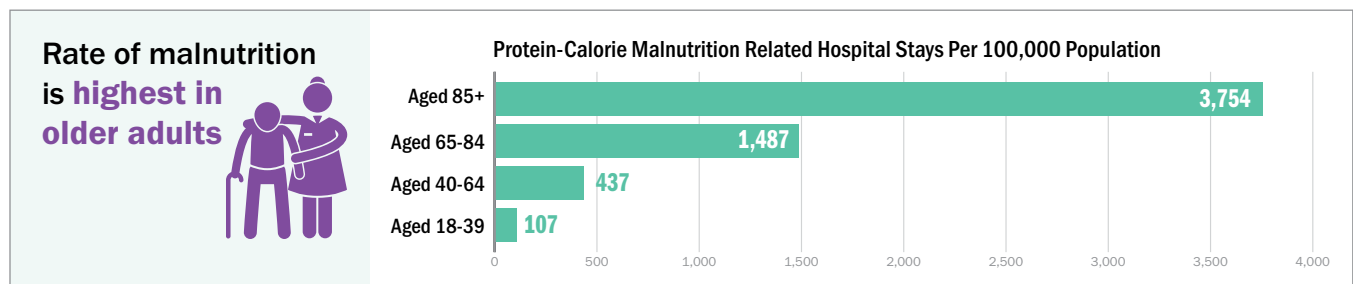


# Why Nutrition is Important: Patient Over the Age of 65

*The older adult has the potential to face significant nutrition issues prior to, during, and after hospitalization. This summary document is intended to provide key details and information about malnutrition in the older adult and how it can be addressed.*

## KEY FACTS



Barrett ML, Bailey MK, Owens PL. Non-maternal and Non-neonatal Inpatient Stays in the United States involving malnutrition, 2016. U.S. Agency for Healthcare Research and Quality. [www.hcupus.ahrq.gov/reports.jsp](http://www.hcupus.ahrq.gov/reports.jsp).

- As aging coincides with various physical, mental, and lifestyle developments that affect food intake, the prevalence of malnutrition in older adults is increased.<sup>1</sup>
- Chronic diseases are more common in older adults<sup>2</sup> and treatment for such diseases may interfere with proper nutrient absorption leading to malnutrition.
- Dementia is one disorder that affects nutritional status; complications range from dysphagia to anorexia, and therefore inhibit proper nutrition.<sup>3</sup>
- Financial instability may contribute to a higher prevalence of malnutrition, as 7.3% of seniors are reportedly food insecure, and 2.7% are very low food insecure.<sup>4</sup> Further, only 43% of seniors eligible for Supplemental Nutrition Assistance Program (SNAP) participate.<sup>5</sup>

- Malnutrition is associated with a variety of health complications, including increased mortality, immune suppression, muscle wasting, longer length of hospital stay and higher health care costs.<sup>6</sup>
- Malnutrition is rarely diagnosed in a hospital setting—a 2018 analysis carried out by the Agency for Healthcare Research and Quality (AHRQ) found that malnutrition was only diagnosed in 8% of hospital visits<sup>7</sup>, despite malnutrition affecting 25%-54% of hospital patients.<sup>8</sup>

*This discrepancy highlights that many are undiagnosed and therefore do not receive adequate nutrition intervention.<sup>8</sup>*

- Disease associated malnutrition (DAM) in older adults costs roughly \$51.3 billion per year.<sup>9</sup>

*In one study, COPD, CHD and dementia made up a large share of this cost.<sup>9</sup> Another found that dementia was the greatest contributor to DAM with costs of \$8.7 billion annually.<sup>6</sup>*



**\$51.3  
BILLION**

**estimated annual cost  
of disease-associated  
malnutrition in older  
adults in the US**

Snider JT, Linthicum MT, Wu Y, et al. Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenter Enteral Nutr.* 2014;38(2 Suppl):77s-85s3.

What Should Clinicians Do? ►

Supported by



## KEY ACTIONS: WHAT SHOULD THE CLINICIAN DO?

- Perform nutrition screening followed by completion of a nutrition assessment by the registered dietitian in those identified at nutrition risk.
- Recognize that older adults often eat poorly in the hospital. Data suggests patients consume less than 50% of both protein and energy requirements from hospital meals.<sup>10,11</sup>
- Avoid dietary restrictions with hospital diets. Providing more liberal oral diets will promote greater nutrient intakes.<sup>12,13</sup>
- Initiate oral nutrition supplements (ONS) when oral intake is inadequate. Use of ONS can improve dietary intake and body weight and lower the risk of complications during the hospital stay.<sup>13</sup>
- Initiate nutrition support (enteral or parenteral nutrition) in malnourished patients or those at risk. A 2019 meta-analysis demonstrated reduced mortality and non-elective hospital readmissions in malnourished or “at-risk” medical inpatients provided with nutrition support.<sup>14</sup>
- Prescribe ONS upon discharge in malnourished patients. Use of supplements post discharge along with regular food intake has been shown to reduce hospital readmissions.<sup>15</sup>
- Continue nutritional care following discharge in malnourished patients through dietitian consultation. Hospital readmissions can be reduced with ongoing nutritional follow-up from a dietitian after hospital discharge.<sup>16</sup>



**Use of oral nutrition supplements post discharge along with regular food intake has been shown to reduce hospital readmissions.<sup>15</sup>**

### References

- <sup>1</sup> Kaiser MJ, Bauer JM, Ramsch C, et al. Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *J Am Geriatr Soc.* 2010;58(9):1734-1738.
- <sup>2</sup> Council on Aging Fact Sheet 2016 [https://d2mkcg26uvq1cz.cloudfront.net/wp-content/uploads/Chronic-Disease-Fact-Sheet\\_Final-Dec-2016.pdf](https://d2mkcg26uvq1cz.cloudfront.net/wp-content/uploads/Chronic-Disease-Fact-Sheet_Final-Dec-2016.pdf); accessed August 20, 2020.
- <sup>3</sup> Espinosa-Val MC, Martín-Martínez A, Graupera M, et al. Prevalence, risk factors, and complications of oropharyngeal dysphagia in older patients with dementia. *Nutrients.* 2020;12(3):863.
- <sup>4</sup> Feeding America. *The State of Senior Hunger in America in 2018: An Annual Report.* Available at: <https://www.feedingamerica.org/sites/default/files/2020-05/2020-The%20State%20of%20Senior%20Hunger%20in%202018.pdf>. Accessed August 20, 2020.
- <sup>5</sup> U.S. Department of Agriculture. *Fact Sheet: USDA Support for Older Americans.* Available at: <https://www.fns.usda.gov/pressrelease/2015/020215>. Accessed July 15, 2020
- <sup>6</sup> Goates S, Du K, Braunschweig CA, et al. Economic burden of disease-associated malnutrition at the state level. *PLoS One.* 2016;11(9):e0161833-e0161833.
- <sup>7</sup> Barrett ML, Bailey MK, Owens PL. Non-maternal and Non-neonatal Inpatient Stays in the United States Involving Malnutrition, 2016. U.S. Agency for Healthcare Research and Quality. Available at: [www.hcupus.ahrq.gov/reports.jsp](http://www.hcupus.ahrq.gov/reports.jsp). August 30, 2018. Accessed July 15, 2020.
- <sup>8</sup> Malone AM. Malnutrition: our time is now! *JPEN J Parenter Enteral Nutr.* 2015;39(1):63-72.
- <sup>9</sup> Snider JT, Linthicum MT, Wu Y, et al. Economic burden of community-based disease-associated malnutrition in the United States. *JPEN J Parenter Enteral Nutr.* 2014;38(2 Suppl):77s-85s3.
- <sup>10</sup> Pullen K, Collins R, Stone T, et al. Are energy and protein requirements met in hospital? *J Hum Nutr Diet* 2017; 31(2):178-187.
- <sup>11</sup> Weijzen ME, Kouw IW, Geerlings P, et al. During hospitalization, older patients at risk for malnutrition consume <0.65 grams of protein per kilogram body weight per day. *Nutr Clin Pract.* 2020Aug;35(4):655-663.
- <sup>12</sup> Rattray M, Desbrow B, Roberts S. Comparing nutritional requirements, provision and intakes among patients prescribed therapeutic diets in hospital: An observational study. *Nutrition* 2017; 39-40:50-56.
- <sup>13</sup> Volkert D, Beck AM, Cederholm T, et al. ESPEN guideline on clinical nutrition and hydration in geriatrics. *Clin Nutr.* 2018;38(1):10-47.
- <sup>14</sup> Gomes F, Baumgartner A, Bounoure L, et al., Association of nutritional support with clinical outcomes among medical inpatients who are malnourished or at nutritional risk an updated systematic review and meta-analysis. *JAMA Network Open;* 2019;2(11):e1915138.
- <sup>15</sup> Sriram K, Sulo S, VanDerBosch G, et al. A comprehensive nutrition-focused quality improvement program reduces 30-day readmissions and length of stay in hospitalized patients. *JPEN J Parenter Enteral Nutr.* 2017;41(3):384-391.
- <sup>16</sup> Pedersen JL, Pedersen PU, Damsgaard EM. Nutritional follow-up after discharge prevents readmission to hospital – a randomized clinical trial. *J Nutr Health Aging* 2017;21(1):75-82.

Visit [nutritioncare.org/Malnutrition](https://nutritioncare.org/Malnutrition) for more Why Nutrition is Important tip sheets and resources on malnutrition.