 – Dec 2024 used a consensus to arrive at recommendations for defining and diagnosing clinical obesity.

Goal was to reframe the definition as a condition which the risk to health associated with excess adiposity is objectively documented by specific s/s reflecting biological alterations of organs and tissues. This is consistent with existing illness.

- Clinical obesity
- Pre-clinical obesity

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Review of What We Know

BMI thresholds for overweight and obese may be considered overly restrictive for older adults. A higher BMI may be protective with regard to all-cause mortality.

Different studies result in different cut-off points of BMI for older adults.

Per the 4th edition Nutrition Care of the Older Adult, the optimal BMI range for older adults is 27-28 for males and 31-32 for females.

BMI classifications are one guide to evaluate weight in older adults. It is also essential to monitor weight changes over time.

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Review of What We Know

Obesity is thought to result in persistent, low-grade inflammation.

Individuals with obesity have a high risk of developing conditions that may reduce mobility and decrease quality of life.

- Type 2 Diabetes
- Certain cancers
- Cardiovascular disease
  - HTN, HLD, CAD, CVA
- Liver or gallbladder disease
- Infertility problems
- Increases risk of severe illness from COVID-19

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Obesity in Older Adults

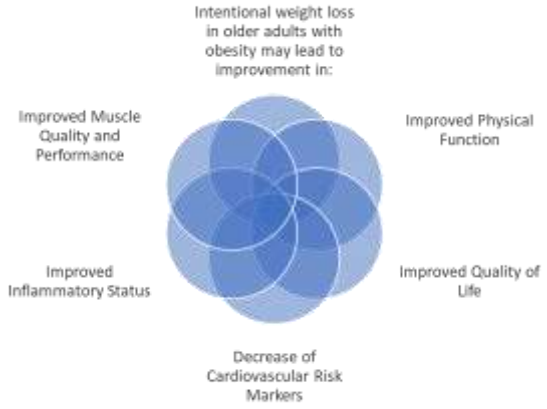
Older adults with obesity face limitations in function that can create a cycle of inactivity, decrease in functional abilities, and additional weight gain.

Additional contributors of weight gain in middle aged and older adults include chronic illness, psychosocial factors, and certain medications, such as antidepressants and steroids.



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Obesity in Older Adults



Cautions Regarding Obesity in Older Adults

Due to lowered energy expenditure, obesity is common among non-ambulatory older adults.	Obesity prevalence decreases after age 80.	The relationship of increased risk of morbidity and mortality to obesity for the general population seems to decline over time.
Weight loss in overweight older adults may contribute to negative outcomes, including decreased bone mineral density and loss of muscle mass.	Achieving and maintaining a stable usual body weight is generally a preferred standard, as changes in an older adult's body weight can substantially affect nutritional health.	Morbidity risks increase when low body weight is associated with illness or injury.

Obesity in Older Adults

Sarcopenic obesity is a coupling of sarcopenia (loss of skeletal muscle mass) and body fat that classifies an individual as overweight or obese. The cut-offs for obesity and diagnostic criteria vary in the literature.

Potential factors that may affect weight: fluid retention, edema, heart failure, renal or liver disease, changes in eating habits and physical activity.

Clinicians should consider the risks vs. benefits before recommending a planned weight loss program for older adults. For many older adults, maintaining UBW may be more prudent than weight reduction.

Planned weight loss efforts should be carefully planned and frequently monitored, with adjustments to the plan of care as indicated.

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Cautions Regarding Obesity in Older Adults

Depending upon the level of commitment to ongoing lifestyle management, older adults with a history of bariatric surgery are especially at risk for sarcopenic obesity and micronutrient deficiencies.

Poor diet quality can be a result of food insecurity, thus may contribute to sarcopenic obesity.

It's possible to have a combination of sarcopenic obesity and malnutrition, in addition to other nutrition related concerns.



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Obesity in Older Adults

CMS Appendix PP F692 Nutrition and Hydration:

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

Definitions:

Acceptable parameters of nutritional status refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values.

Guidance:

Body weight and laboratory results can often be stabilized or improved with time, but may not be correctable in some individuals.

Assessment:

Weight goals should be based on a resident's usual body weight or desired body weight.

https://www.cms.gov/files/document/qso-25-14-nh.pdf (pages 378-381).

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Suggested Documentation

- "Although BMI = 31.3, obesity class 1, may be healthy weight for older female."
- BMI = 28.8, overweight. Nutrition CAA: "Do not proceed for overweight. Not acutely affecting nutrition status at this time and may be healthy weight for older adult."
- "CBW = 188 lb, trending weight loss of 8 lb, 4% x 1 month. However, slow wt loss may be beneficial without compromising nutrition status d/t BMI = 29.7. This indicates overwt, yet may be considered healthy weight for older adult. Meal intake is 50-100% per usual. Resident denies any change in appetite. Enjoys food related activities. Recent increased activity with PT x 4 weeks may have resulted in increased energy expenditure. Continue to monitor weight and intake."

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Obesity in Older Adults

- Combining physical activity with dietary changes is essential to aid in preserving lean body mass and bone density.
- Both resistance and aerobic exercise are most effective in improving functional status of older adults with obesity that are attempting weight loss.
- The rate of weight loss in sedentary older adults may be much slower than in younger adults.



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Obesity in Older Adults

Knowledge and consent of the patient and medical provider should be in place before initiating a planned weight loss program.

Considerations before determining whether weight loss may be appropriate for older adults with obesity.

- What are the risks associated with obesity treatment?
- Will weight loss reduce risk factors for other complications?
- May weight loss prolong the individual's life?
- Does the individual desire weight loss? Are they motivated to make lifestyle changes needed to support weight loss?
- Will a decreased calorie diet reduce the individual's ability to consume adequate nutrition to maintain health?

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Obesity in Older Adults

If the individual desires weight loss, the Nutrition Professional is advised to

- Care plan and supervise/monitor the weight loss.
- Provide appropriate calorie level and adjust as weight is lost.
- Take measures to prevent malnutrition and vitamin/mineral deficiencies.
- Preventing complications such as bone and muscle loss, pressure injuries, weakness, and falls is a priority.



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Obesity in Older Adults



Patients that are obese and have pressure injuries may have a more appropriate goal of weight maintenance rather than weight loss d/t increased calorie and protein needs to support wound healing.

Planned weight loss is not appropriate for patients with dementia, frail older adults, those with serious medical conditions that threaten mortality, and those who do not want to lose weight.

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Obesity in Older Adults

Weight management challenges in older adults:

- Metabolism declines with age therefore, older adults require fewer calories to meet energy needs, and even fewer to lose weight.
- Taste and smell are often decreased r/t aging or medications, thus making food taste different.
- Food is readily available and eating habits are well established. To achieve goals, behavioral changes will be needed.
- To improve success, a combination of calorie reduction, increased physical activity, and behavioral strategies are indicated. However, what if the individual is still not successful in achieving weight loss goals??.....

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Weight Loss Medications

Over the counter (OTC) medications:

- May interact with prescription medications to increase or decrease effectiveness.
- May have negative side effects.
- May lose effectiveness over time.
- Alli (half-strength prescription Xenical)
  - Blocks approx. 25% dietary fat absorbed
  - Accompany with a low-fat diet to avoid negative GI side effects
- OTC appetite suppressants (such as Dexatrim)
  - Increase serotonin or catecholamine, brain chemicals that may aid in feeling full or not hungry.
  - Should not be used by those with heart disease, as they can increase BP and hear rate.
  - May cause lightheadedness or drowsiness.
  - Larger doses are essentially stimulants

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Weight Loss Medications

Herbs and Supplements

- No scientific evidence of efficacy

Herbal supplements/remedies and OTC meds for weight loss are generally not recommended by healthcare professionals for effective, long term weight loss. They may be addictive and harmful. However, the popular press and lay media may tout their benefits.



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Medications for Diabetes

SGLT2 Inhibitor: Inhibits SGLT2 (sodium-glucose transport 2) in the kidney's proximal nephron. This results in glucose excretion in the urine, when it would normally be reabsorbed. Once daily dose. Does not cause hypoglycemia. **May promote weight loss** and hypotension.

- Invokana (canagliflozin)
- Farxiga (dapaglifozin)
- Jardiance (empaglifozin)
- Steglatro (ertugliflozin)

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Medications for Diabetes

SGLT2 potential adverse effects, nutrition considerations, and concerns in older adults:

- Nausea, urinary frequency, genitourinary infections.
- Dehydration
- Hypotension
- Cost



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GLP-1R Agonists

GLP1 (glucagon-like peptide 1) Receptor Agonists or Incretin Mimetics

- **GLP1 is an incretin hormone** produced by L-cells in the small intestine and is released into the bloodstream after eating. Enhances insulin secretion from the pancreas, suppresses glucagon secretion from the liver, shows gastric emptying, and suppresses the appetite only in the presence of glucose.
  - **A group of metabolic hormones, incretins stimulate a decrease in blood glucose levels.**

- Resists DPP-4 (dipeptidyl peptidase 4) breakdown, allowing them to last hours, instead of minutes in the natural state
  - DPP-4 is an enzyme that acts on incretin hormones, mainly GLP1 and GIP (gastric inhibitory peptide).
  - By inhibiting DPP-4, levels of GLP-1 and GIP increase, which result in increased beta-cell insulin secretion in the pancreas, thus reducing postprandial and fasting hyperglycemia.

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GLP-1R Agonists

There is an increased understanding of the role incretin hormones play in obesity.

Like the hormone insulin, incretin hormones are crucial regulators of metabolism. They are now recognized to have a significant impact on glucose and lipid levels, as well as body weight.

In summary, incretin-based therapies, such as Glucagon-like peptide-1 receptor agonists (GLP-1RAs) have the effect of appetite suppression and increased release of insulin by the pancreas when glucose levels rise after eating.



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Medications for Diabetes

GLP1 (glucagon-like peptide 1) Receptor Agonists or Incretin Mimetics

- Target post meal blood sugar levels.
- Promotes average weight loss of 10 lb.
- Doses and frequencies of injections vary from following a meal to weekly
- Possible Side Effects:
  - Nausea and vomiting (especially with high-fat or large meals)
  - Delayed gastric emptying
  - Constipation appears to have greatest duration (of GI side effects)
  - Recent concerns about acute pancreatitis
  - Not known to cause hypoglycemia, unless paired with sulfonylureas
  - Not recommended if the presence of renal disease or GI disorders
  - **Some result in weight loss, which is often a desired side effect**

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Medications for Diabetes

SGLT2 positives:

- Demonstrated to improve glycemic control and BP in patients with type 2 DM, including older adults.
- Can be used alone and in combination with other medications.

GLP-1 and GIP positives:

- Low hypoglycemia risk.
- Benefit of weight loss for overweight patients.

Medications for Diabetes

The 2023 American Diabetes Association Standards of Care gave special consideration to SGLT2 and GLP-1 due to their benefits of reducing the risk of major adverse cardiovascular events, as well as heart failure, and heart-related deaths. They have also shown to decrease the progression of CKD.

GLP-1 medications are now considered the first-line injection treatment before insulin.



GLP-1 Receptor Agonists

Brand Name (Generic Name). Approval date.

- Byetta (exenatide). 2005
- Victoza (liraglutide). 2010
- Saxenda (liraglutide). 2014
- Trulicity (dulaglutide). 2014
- **Ozempic (semaglutide).** 2017
- **Wegovy (semaglutide).** 2021
- **Mounjaro (tirzepatide).** 2022
- **Zepbound (tirzepatide).** 2023

Rx for GLP-1R agonist increased by >2000% over the year 2023.



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GLP-1 Receptor Agonists

GLP-1 (oral): Semaglutide (Rybelsus):

Site and mechanism of action: GI tract, pancreas, and liver. Enhances glucose-dependent insulin release, suppresses postpradial glucagon secretion, and slows gastric emptying.

Potential adverse affects:

Constipation, nausea, diarrhea.

Concerns for older adults:

Side effects, cost, titration complexity unless treatment plan is simplified.



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GLP-1R Agonists

Byetta (exenatide)

Victoza (liraglutide)

**DM mgt

Saxenda (liraglutide)

****Specific for wt loss. Similar mechanism as Ozempic, but given daily instead of wkly injections.**

Trulicity (dulaglutide)

**1x/wk injection used to tx type 2 DM. Not approved specifically for wt loss.

Ozempic (semaglutide)

Wegovy (semaglutide)

****Same active ingredient as Ozempic, but specifically approved for wt loss, rather than DM mgt. Higher dose than Ozempic.**

Mounjaro (tirzepatide)

****Targets both hormone receptors GLP-1 and GIP. Used for type 2 DM mgt, but being studied for wt loss. Showing sig effects on decreasing appt and wt.**

Zepbound (tirzepatide)

****Obesity**

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GLP-1 Receptor Agonists

Variable weight loss results after one year of treatment:

- Approx 25% did not lose >10% body weight
- Approx 10% of people did not lose >5% of body weight
- Not an exact comparison, but studies suggest tirzepatide may more effective
- Variables influencing successful weight loss: glycemic status, gender, higher BMI

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GLP-1 Receptor Agonists

- With many incretin mimetics in the pharmaceutical market, it is unlikely that they will fade away or become a fad.
- This stresses the importance of understanding key nutritional considerations for patients.
- This could support the pivotal role dietitians play in facilitating healthy weight loss.



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Dietary Considerations

- It is imperative to incorporate nutrition and lifestyle interventions in the comprehensive management of obesity across the continuum of care.
- Access to evidenced-based lifestyle interventions with MNT must be available to individuals taking obesity medications to optimize health outcomes and to address the multifaceted aspects of obesity.
- Individuals taking obesity medications eat less, so a healthful eating plan is important to promote the loss of excess fat vs. lean body mass, and to ensure adequate intake of essential nutrients.
- Nutrition professionals are skilled to assess and mitigate common side effects from obesity medications, such as adverse GI symptoms, malnutrition, loss of lean muscle, recognizing signs of dehydration, disordered eating patterns, and/or other unintended consequences.

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Dietary Considerations

The Academy of Nutrition and Dietetics urges pharmaceutical manufacturers of obesity medications, along with obesity medicine providers and other health care practitioners specializing in obesity management, to enhance the efficacy and successful use of these medications by including, alongside the prescription, a referral for medical nutrition therapy (MNT) delivered by a registered dietitian nutritionist (RDN).

Researchers should closely monitor the obesity/malnutrition paradox among people living with overweight or obesity and consider social determinants of health, including access to these medications and lifestyle interventions delivered by an RDN.

Policy changes are necessary to ensure individuals have access to both lifestyle interventions and obesity medications that have the potential to improve the health of many people in the U.S. and are essential to reduce health inequity and disparity.

www.eatrightpro.org/obesity-medication

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Dietary Considerations

Concern: One analysis revealed 40% fat-free mass loss, but other data is less concerning.

Reason: Lean mass helps maintain metabolic rate, as well as decreasing risk for osteoporosis, falls, and injuries.

Recommendation: Emphasize high quality protein, preferably in 20-30 g increments, especially combined with exercise.

Concern: GLP-1 rx slow gastric motility and digestion.

Reason: Constipation and diarrhea among potential GI side effects.

Recommendation: Hydration, soluble fiber and insoluble fiber may aid in relieving constipation.

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Dietary Considerations

Concern: Medication continuation is an issue. EMR data suggest a large portion of users discontinue GLP1R agonist therapy.

Reason: Variety of reasons; may presume cost and/or side effects.

Recommendation: Studies show a lower CHO approach **may** limit weight regain.

Concern: GLP1R agonist use may be likened to vertical sleeve gastrectomy obesity. Very low-calorie diets and obesity increase risk of vitamin and mineral deficiencies.

Recommendation: Be aware of micronutrient deficiency symptoms. Focus on calcium, zinc, Mg+, Vitamins A, D, E, C, B vitamins.

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Dietary Considerations

Goals of Dietary Management:

- Maintain muscle mass
- Prioritize nutrient dense foods
- Avoid nutritional deficiencies
- Reduce and/or manage GI side-effects
- Emphasizing reasons why the above are important
- Support transition/avoidance of weight gain after rx therapy ends
- Consider personal and religious preferences



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Dietary Considerations



Benefits of Protein:

- Support blood sugar management when compared to high CHO meals
- Often nutrient dense foods, particularly related to insufficiencies seen in obesity (zinc, iron, B vitamins)
- Aids in satiety
- Minimizes lean body mass during weight loss
- Assist with avoiding weight regain.

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Dietary Considerations

Ideally, protein intake should be distributed across the day.

Encourage intake of Essential Amino Acids and Branch Chain Amino Acids.

Both normal protein and high protein diets noted to assist with blood sugar control in individuals with Type 2 DM.



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Dietary Considerations

Healthy fats:

- Contribute to increased satisfaction and mouth feel
- Not associated with weight gain
- May contribute to improved physical strength
- Important role in brain health

Fried foods and high fat meals may increase GI symptoms for those rx GLP-1 agonists.



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Dietary Considerations

Constipation:

- Fiber intake may assist with relieving constipation.
- Adequate hydration
- Encourage physical activity



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Dietary Considerations



Animal and human studies with primary polydipsia suggest that GLP-1R agonists may suppress thirst.

Those in hot climates and older adults may be at increased risk of dehydration.

Recommended fluid intake: >2-3 Liters/day.

GLP-1R Agonists

Weight regain may occur after withdrawal of semaglutide, as similar changes in cardiometabolic variables.

Studies support the chronicity of obesity. Suggest ongoing treatment is needed to maintain improvements in weight and health.

The efficacy of GLP-1R agonists is supported by multiple high-quality clinical trials.

Data indicates GLP-1R agonists work through multiple mechanisms, including enhancing satiety and taste-perception and cravings. New mechanisms of action are being discovered.

Delayed gastric emptying and slowed intestinal transit should be considered with nutrition recommendations, similar to other major weight loss interventions and accompanying low-calorie intakes.

GLP-1R Agonists

Ecnoglutide is an emerging GLP-1 agonist, demonstrating significant weight loss benefits in a recent phase 3 trial. The trial reported a positive safety profile, with generally mild and transient GI side-effects being the most common.

For dietitians, the developments with GLP-1s emphasize the growing role of pharmacotherapy in comprehensive weight loss strategies.

Lifestyle interventions remain foundational, however, ecnoglutide may enhance outcomes when combined with behavior change support and nutrition counseling.



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GLP-1R Agonists and Older Adults

- There is need to be cautious with GLP-1R Agonists and older adults due to changes with the aging body. Older adults may not see the results seen in younger people.
- Risk of loss of muscle and bone. For every pound lost, about 25% is muscle and bone, which older adults have less to start with.
- Risk of nutrient deficiencies related to reduced appetite (leading to decreased intake).
- Unintended ongoing weight loss.
- Previously noted, an overweight BMI (25-29.9) may be protective for older adults.
- Caution with alcohol, which may increase hypoglycemia and pancreatitis risk.

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GLP-1R Agonists and Older Adults

Questions to consider:

1. Is the individual willing (and able) to stay on the med for life? Some studies show weight regain after the med is discontinued.

2. Do the benefits outweigh the potential risks?

3. Does the individual have a stable mental state? Some patients have reported increased depression and suicidal ideation.

4. Does the individual have access to ongoing care?



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GLP-1R Agonists and Older Adults



5. Can the individual follow a strength training routine? This aids in protecting bones and muscle, especially for adults older than 50.

6. Is the individual able and willing to consume adequate protein?

7. Can the individual support the financial commitment?

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GLP-1R Agonists and Older Adults

Medicare does not cover meds prescribed for weight loss, but Medicare Part D may cover GLP-1R Agonists when prescribed for other reasons, such as CVD or DM.

- Legislation from 2003 prohibits Medicare from covering drugs for weight loss.

Treat and Reduce Obesity Act (TROA) of 2025

- Would amend the Social Security Act
  - To expand Medicare coverage for FDA-Approved anti-obesity medications.
  - To expand Medicare Coverage for Intensive Behavioral Therapy (IBT)
  - Latest action – As of June 5, 2025, referred to the Senate Committee on Finance.

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GLP-1R Agonists and Older Adults

Does Medicare cover Ozempic and drugs taken for weight loss? AARP September 13, 2023

Does Medicare Cover Ozempic and Other Weight Loss drugs? (aarp.org)

- **Ozempic** is FDA-approved for treating diabetes but not for weight loss, even though some people use it off-label for that purpose.
- **Wegovy** is approved by the FDA for weight loss for people with a BMI of 30 or higher, or with a BMI of 27 or higher and at least one weight-related health issue, such as high blood pressure or high cholesterol, and now for adults with cardiovascular disease who are also overweight.
- **Mounjaro** (tirzepatide) is an FDA-approved diabetes drug that Lilly is investigating using for weight loss. More than 90 percent of commercial and Part D plans cover Mounjaro for people with type 2 diabetes, according to a Lilly spokesperson.
- **Zepbound** (tirzepatide) is FDA-approved for weight loss but not for other conditions, so Medicare doesn't cover it.

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GLP-1R Agonists and Older Adults

- Insurance may be a main limiting factor for doctors to prescribe. Different insurance plans carried by different employers follow different plans.
- GLP-1R Agonists may cost around $800 per month in the U.S.
  - Although similar costs to produce, U.S. price is approximately 20x higher than estimated minimum price globally.
- Typical requirements/candidates may include:
  - BMI >/= 30 with or without comorbid condition or >/= 28 with co-morbid condition (DM, HTN, joint disease) (*Consider BMI of >/= 23 and >/=25 for Asian Americans)
  - Have attempted nutrition and lifestyle interventions
  - Willing to keep regular f/u visits with PCP, RDN, behavioral health counselor (if indicated)
- Employers may require employees to participate in a lifestyle modification program.

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GLP-1R Agonists

As always, patients should be evaluated on an individual and personalized basis, with evidenced-based support and interventions, so recommendations can facilitate success.



Cost of GLP-1 agonists remains a major barrier.

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Consultant Experiences

Consultant E.C.:

I have seen it for DM and planned weight loss. One resident in particular was in her 50-60s with DM. Although her BS was better controlled, she had low energy expenditure and would drink SSBs despite education- so she never lost weight.

Consultant B.C.:

I have a Resident on Ozempic with a SWL trigger and I have noted this med as a possible reason for his WL trend. He has a lot going on, so it is hard to say if the med was the sole reason for the WL trend.

Truthfully, most of the Residents that I see on Ozempic are not losing weight (most are obese and non-compliant with diet).

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Consultant Experiences

Consultant K.M.:

We have one resident on Ozempic. She is very involved in making decisions regarding her meals, intake, etc. She usually eats two meals and will have a snack in the evening (She does snack on food in her room as well). She does experience nausea, but this has improved. Continued education provided on drinking more water and focusing on protein-based foods to assist with the nausea. I do think they decreased the dose at some point to see if this would help. She has a wound and will only accept Boost glucose one time per day and no other high protein supplements. Family does try to provide snacks with protein. Since last October her weight hx: 176# with cbw 157#.

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Consultant Experiences

Consultant G.B.:

Wt 6-13-24 216.4 lb, sig wt loss 12.4 lb, 5.4% > 30 days. Reweighed to verify from monthly wt on 6-2-24. Wt loss is expected (planned) d/t rx ozempic on 5-20-24 and wt loss is an expected side effect. Slow wt loss is also beneficial without compromising nutrition status d/t obesity BMI 31.2.

Meal intake varies, but often good. No new labs since recent Q review. BS may range 90-227.

RDN attempted to speak w/ R, but she was sleeping soundly and unable to arouse. Significant amount of food observed on shelf in room, as well as personal fridge. Inform MD/NP of wt loss.

Current wt indicates 17 lb wt loss x 1 year, but some weight discrepancies probable.

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Consultant Experiences

Consultant A.B. She also shared the meal plan provided by the physician.

Recent experience:

Mounjaro & Wegovy- R consulted weight loss clinic was prescribed Reduced Calorie/Carb controlled diet. Received weekly injection & routine follow-up appt.

Ozempic: Experience with Rehab/short term Residents, however, unable to get from pharmacy & Residents have to bring in from home



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Consultant Experience from A.B.

Resident #1 (Mounjaro):

(8/9/23) 285.9#, BMI 47.7; experienced 20.9#/7.3% loss x 30d (9/11/23) 254# BMI 44.2; additional -5# (10/26) 259.9# (lowest weight)

Then experienced gradual gain; 1 yr later (8/14/24) 278# BMI 46.2

Initial note:

Dietary note, consult for diet clarification. R s/p appt 8/2/23 St. Elizabeth's Bariatric Center: Dr. R. for weight loss. Instructions received for reduced caloric meal plan ~1200kcal/d. Diet instructions reviewed with R at length, verbalized understanding & desire to proceed w/ recommendations. R states "I'm going to follow exactly what he says" for desired weight loss. High protein shakes recommended BID as meal replacements; facility supplement options discussed. R agreed to 8oz House Glucose BID (500kcal, 28g) & 30mL House Liquid protein QD (100kcal, 15g). Cereal & "snack" options outlined by MD and facility options discussed w/R & preferences updated. Cereal & Lactose-free milk to be provided at breakfast & fat snack option for lunch with protein supplement only. Frozen meal recommended for dinner per MD; facility to provide scheduled meal for dinner & R in agreement. Apple Cider vinegar advised per MD, R requests not to provide at this time. Risk for constipation discussed, R in agreement to proceed w/ fiber supplement & discussed w/ CNP: rec. Metamucil 1 capsule QD. Adequate water intake reviewed; R aware of 64oz/d recommended. N.O. Mounjaro, MVI+min. QD & Lactase w/ meals per MD. Nsg & dietary updated on above. Will proceed and follow, anticipated desired weight loss with above dietary meal plan.

Issues: significant constipation initially. Continued compliance & insurance coverage. As facility, limited to accommodating specific diet recommendations provided & R/family not always able to provide

Currently, unable to get insurance to cover. Last received dose (8/30/24). A1C 4.4%(5/31)

Weight loss MD to clarify but R refusing to go to follow-up appt.

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Consultant Experience from A.B.

Resident #2(Wegovy):

Issue getting coverage; received for (2) month then insurance wouldn't cover.

Did reconsult w/ weight loss clinic & physician, attempting to get Wegovy covered for dx HTN (did not qualify for dx DM r/t A1C WNL).

Wegovy 6/13/24-7/30/24

(7/12) 266.8lb (BMI 44.5)

(8/9) 263lb

(9/13) 271.9lb

(8/12) A1C 6%

Dietary note. R s/p weight loss consultation 6/4/24. MD orders reviewed; N.O. Wegovy for appetite suppressant pending approval per Nsg. Diet recommendations as follows: CCD, Reduced calorie meal plan: 1300kcal/d, 72g protein, 22g fiber, 64oz water with 8oz ONS BID & PT referral. Fiber capsule (6/5-6/19) ordered. Met with R at length this date. Meal plan & meal preferences updated with recommended guidelines discussed in detail. Portion control reinforced with food & meal options adjusted. R requests cont.30mL House Liquid protein BID in addition to above ONS BID, aware of additional calories with risk of exceeding set goal per MD, however, wishes to maintain additional protein at this time. Preferences communicated with dietary & Nsg updated with supplement orders clarified per R request. Will proceed and follow.

Resident #2; Nsg told me despite running all dx options for Wegovy, insurance denied coverage for Wegovy.

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THANK YOU!

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