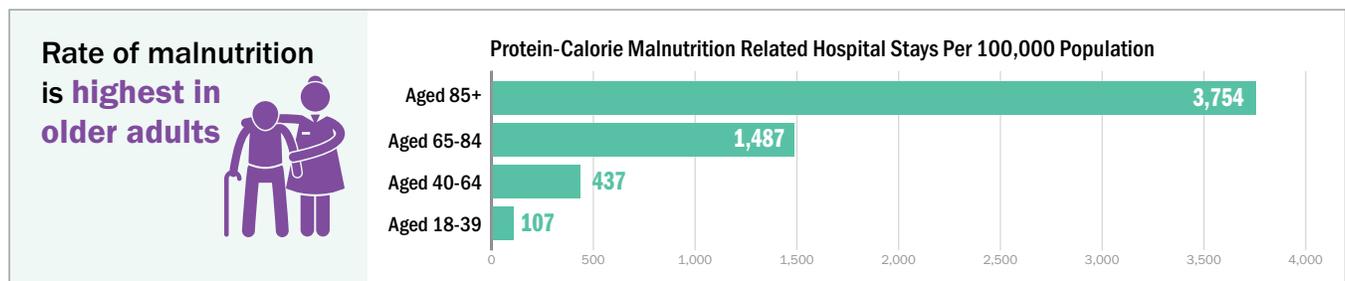


Why Nutrition is Important: Patient Over the Age of 65

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.

- As aging coincides with various physical, mental, and lifestyle developments that affect food intake, the prevalence of malnutrition in older adults is increased.¹
- Chronic diseases are more common in older adults² 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.³
- 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.⁴ Further, only 43% of seniors eligible for Supplemental Nutrition Assistance Program (SNAP) participate.⁵

- 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.⁶
- 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 visits⁷, despite malnutrition affecting 25%-54% of hospital patients.⁸

This discrepancy highlights that many are undiagnosed and therefore do not receive adequate nutrition intervention.⁸

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

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



**\$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.^{10,11}
- Avoid dietary restrictions with hospital diets. Providing more liberal oral diets will promote greater nutrient intakes.^{12,13}
- 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.¹³
- 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.¹⁴
- Prescribe ONS upon discharge in malnourished patients. Use of supplements post discharge along with regular food intake has been shown to reduce hospital readmissions.¹⁵
- 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.¹⁶



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

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