

Advancing the Quality of Malnutrition Care for Older Adults Through Community Prevention and Response

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INTRODUCTION

Malnutrition poses a significant threat to the health, well-being, and independence of older adults. As this population continues to grow in the United States, greater efforts are needed to prevent and address malnutrition where individuals live and manage their health: in their homes and communities. This commentary proposes a community-focused approach for further advancing malnutrition care for community-dwelling older adults, by recognizing the broader social factors that contribute to and exacerbate malnutrition. Suggested approaches to support and build upon the numerous existing efforts to improve malnutrition care are discussed. Specifically, strategies and recommendations are provided for proactively addressing and preventing malnutrition among community-dwelling older adults by:

- Expanding screening in the community
- Leveraging existing community-based programs and services
- Strengthening collaboration and communication between clinical and community settings

Malnutrition as a Multifaceted Condition

Malnutrition disproportionately affects older adults, with up to 1 out of 2 older adults at risk for malnutrition.^{1,2} Malnutrition impacts almost all bodily functions, organs, and systems; it is associated with poor health outcomes and costly healthcare utilization, including increased length of hospital stays and greater re-admission rates.³⁻⁹ Malnutrition-related costs place a substantial burden on the American economy, and older adults represent a disproportionate share of costs compared to the general population.^{10,11}

The risk factors associated with malnutrition are multifaceted and often synergistic or bidirectional. Clinical (medical) risk factors include (but are not limited to) chronic conditions, age, frailty, depression, polypharmacy, poor oral health, and impaired swallowing.¹²⁻¹⁶ Social (nonmedical) risk factors for malnutrition include (but are not limited to) food insecurity, low-quality diets, food deserts, limited access to federal-assistance programs, low-income status or living in poverty, limited mobility, lack of transportation, living alone, and social isolation.¹²⁻¹⁶

SDOH are defined by the World Health Organization (WHO) as “the conditions in which people are born, grow, live, work and age.”

While there have been substantial efforts to address clinical risk factors for malnutrition, there is a growing awareness of the significant impact of social factors on health (also referred to as the social determinants of health [SDOH]), especially within the healthcare community.¹⁷ SDOH are defined by the World Health Organization (WHO) as “the conditions in which people are born, grow, live, work and age”¹⁸ and must be addressed to promote health. Research shows that social factors account for greater negative health outcomes, including increased morbidity and mortality, and greater healthcare costs than medical care,^{17,19,20} with medical care determining as little as 10% of one’s health.^{17,19} As a result, efforts to address the SDOH, including social factors that contribute to malnutrition or increase the risk of becoming malnourished, could have a substantial impact on older adults’ nutritional status, as well as their overall health and well-being.

Building on Efforts to Advance Malnutrition Care

There are numerous trailblazing organizations, coalitions, and initiatives—as well as extensive research efforts—that have advanced the quality of malnutrition care for older adults. Examples of such efforts include (but are not limited to):

- Improving and promoting malnutrition screening, diagnosis, and treatment in clinical settings²¹⁻²³
- Addressing malnutrition and unmet nutritional needs in the community setting²⁴⁻²⁶
- Advocacy and educational efforts to increase awareness about the importance of addressing and preventing malnutrition among older adults

[Defeat Malnutrition Today](#) is a multidisciplinary coalition of over 70 organizations and stakeholders (many of which are represented in Figure 1), all working toward the singular goal to defeat older adult malnutrition. Defeat Malnutrition Today is driving advancement across key efforts, as well as fueling change and innovation, such as the development of the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults* (the *Blueprint*).²⁷ Click on the resources in Figure 1 for more information about many of the groundbreaking efforts to advance malnutrition care and prevention.

Given the numerous efforts, this commentary identifies opportunities to build upon existing work for further advancing comprehensive malnutrition care and prevention among community-dwelling older adults. An important first step is to expand the role of community-based organizations (CBOs), such as Area Agencies on Aging (AAA), social-service agen-

Continued on page 22

Innovations

Continued from page 21

cies, nutrition services, senior centers, adult daycare centers, and faith-based organizations. These organizations can identify and address malnutrition by recognizing unmet social needs as a critical element to achieve comprehensive malnutrition care, response, and prevention. CBOs are capable of addressing a variety of unmet social needs, including transportation barriers, social isolation or loneliness, nutritional needs, activities of daily living (ADLs), instrumental activities of daily living (IADLs), and access to federal assistance programs through the provision of supportive services. In addition, CBOs have well-established, trusted relationships with the older adults they serve. Because of these existing capabilities inherent to CBOs, they are uniquely positioned to play a larger role in addressing and preventing malnutrition.

EXPANDING SCREENING IN THE COMMUNITY

There is growing recognition of the increased role that CBOs can play in identifying and addressing the social risk factors that may cause or exacerbate

malnutrition. As such, an opportunity exists for CBOs to utilize their existing capabilities to expand and enhance screening in the community for both malnutrition and unmet social needs, and to respond accordingly. For example, CBOs could play a more prominent role in addressing and preventing malnutrition by incorporating systematic screenings into their workflows. This is aligned with recommendations from the *National Blueprint*,²⁷ which promotes the adoption and standardization of validated national community screening tools for malnutrition, such as the Mini Nutritional Assessment Short Form ([MNA-SF](#)). Additionally, the *National Blueprint*²⁷ recognizes that food insecurity is an important social risk factor for malnutrition, and promotes screening for food insecurity using a validated tool (such as the [Hunger Vital Sign](#)).

Though food insecurity is an important and widely recognized social risk factor for malnutrition because it inhibits older adults' ability to access nutritious food, it is only one of the numerous social risk factors for malnutrition. As a result, it is important to expand efforts in the community to include screening for a broad-

er array of social needs. Examples of validated screeners that assess for multiple social needs (such as transportation, housing, food insecurity, social isolation, and financial stability) include (but are not limited to):

- *Accountable Health Communities Screening Tool*²⁸
- *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)*²⁹
- *Health Leads: Social Needs Screening Toolkit*³⁰

Once identified, CBOs are well positioned to respond by linking older adults with the necessary services and supports to address their unmet social needs, and simultaneously help mitigate malnutrition risk and help them age in place successfully.

LEVERAGING EXISTING COMMUNITY-BASED PROGRAMS AND SERVICES

Another area of opportunity to advance malnutrition care older adults living at home or in the community is by integrating malnutrition care, response, and prevention into existing community-based

Continued on page 23



Figure 1: National efforts to promote quality malnutrition care

Organizations' logos printed with permission from the sources (from left to right): Defeat Malnutrition Today, Academy of Nutrition and Dietetics (the Academy), American Society for Parenteral and Enteral Nutrition (ASPEN), National Council on Aging (NCOA), Meals on Wheels America (MOWA), Administration for Community Living (ACL).

Innovations

Continued from page 22

programs. For example, existing health self-management programs offered in the community through the [National Aging Network](#), a national collection of organizations under the auspices of the Administration for Community Living (ACL), could be leveraged to respond to social risk factors that contribute to or exacerbate malnutrition.

Evidence-based health self-management programs are recommended by the U.S. Surgeon General as a method to promote healthy aging.³¹ These programs were developed for individuals with numerous [chronic diseases](#) and specific health conditions (such as diabetes, hypertension, frailty, and fall prevention), as well as overall wellness and lifestyle. Many of these self-management programs already address multiple social and clinical risk factors for malnutrition, including nutrition-related components. Studies show that the nutrition counseling or education components of these types of programs are frequently positively associated with nutrition-related health outcomes, including improved diet quality, decreased frailty markers, and increased physical function among community-dwelling older adults.^{32,33} There are opportunities to expand these existing programs by incorporating screening for malnutrition, as well as adding course components focused on malnutrition awareness and education. In addition, there is an opportunity to develop and evaluate new innovative community-based self-management programs designed to address and prevent malnutrition by targeting nutritional needs as well as additional social risk factors.

STRENGTHENING COLLABORATION AND COMMUNICATION ACROSS SETTINGS

There is increased recognition that bridging clinical and community efforts via

established partnerships is important, and enhanced communication is needed among these groups to improve comprehensive malnutrition care for older adults. The *National Blueprint*²⁷ notes that successful partnerships between clinical and community-based providers are critical to attain comprehensive malnutrition care for older adults. However, the current healthcare landscape is divided, where care is often fragmented across a wide array of clinical and social providers. A major barrier is that healthcare providers and CBOs typically operate in silos, where the clinical and non-clinical providers work in isolation and do not share valuable information about the patient or client. Additionally, there is a lack of infrastructure to support this data-sharing exchange, even when the value is recognized. Therefore, there is a significant opportunity to leverage CBOs' existing supports and services currently provided to older adults by forming partnerships and strengthening the connections and information-sharing capacity between clinical and community settings to identify and address malnutrition comprehensively.

There is emerging evidence about the benefits of such partnerships. For example, a recent evaluation found the partnerships between 22 healthcare entity-based programs that screened for food insecurity and the community providers that responded by linking patients to existing food resources were effective in addressing food insecurity.³⁴ Another study found that cross-sectoral partnerships between AAAs with healthcare and non-healthcare organizations are an effective approach to help address SDOH and are associated with decreased healthcare utilization.³⁵ The findings from both studies highlight the benefits of utilizing clinical and community partnerships to address social needs; as such, partnerships between CBOs and healthcare providers should be further cultivated and scaled. At present, there is a lack of well-established connections among most of healthcare providers and

CBOs, and funding for care coordination or meaningful data collection and evaluation is insufficient both within and across these two distinct and siloed delivery systems.

The *National Blueprint*²⁷ recognizes opportunities to improve malnutrition care during transitions of care from clinical to community settings (for example, when older adults are discharged with a care plan to their homes). Specifically, there is an opportunity to strengthen the community response and empower CBOs to play a more prominent role by supporting the clinical care plan. Evidence-based care-transition programs have demonstrated success across outcomes, including reduced hospital readmission rates and total costs, as well as improved general health outcomes.³⁶⁻³⁹ Common elements across successful care-transition programs are improved communication and coordination across care settings and the ability to address all of the patient's needs, including social needs (such as housing, nutrition, transportation, and socialization).³⁷ Further success can be achieved by incorporating screening for malnutrition into existing evidence-based care transition practices to ensure that malnourished and at-risk patients receive support. These innovative care-transition practices can be embedded into clinical workflows by creating a direct pathway to the CBOs, and providing coordinated care that addresses all clinical and social needs.

Technology provides numerous opportunities to facilitate enhanced communication and coordination across settings. For example, it is possible to develop secure platforms or adapt existing electronic health records to share data in real time among providers across care settings. Data and information exchanged across the care continuum can support healthcare providers to deliver a holistic, patient-centered care plan, and enable CBOs to obtain information to tailor their

Continued on page 24

Innovations

Continued from page 23

responses to individuals' social and clinical needs. The CBOs' ongoing contact and established relationships could function as "eyes on the ground" and allow for quick alerts of changes in patients' conditions to be shared with the health-care provider.

CONCLUSION

Successfully achieving comprehensive malnutrition care to enable older adults to age in place will require expanding screening in the community, leveraging existing community-based programs and services, and strengthening collaboration and communication between clinical and community settings. To improve the identification of those at risk for malnutrition and support better malnutrition care among older adults, we must bring the care to where they live: in their homes and communities.

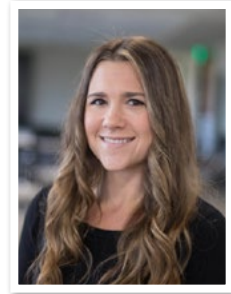
At the same time, funding for the CBOs programs and services that support older adults' health, safety, and well-being must be increased to keep pace with this rapidly growing segment of the population. To have an effective community response to malnutrition, the CBO workforce must be adequately trained to appropriately identify and address malnutrition. For example, it is necessary to increase awareness about malnutrition and train the workforce to administer ongoing screenings for malnutrition and social risk factors. As the *National Blueprint*²⁷ suggests, one possible solution to these funding and workforce-related barriers is to integrate quality malnutrition care in payment and delivery models to align incentives and reduce barriers. More broadly, there is a need for bipartisan support to address current regulatory, payment, and other perceived barriers that impede provision of health-related interventions and social supports in the community.

It is essential to ensure that the multiple

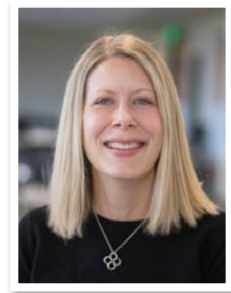
social and clinical risk factors for malnutrition are assessed and addressed among older adults identified as malnourished or at risk. CBOs are already addressing many social risk factors of malnutrition, but there is an opportunity to expand the role they play to advance malnutrition care and prevention even further. Simultaneously screening older adults' malnutrition risk and social risk factors is the first step to establishing a rapid response, in both clinical and community settings. The community response should include ongoing malnutrition risk assessment and monitoring, as well as developing self-management programs that explicitly address malnutrition risk factors and evaluating approaches to determine best-practices. Establishing linkages between clinical providers and CBOs with the capacity to implement complementary strategies that support adherence to the plan of care will strengthen malnutrition responses and care transitions. As the American population continues to age, it will be necessary for healthcare payers and providers, researchers, policymakers, and community-based providers to work together in innovative ways toward achieving a shared vision and common goal: providing comprehensive malnutrition care that addresses the holistic needs of older adults.

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Solely funded by philanthropists Gary and Mary West, West Health includes the nonprofit and nonpartisan Gary and Mary West Health Institute and the Gary and Mary West Foundation in San Diego, as well as the Gary and Mary West Health Policy Center in Washington, D.C. These organizations are working together toward a shared mission dedicated to enabling seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life, and independence. For more information, please visit westhealth.org and follow @westhealth.



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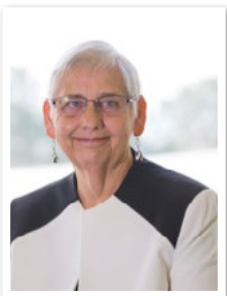
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Continued on page 25

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Innovations

Continued from page 26

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The Healthy Aging DPG [calendar](#) contains events of interest to RDNs and NDTRs who work with older adults. If you would like to suggest a conference or event for our calendar, please email Robin Dahm (dahmRD@gmail.com) with your information. The event must focus on the nutritional and physical health of older adults.

[Click here](#) for a list of upcoming conferences, workshops, webinars, and other events related to healthy aging.