Provision and Access to Nutrition Care for the Prevention and Treatment of Malnutrition in Older Adults Within Long-Term Care and Community Settings: A Consensus Statement of the Academy of Nutrition and Dietetics

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ABSTRACT

It is the consensus of the Academy of Nutrition and Dietetics that equitable access to nutrition care, including medical nutrition therapy provided or facilitated by registered dietitian nutritionists (RDNs), can improve nutrition and health outcomes for older adults in long-term care and community settings. The target audience includes RDNs, policymakers, insurance providers, and other interested parties. The consensus statement is based on the Evidence Analysis Center's malnutrition in older adults systematic reviews that evaluated nutrition assessment and nutrition interventions, and the expertise of content experts. Strategies to improve access to nutrition care within a regulatory and systemic context are presented. The consensus statement identifies key barriers to nutrition care, including fragmented health care systems, insufficient research, and limited reimbursement for nutrition services. Several strategies are proposed, including policies to ensure comprehensive screening and referral, evidence-based individualized nutrition care, expanded reimbursement for nutrition services, adequate RDN staffing, increased research, and coordination with available community nutrition programs. Improved access to nutrition care is essential to reducing malnutrition and improving the overall health of older adults.
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Consensus Statement

It is the consensus of the Academy of Nutrition and Dietetics that equitable access to nutrition care, including medical nutrition therapy provided or facilitated by registered dietitian nutritionists, can improve nutrition and health outcomes for older adults in long-term care and community settings. Evidence-based nutrition screening, assessment, and interventions are critical to addressing malnutrition, with registered dietitian nutritionists playing a vital role in delivering care and coordinating services. Enhanced staffing, regulatory changes, and systemic strategies are needed to overcome barriers such as workforce shortages, fragmented care, and limited financial resources that cover reimbursement. Expanding research efforts, increasing interdisciplinary collaboration, and advocating for policies that prioritize nutrition care will help ensure that older adults receive the nutrition needed to maintain their health and quality of life.

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According to the Centers for Disease Control and Prevention, in 2022, 57.8 million US adults were aged 65 years or older, representing 17.3% of the population.[1,2] By 2040, it is estimated that the number of adults aged 65 years and older is expected to reach 78.3 million, representing 22% of the US population.[1,2] The United States faces major challenges to ensure the optimal health of the aging population. Maintaining adequate nutritional status is among the key factors to maintain and/or improve health and quality of life. However, older adults are at increased risk for malnutrition due to variety of factors, including higher susceptibility for chronic disease, age-related physiological changes like decreased appetite and loss of taste, and psychological and societal factors such as isolation[3] and food insecurity.[4-8] Malnutrition is associated with physical decline,[9] pressure injuries,[10] lower quality of life,[11] and increased morbidity and mortality among other negative health outcomes.[12] Malnutrition-related deaths among older adults is at a historical high,[13] despite most cases of malnutrition caused by noninflammatory factors such as inadequate dietary intake or age-related changes in metabolism being preventable with appropriate screening, food security, and nutrition care.[14]

Approximately 97.5% of older adults in the United States live in the community, and the remaining 2.5% live in long-term care (LTC).[15] Most older adults (88%) wish to remain in their homes for as long as possible.[16] Older adults should have access to nutrition care within LTC and the community to prevent malnutrition and related consequences. Unfortunately, integration of nutrition care throughout the

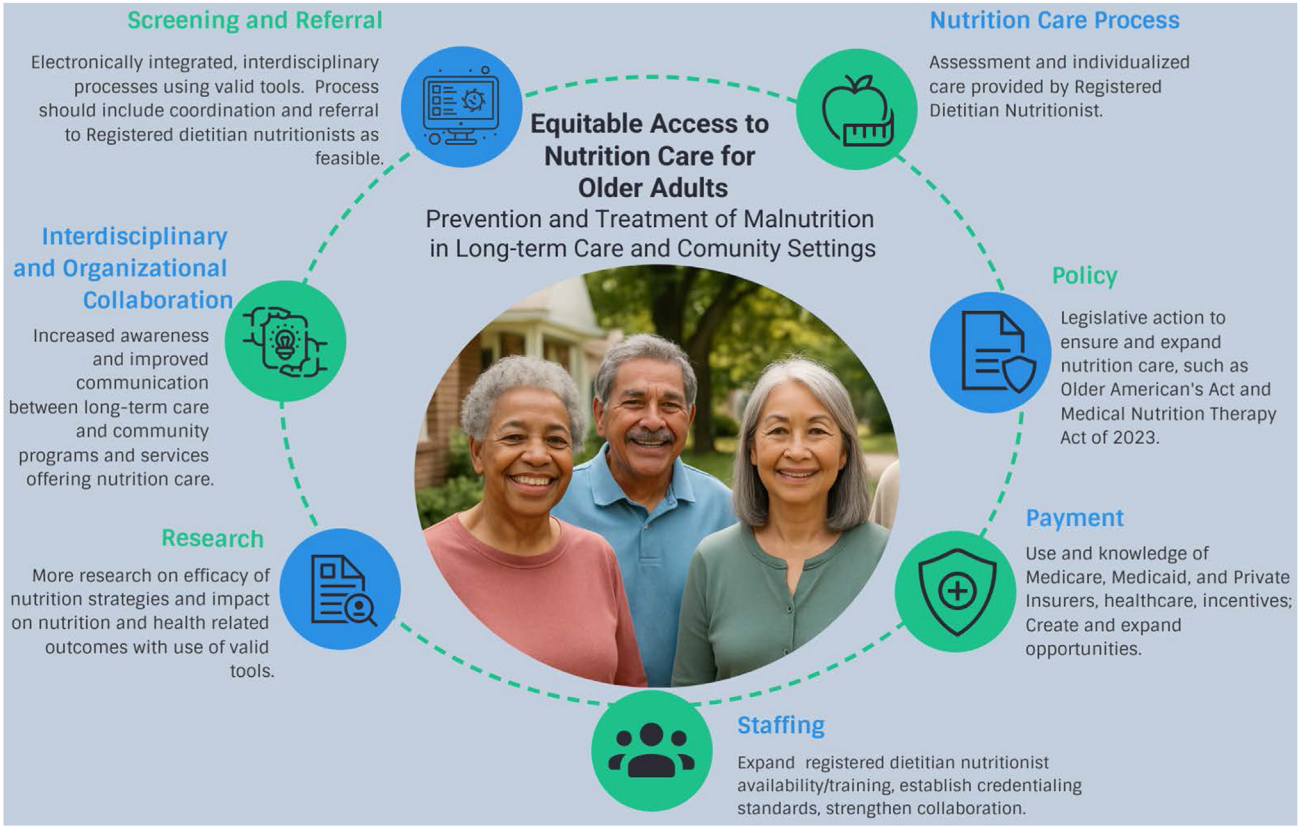

Figure 1. Access to nutrition care for older adults in long-term care and community settings infographic.

continuum of health care is limited at best.[17] As more individuals age in place and life expectancy increases, frequent movement across health care and community settings occur. Transitions of care, such as those from hospital discharge to LTC facilities or the community require greater attention and improved planning. The overall lack of continuity of care within the US health care system further complicates access to nutrition care. Fragmented health care increases cost and decreases quality of life particularly for older adults.[13,18,19]

To improve the overall health of the aging US population, it is essential to prioritize access to and provision of continued nutrition care across settings, including LTC settings and community-based living arrangements. Achieving this goal requires multidisciplinary and multitiered approaches. As food and nutrition experts, registered dietitian nutritionists (RDNs), contribute the knowledge, experience, and skills to prevent, provide nutrition diagnosis to identify, and treat malnutrition. Their contributions enable multidisciplinary teams to address the complex barriers that hinder access to optimal nutrition and quality care for older adults.

CONSENSUS STATEMENT FOCUS

The purpose of this consensus statement is to provide strategies within regulatory and systemic context to improve access to ongoing nutrition care, including medical nutrition therapy (MNT) provided by RDNs, while addressing common barriers to equitable access (Figure 1). This statement is intended for RDNs, policymakers, insurance providers, and other interested parties involved in expanding access to nutrition care for older adults in LTC and community settings. This article does not focus on nutrition care of older adults with specific diseases or conditions but instead focuses on the general older adult population outside of acute care, therefore including post-acute care, LTC, and the community. Practice-based nutrition recommendations are outside the scope of this article and are available in "Prevention and Treatment of Malnutrition in Older Adults Living in Long-Term Care or the Community: An Evidence-Based Nutrition Practice Guideline."[20]

CONSENSUS STATEMENT DEVELOPMENT PROCESS

This consensus statement is guided by the Academy of Nutrition and Dietetics' (Academy) malnutrition in older adults (MiOA) systematic reviews, expertise of content experts, and reputable supporting resources. Systematic reviews are the backbone of evidence-based practice and are therefore used to support the development of Academy Evidence Analysis Center position and consensus papers.[21] The MiOA Expert Panel conducted systematic reviews to investigate the following research questions: "In older adults living in LTC or community settings, what is the validity and reliability of malnutrition assessment tools?" and, "In older adults living in LTC or community settings, what is the effectiveness of nutrition interventions on nutrition related outcomes?"[20]

The MiOA Expert Panel established systematic review criteria based on

their expertise and the MiOA scoping review.[22] The nutrition assessment systematic reviews included studies of older adults (mean age = 65 years and older), that evaluated a tool with a static and change in body measurement and reported validity (concurrent and predictive) or reliability outcomes. Eligible study designs included cross-sectional, observational, and clinical trials. The intervention systematic reviews were also limited to older adults (mean age = 65 years and older), intervention topics included oral nutrition supplements, food fortification, dietitian interventions (eg, MNT), and congregate and home delivered meals (community only); and outcomes of interest included mortality, nutritional status, body weight/body mass index, calorie and protein intake, health care cost, and physical function. Except for congregate and home delivered meals, intervention reviews were limited to randomized controlled trials due to their ability to reduce bias and errors. Both systematic reviews were limited to studies published in the English language in peer-reviewed journals.

Systematic Review Results

The only malnutrition assessment tools with available data were Subjective Global Assessment, Patient-Generated Subjective Global Assessment, and the Mini-Nutritional Assessment tools, all with limited certainty evidence. The MiOA community systematic review found that MNT provided by an RDN increases calorie and protein intake and can help maintain or increase weight (low certainty evidence), but no studies met inclusion criteria for MNT effectiveness in LTC. Oral nutrition supplements were found to increase calorie and protein intake in LTC and community settings (moderate certainty evidence), increase weight in LTC (moderate certainty evidence), and improve nutritional status in older adults living in LTC and those discharged from acute care to the community (low-certainty evidence). Evidence on food fortification in LTC and community settings was insufficient. Congregate and home-delivered meals were associated with increased calorie and protein intake and decreased incidence of malnutrition in the community.

Results of the systematic reviews were incorporated in an evidence-to-decision framework to develop evidence-based nutrition practice recommendations, which can be found in the MiOA Evidence-Based Nutrition Practice Guideline.[20]

Identified Research Gaps and Nutrition Care Barriers

During the development of MiOA Evidence-Based Nutrition Practice Guideline 2 major themes emerged: the limited evidence on nutrition care of older adults in LTC and community settings, and the numerous complex barriers to implementing quality nutrition care. These challenges highlighted the need for a consensus statement to inform interested parties of current best nutrition practices, necessary actions to achieve implementation, and to highlight the importance of nutrition research for older adults in LTC and community settings. A Consensus Paper was developed in lieu of a Position Paper due to the lack of moderate-to-high certainty evidence according to the Evidence Analysis Center position statement process.[21]

NUTRITION CARE

Nutrition screening, the Nutrition Care Process (NCP), which includes nutrition assessment, diagnosis, interventions, and monitoring and evaluation,[23,24] along with supportive policies such as regulatory requirements, are essential mechanisms in addressing health disparities and enhancing health equity.[25] Screening and the NCP should be incorporated into electronic health records in health care settings and related systems in community settings to improve nutrition care, patient outcomes, and access to data to enhance research. To enhance individualized and continued nutrition care, practitioners should involve individuals who reflect the communities served in the development and implementation of the NCP, to strengthen their influence and cultural relevance.[26]

Screening and Referral

Nutrition screening is a simple, low resource process used to identify individuals at risk of malnutrition who may benefit from nutrition assessment by an RDN for further evaluation.[27] Validated malnutrition screening tools should be utilized to ensure accuracy. Based on a systematic review of the evidence, the Academy recommends the validated Malnutrition Screening Tool.[25,28] Other validated screening tools, such as the Mini-Nutritional Assessment Short Form,[17] or Seniors in the Community Risk Evaluation for Eating and Nutrition,[29] whereas longer than the MST, can also be considered. In addition, some validated screening tools are effective for self-administration by older adults to identify their own risk of malnutrition.[30]

Routine nutrition screening is essential. Uniform screening at initial contact and periodic intervals helps identify malnutrition risk early, allowing for timely intervention. Although RDNs should be involved in selecting nutrition screening tools, and overseeing nutrition screening processes, screenings are often conducted by nutrition and dietetics technicians, registered, or other trained individuals.

Nutrition screening requirements differ across settings. In LTC facilities, federal regulations, including those set by the Centers for Medicare and Medicaid Services (CMS), require a comprehensive nutrition assessment of each new resident within 14 days of admission.[31] In community settings, screening may occur in a variety of locations, including primary care clinics, outpatient facilities, or community-based aging services such as senior centers. However, despite its importance, nutrition screening is not routinely practiced in community settings, and data on the prevalence is limited.[14] RDNs and collaborators should advocate for incorporation of nutrition screening into older adult surveys and Medicare-related examinations.[32] Individuals at risk for malnutrition should be referred to an RDN for comprehensive nutrition assessment and individualized care. After screening, timely and appropriate referrals are essential for ensuring continuity of nutrition care.[33] Successful referral systems are optimally electronic, integrated into routine processes, and facilitate open communication among participants.[21] When referral to an RDN is not feasible, health care providers are ethically bound to address identified malnutrition risk.

In community settings, referral to an RDN may not always be feasible. In such cases, organizations should connect individuals with community nutrition programs and services to address nutritional risk and their underlying social determinants of health (Figure 2). Community programs and benefits are frequently underutilized. For example, according to the Food Action & Resource Center, only 40% of older adults who qualify for Supplemental Nutrition Assistance Programs are enrolled.[34] Underuse could be due to lack of awareness, stigma, or difficulties in application limiting access to nutritious food. Health care–community partnerships, such as contracting with Community Care Hubs,[35] which are available in most US states or other organizations, can enhance access and availability to community-based services.

RDNs and interested parties should prioritize integration of nutrition screening, along with indications for referral to RDNs and/or other services, into electronic health records, policies, and procedures to improve continuity, access, and quality of nutrition care.

NCP: Assessment

The MiOA guideline states that RDNs should use valid and reliable nutrition assessment tools when conducting a nutrition assessment.[20] Practitioners may consider use of existing validated nutrition assessment tools, such as the Academy/American Society for Parenteral and Enteral Nutrition Indicators to Diagnose Malnutrition or other tools as new validity and reliability data are published.[36-38] As stated above, evidence was available for the Mini-Nutritional Assessment, Subjective Global Assessment, and Patient-Generated Subjective Global Assessment; however, certainty of evidence was low to very-low due to limited available evidence. More research is needed on nutrition assessment and malnutrition diagnosis tools for older adults outside of hospital settings.

NCP: Interventions

Availability of evidence for the effectiveness of nutrition strategies used in LTC and community settings was extremely limited. Oral nutrition supplements, food fortification, and referral to congregate and home delivered programs are commonly used nutrition strategies that should be considered as part of comprehensive individualized nutrition care plans provided by RDNs. The MiOA guideline intervention recommendations align with current Academy position statements, emphasizing individualized nutrition care to improve older adults' nutrition-related outcomes, as well as access to programs that support optimal nutrition.[20,39,40]

LTC. Nutrition interventions for individuals in LTC facilities should focus on individualized care plans that address residents' needs and preferences. In LTC settings, RDNs should collaborate with interdisciplinary health care teams to ensure that all members are informed of resident's nutrition care plans, promoting comprehensive and coordinated care. Common nutrition interventions include frequent small meals, high-protein and nutrient-dense foods, food fortification, use of oral nutrition supplements, assistance during meals, and frequent reassessments by an RDN. When creating personalized nutrition care plans it is crucial to let patients choose foods that align with both their nutrition needs and cultural preferences. Allowing patients to pick familiar foods they enjoy will enhance their commitment to the plan.[41] To ensure personalized nutrition care, therapeutic and mechanically altered diets are often part of the nutrition care plan. Individualized nutrition approaches are key in promoting the quality of life of older adults residing in LTC and may require liberalizing dietary restrictions.[39]

Community. In community settings, RDNs are encouraged to work directly with older adults; involving their partners, spouses, or caregivers can also be highly beneficial. These individuals may play significant roles in food shopping, meal preparation, and related activities, especially if the older individual has physical disabilities or other limitations influencing these areas. Interventions like those offered in LTC can be considered in the context of physical abilities, behavioral health challenges, any needed supports for shopping and meal preparation and socioeconomic factors, such as income limitations and housing instability.

Community settings offer a variety of services tailored to an individual's needs, preferences and circumstances to address malnutrition and malnutrition risk (see Figure 3). These interventions can include social service programs, recreational activities, and community-based health services. A robust referral system with a wide variety of partners allows RDNs to implement personalized nutrition care plans. The availability of referral options can enhance the potential for positive long-term outcomes and expand research opportunities. For example, Older Americans Act nutrition programs, such as congregate and home-delivered meals have been shown to reduce malnutrition in older adults living independently.[20,42]

Looking forward, further research on the roles of RDNs in LTC and community settings utilizing valid nutrition screening and nutrition assessment tools are needed to enhance nutrition care. RDNs in LTC and community settings can facilitate research efforts by forming partnerships with academia and applying for federal, state, local, and/or charitable foundation grants.

POLICY

Ensuring access to quality nutrition care is essential for preventing malnutrition and promoting health equity among older adults. Nutrition care should be recognized as a fundamental human right, a principle formally established with the signing of the International Declaration on the Human Right to Nutritional Care in Vienna during the European Society for Clinical Nutrition and Metabolism conference in 2022.[43] Policy development can occur at any level of government. RDNs within LTC and community organizations (eg, academia; nonprofits; or county, state, and federal organizations) can establish policies, implement quality metrics, create funding opportunities, and issue regulations supporting the implementation of NCPs, including MNT. Technical assistance, in the form of training and practice tools can enhance consistent and high-quality implementation of nutrition care across LTC and community settings.

Nutrition program	Screening and Nutrition Care Process	Best practices	Resources
Health and Human Services: Older Americans Act Title III-C Nutrition Services[72-75]	Older Americans Act authorizes nutrition screening and assessment Nutrition Screening Initiative must be collected and reported annually Nutrition Assessment implementation varies based on resource availability and community needs	Coordinating community and health care/registered dietitian nutritionist referrals based on Nutrition Screening Initiative screening results, guided by: Policies and procedures from state, Area Agencies on Aging, and local nutrition programs that integrate risk screening for malnutrition, falls, frailty, and other nutrition-sensitive conditions Requirements for employing or consulting a registered dietitian nutritionist for a minimum number of hours/full time employees. Standardized forms, information technology systems, and protocols for nutrition counseling and documentation	Administration for Community Living, Nutrition and Aging Resource Center, Malnutrition webpage https://acl.gov/senior-nutrition/malnutrition Nutrition Counseling webpage https://acl.gov/senior-nutrition/nutrition-counseling
Centers for Medicare and Medicaid Services: Program of All-Inclusive Care for the Elderly[76,77]	Requirement for regular nutrition assessment and personalized nutrition care plan An 8-member interdisciplinary team that includes a registered dietitian nutritionist must conduct all pre-enrollment assessments in person, without using external assessments or copied records	Ensure compliance with Program of All-Inclusive Care for the Elderly regulations Collaborate with interdisciplinary team members; use comprehensive nutritional assessments; ensure access to registered dietitian nutritionists for assessment and counseling; provide medically appropriate meals; partner with Older Americans Act to provide home-delivered or meal assistance	Program of All-Inclusive Care for the Elderly General Information www.hhs.gov/guidance/document/pace-program-general-information Interdisciplinary team approach www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pace111c08.pdf

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Figure 2. Examples of community-based nutrition programs that can be incorporated in nutrition care pathways to prevent or treat protein-energy malnutrition in older adults. None of the organizations listed in Figure 2 are endorsed by the Academy of Nutrition and Dietetics.

Nutrition program	Screening and Nutrition Care Process	Best practices	Resources
US Department of Agriculture Commodity Supplemental Food Program[78,79]	States may require that participants be at nutrition risk, as determined by a physician or by local agency staff	Ensure compliance with Commodity Supplemental Food Program requirements. Partner with Supplemental Nutrition Assistance Program, Supplemental Nutrition Assistance Program Education, and Supplemental Nutrition Assistance Program Outreach and Older Americans Act. Incorporate nutrition education and counseling	Applicant Requirements www.fns.usda.gov/csfp/applicant-recipient How to Boost Your Diet with the Senior Food Box Program www.ncoa.org/article/how-to-boost-your-diet-with-the-senior-food-box-program/?utm_source=chatgpt.com Supplemental Nutrition Assistance Program www.fns.usda.gov/snap/supplemental-nutrition-assistance-program
US Department of Agriculture Seniors Farmers Market Nutrition Program[80]	Does not mandate formal nutrition screening or assessments for participants	Ensure compliance with Seniors Farmers Market Nutrition Program regulations Partner with Older Americans Act and educate seniors on program benefits Partner with local farmers markets and ensure market staff are trained to accept and process Seniors Farmers Market Nutrition Program benefit. Integrate in nutrition education and counseling	Seniors Farmers Market Nutrition Program www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program

Figure 2. *(continued)* Examples of community-based nutrition programs that can be incorporated in nutrition care pathways to prevent or treat protein-energy malnutrition in older adults. None of the organizations listed in Figure 2 are endorsed by the Academy of Nutrition and Dietetics.

There has been considerable progress in improving access to nutrition care in the United States. Expanded initiatives for screening and subsequent provision of MNT for those at risk for malnutrition have been supported by the 2020 reauthorization of the Older Americans Act.[44] Due to the legislative focus on malnutrition, every State Unit on Aging is required to develop written plans for their respective nutrition services to address malnutrition; this mandate is expected to improve MNT access.[3] In 2024, the federal Administration for Community Living led a multi-agency Strategic Framework for a National Plan on Aging to raise awareness of federal efforts aimed at maximizing older adults' independence, well-being and health.[45] Among the aims is to promote sufficient and high-quality health and social services and support across institutional and community-based care.

The 2022 White House Conference on Hunger, Nutrition, and Health, resulted in a National Strategy on Hunger, Nutrition, and Health along with a subsequent Challenge to End Hunger and Build Healthy Communities.[46] Collectively, these efforts secured nearly $10 billion in funding and promoted cross-governmental and non-governmental initiatives aimed at enhancing food security and nutritional status for older adults. In addition, the US Department of Health and Human Services' Healthy People 2030 goals for older adults underscore the importance of addressing malnutrition.[47]

In 2023, the US Department of Health and Human Services launched the Food is Medicine (FIM) Initiative to reduce nutrition-related chronic diseases and food insecurity, and to improve health and racial equity. The FIM framework introduced by Mozaffarian and colleagues in 2022,[48] is represented as a pyramid consisting of public health, food based-programs, and medically tailored meals. Key challenges to implementing FIM have included difficulties with referrals to and reimbursement for RDN nutrition care.[49] Although the FIM evidence-base

Food and nutrition (Z594)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Commodity Supplemental Food Program www.fns.usda.gov/csfp/applicant-recipient
Congregate meal site
Food bank, food pantry, or emergency food www.feedingamerica.org/find-your-local-foodbank
Home-delivered meals
Hospital outpatient or postdischarge nutrition services: medically tailored meals, medical nutrition therapy
Older Americans Act nutrition program: medical nutrition therapy /counseling, nutrition education, supplemental foods
Registered dietitian nutritionist hwww.eatright.org/find-a-nutrition-expert
Senior Farmers Market Nutrition Program www.fns.usda.gov/sfmnp/senior-farmers-market-nutrition-program
Health education (Z550)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Community college, university, or lifelong learning class
Evidence-based workshops • Caregiver support and assessment • Care transitions • Falls prevention • Mental health and social engagement • Medication management • Nutrition and weight • Self-management (chronic conditions including chronic pain) https://eldercare.acl.gov/Public/Index.aspx
Senior center activities
YMCA classes
Wellness center/gym
Employment (Z560)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Senior center
Senior Community Service Employment Program www.dol.gov/agencies/eta/seniors
State Workforce Employment and Training Agencies www.dol.gov/agencies/eta/wotc/contact/state-workforce-agencies
Volunteer opportunities www.volunteer.gov/s/

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Figure 3. Social determinants of health (and International Classification of Diseases 10th revision codes) related to malnutrition and sample community-based programs and contact information for older adults[a,b,c]

Financial (Z590)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Assistance with dental, eye care, hearing aids
Benefits assistance:
• Energy assistance
• Income tax assistance
• Medicaid
• Medicare Parts A, B, C, D (State Health Insurance Program) www.shiphelp.org
• Supplemental Nutrition Assistance Program www.feedingamerica.org/our-work/hunger-relief-programs/snap www.fns.usda.gov/snap/supplemental-nutrition-assistance-program
Medicaid and Medicare enrollment, billing, appeals, denials, fraud assistance
Prescription assistance
Health care (ICD-10 code dependent on root cause)
Adult medical day care
Clinics: Dental, eye, physical therapy
Community health worker
Health department
Health fair screenings
Home care agency
Medical supplies
Primary care physician
Senior center flu shots and health fairs
Housing (Z590) and utilities (Z590)
Aging and Disability Resource Center
Assisted living
Assistive rechnology (assessment/solutions for disabilities (eg, limited vision or hearing)
Durable medical equipment
Electric Universal Service Program (contact local utility provider)
Home modification, ramp assistance
Housing assistance www.usa.gov/housing-help
Low-Income Home Energy Assistance Program https://liheapch.acf.hhs.gov/search-tool
Senior housing (may have income requirements, include meals or other social services)
Universal Service Protection Program (contact local utility provider)

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Figure 3. *(continued)* Social determinants of health (and International Classification of Diseases 10th revision codes) related to malnutrition and sample community-based programs and contact information for older adults[a,b,c]

Utility assistance, other (contact local utility provider)
In-home care (Z602)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Home care agency
Home-delivered meals
Personal care services, chore service, sitters
Senior villages
Mental health (Z640 or Z650)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Alzheimer/dementia
• Aging and Disability Resource Center (services, assessment)
• Alzheimer's Association (education, referral, screening, support) www.alz.org
Evidence-based workshops www.ncoa.org/evidence-based-programs
• Caregiver support
• Mental health and social engagement
State mental health agency https://findtreatment.gov/state-agencies
Personal safety (Z600)
Adult Protective Services (elder abuse, neglect, exploitation) www.napsa-now.org/help-in-your-area/
Aging and Disability Resource Center
Emergency response systems (911)
Social supports (Z600 or Z630)
Adult day care (also known as social day care)
Aging and Disability Resource Center https://eldercare.acl.gov/Public/Index.aspx
Senior center
Support groups (eg, Alzheimer, caregivers, evidence-based workshops)
Telephone reassurance
Volunteer opportunities www.volunteer.gov/s/
[a]None of the organizations listed in the Table 2 are endorsed by the Academy of Nutrition and Dietetics. [b]Adapted from: Maryland Department of Aging, Addressing Malnutrition in Community Living Older Adults: A Toolkit for Area Agencies on Aging, Version 2, July 2019.[81] [c]For programs and services without website links, contact the Eldercare Locator (800-677-1116) to identify if the program is available in an older adult's community.

Figure 3. *(continued)* Social determinants of health (and International Classification of Diseases 10th revision codes) related to malnutrition and sample community-based programs and contact information for older adults[a,b,c]

is still growing and is just 1 aspect of nutrition care across the community-based nutrition care spectrum, its implementation incorporates nutrition screening and referral systems within FIM programs. Consistent with the guidance in this article, these referrals connect individuals at risk of malnutrition to a broader range of community services, programs, and FIM interventions, including medically tailored meals overseen by RDNs.[48]

The Academy, in collaboration with Avalere Health, developed the Global Malnutrition Composite Score as a hospital quality measure to enhance the identification and treatment of malnutrition in hospitalized patients.[50] Accepted by CMS in 2022, the Global Malnutrition Composite Score became a part of the Hospital Inpatient Quality Reporting Program in 2024.[51] Although designed for hospital settings, Global Malnutrition Composite Score principals have implications for LTC and community settings because malnutrition care should extend beyond hospitalization. In 2024, CMS released the final rule for the 2025 Medicare Hospital Inpatient Prospective Payment System and the LTC Hospital Prospective Payment System.[52] These measures include screening and treatment for malnutrition that may enhance access to nutrition care across clinical and community settings.

Legislative initiatives can be promising opportunities to support employment of RDNs and the nutrition care they provide. RDNs are encouraged to respond to Academy Action Alerts and participate in similar efforts to continue and expand nutrition services and RDN-delivered nutrition care. The Medical Nutrition Act of 2023 aimed to expand the availability of MNT services under Medicare by reimbursing MNT for any condition that may cause unintentional weight loss.[53] As of March 2025, the Medical Nutrition Act of 2023 remains under consideration in congress.[54]

In summary, malnutrition among older adults remains a pressing public health issue that requires policy and legislative action. Recent initiatives, strategies, and legislative efforts have advanced access to nutrition care, yet challenges such as limited research and resources (eg, staffing and reimbursement) remain. RDNs and policymakers should actively engage in advancing policies that promote access to quality nutrition care to reduce malnutrition and improve other nutrition and health-related outcomes for older adults in LTC and community settings.

STAFFING

The availability of RDNs in LTC and community settings is crucial to meeting the growing demand for nutrition care driven by an aging population and rising chronic disease prevalence. However, a shortage of RDNs, particularly in rural areas, persists due to geographic disparities.[55] Addressing this requires strategies such as loan repayment programs, continuing professional education, and enhancing recruitment in underserved areas.[4] RDN collaboration across acute, LTC, and community settings can improve access to nutrition care and improve health outcomes.[56] For example, the Academy is utilizing the Academy Health Informatics Infrastructure tool in a 5-year project from 2023 to 2028 to screen, assess, and provide nutrition care and access by sharing nutrition information from acute care hospitals to community-based senior meal programs.[57]

According to CMS regulations, LTC facilities are not required to employ full-time RDN. They may hire an RDN on a full-time, part-time, or consultant basis.[58] If a full-time RDN is not employed, the facility must appoint a food and nutrition services director with specific qualifications, such as certified dietary manager, certified food protection professional. In addition, the facility must ensure regular consultations with an RDN to meet residents' nutrition needs. It is important to note that certified dietary managers do not have the expertise to provide MNT, including conducting nutrition assessments, identifying malnutrition, and developing and implementing individualized nutrition care plans. Although federal regulations set this framework, individual states may impose additional requirements for RDN employment.[58] Limited availability of RDNs within LTC facilities may be a barrier to all residents at risk for malnutrition receiving comprehensive nutrition assessment and individualized care performed by RDNs. CMS requires RDNs to report staffing hours in Payroll-Based Journals if they provide direct resident care but no minimum staffing requirements exist.[59] Payroll-Based Journal data could potentially help establish staffing requirements; however, it doesn't include hours worked by other nutrition practitioners like certified dietary managers or nutrition and dietetics technicians, registered, potentially skewing the resident-to-RDN ratio. Establishment of minimum standards should consider Payroll-Based Journals in addition to other metrics such as the Patient Driven Payment Model.[60]

Availability of RDNs is also a barrier in community settings.[33,61] One-third of participants in a qualitative study analyzing RDNs' perspectives on the coordination and continuity of nutrition care for malnourished or frail clients, reported that lack of community dietitians and/or services as a primary barrier in the provision of nutrition care.[33] Adequate RDN staffing is essential for all older adults at risk for malnutrition to receive comprehensive nutrition assessment. The nutrition focus within the 2020 Older Americans Act may increase opportunities for the RDN workforce and other community programs. For example, the CMS' All-Inclusive Care for the Elderly program requires RDNs to be part of the interdisciplinary care team (see Figure 2).

Efforts to improve RDN staffing may include increasing LTC and community opportunities in the Academy's internship program and establishing enforceable competency-based standards for LTC and community nutrition roles, with clear hiring requirements. Strengthening communication among internship directors, preceptors, and LTC/community organizations is also essential for enhancing training and workforce development. Regulatory changes, such as establishing minimum RDN-to-resident ratios, increasing resources for LTC and community-based nutrition programs, and improving reimbursement for RDN-led services under Medicare and Medicaid are crucial. In addition, RDNs should collaborate with employers, health care payers, and other stakeholders to demonstrate the value of nutrition care by publishing peer-reviewed studies that highlight the return on investment. Research on the cost-effectiveness of community-based

nutrition care is limited. However, a recently published study by Sulo and colleagues,[62] reported that providing nutrition care to older adults in the community in Colombia reduced overall use of health care resources by more than 40%, with modeling estimating a per-person cost savings of $210. Minimum staffing levels may be required by state or local policies or regulations (eg, Older Americans Act, Program of All-Inclusive Care for the Elderly).

The Commission on Dietetic Registration's Board of Certification in Gerontological Nutrition equips RDNs with specialized expertise in providing nutrition care for older adults.[63] Further professional development opportunities include training in public health, policy, or other related fields; increased internship rotations or placements within LTC and community programs; participation in continuing professional education; and involvement in Academy Dietetic Practice Groups can further strengthen an RDN's skills in delivering MNT to older adults. Community-based programs and organizations serving older adults can access a wealth of resources through Academy websites (www.eatright.org) and federal platforms, such as the Administration for Community Living's Nutrition and Aging Resource Center (www.acl.gov.senior-nutrition).

PAYMENT

In 2019, the Patient Driven Payment Model for LTC and skilled nursing facilities recognized nutrition services as part of the Non-Therapy Ancillary (NTA) component.[64] This reimbursement system compensates LTCs and skilled nursing facilities based on the specific services for Medicare beneficiaries covered under Part A.[58,65] RDN services are included under the NTA category, covering MNT for conditions such as full thickness pressure injuries, severe obesity, malnutrition, and enteral or parenteral nutrition. Higher NTA scores may qualify skilled nursing facilities patients for increased reimbursement rates. To ensure eligibility, NTAs must be documented in the Minimum Data Set and supported by a physician's documentation.[64] RDNs must maintain thorough and accurate documentation of all nutrition assessments, care plans, interventions, and outcomes. This documentation is subject to review during state surveys and inspections to ensure that LTC facilities are meeting regulatory standards.

Salaries for community-based RDNs can be partially supported by Medicare, Medicaid, and/or insurance billing (eg, National Diabetes Prevention Program,[66] Diabetes Self-Management Training,[67] and MNT), or direct health care payments based on state or local health care incentives for health care quality metrics, such as the CMS-approved statewide All-Payer Health Equity Approaches and Development Model.[68] RDN-provided nutrition care is reimbursable through Medicare's Community Health Integration and Principal Illness Navigation service payments.[69] Medicaid may also cover medically tailored meals or nutrition counseling for low-income individuals, although coverage varies significantly by state, Medicaid plans, and waivers.[70] In addition, some health insurance companies and Medicare Advantage plans offer similar benefits for a limited time.[71] RDNs can visit the Academy's professional website Payment webpage on www.EatrightPro.org for more details on Medicare and Medicaid billing opportunities.[71]

CONCLUSIONS

Addressing malnutrition in older adults is critical for their health and quality of life, particularly in LTC and community settings. RDNs play a key role in improving nutrition outcomes, but barriers such as limited access to nutrition care, staffing shortages, fragmented care, and a lack of available research hinder progress. To overcome these challenges, strategies should focus on expanding RDN services, enhancing training, and implementing regulatory changes to improve access. Research incorporating valid nutrition screening and assessment tools should demonstrate the influence of nutrition care to improve quality of practice, improve nutrition and health outcomes, and justify continued investment. Policies and procedures in LTC and community settings should include screening and referral processes, individualized care, and interdisciplinary collaboration. By fostering partnerships across care settings and improving health care payment access, RDNs can advance nutrition care, reduce malnutrition, and improve health outcomes for older adults.

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