



Nutrition Security at the Intersection of Health Equity and Quality Care

IMPROVING THE HEALTH OF Americans requires a dedicated and holistic advancement of access to quality and affordable health care as well as a strong focus on preventive care. Such prevention requires comprehensive nutrition care and services. The COVID-19 pandemic reinforced that social determinants of health (SDOH),¹ including access to nutritious food, have a major impact on people's health, well-being, and quality of life and that SDOHs are intrinsically linked to health equity. Malnutrition (most often protein-calorie malnutrition/undernutrition, particularly in older adults) can be a contributing factor to health inequities, whether caused by challenges from disease and functional limitations, food insecurity, other factors, or a combination of multiple causes. Awareness of the issues of malnutrition and limited access to nutritious food have helped propel an increased focus among policymakers and advocates to promote nutrition security. This article identifies how nutrition security for older adults (aged 65+ years) intersects with health equity and then identifies specific policies to help ensure nutrition security. In addition, the article defines links between nutrition security for older adults and quality health care, particularly links supporting the three aims of the National Quality Strategy. Specific opportunities for action are identified throughout the article, highlighting how credentialed nutrition and dietetics practitioners can help support nutrition security.

NUTRITION SECURITY AND HEALTH EQUITY

Over the past five decades, there has been increased understanding of the nature and scope of health disparities in the United States and that the burdens of disease and poor health and the benefits of well-being and good health are not equitably distributed.² An unhealthy diet is recognized as one of the top contributors to poor health,³ and disparities in diet quality by socioeconomic status can contribute to health disparities.⁴ Communities of color are disproportionately impacted; for example, data from the U.S. Department of Agriculture (USDA) Economic Research Service consistently document non-Hispanic Black and Hispanic populations have had, and continue to have, higher rates of food insecurity and very low food security compared with all households and with White non-Hispanic households.^{5,6}

Concerns about disparities in health outcomes have led to a call for shifting from domestic policies primarily focused on providing sufficient calories and quantities of food to a less siloed approach that can advance both nutrition and food security priorities by addressing nutrition security holistically. Nutrition security is defined as having consistent access to and availability and affordability of foods that promote well-being and prevent disease.⁷ Although nutrition security has long been recognized as a global health issue,⁸ the focus within the United States on nutrition security has emerged more recently. Some scholars advise that the term food security has long included a nutrition domain and thus the move to a new measure of nutrition security is not needed.⁹ In 2021, the Biden Administration announced its intention to invest \$5 billion to “strengthen food systems in the United States, including through investments in systems and

infrastructure to ensure access to healthy diets for all Americans.”¹⁰ Further reinforcing this message, USDA's *Actions on Nutrition Security* report comments that “Promoting both food and nutrition security is a core priority for the U.S. Department of Agriculture and supports the Biden administration's whole-of-government approach to improve health and wellness, reduce diet-related chronic diseases, and advance health equity.”¹¹ More recently, the Biden Administration has announced plans for a White House Conference on Hunger, Nutrition and Health that “will accelerate progress and drive significant change to end hunger, improve nutrition and physical activity, reduce diet-related disease, and close the disparities around them.”¹²

Policies and Programs to Help Ensure Nutrition Security

The approach to address nutrition security is multifaceted. It starts with understanding the links between nutrition security, SDOH, and health equity. The Department of Health and Human Services' Healthy People 2030 framework categorizes SDOH into five core domains (Figure 1). Healthy People 2030 references nutrition in explaining how SDOH contribute to wide health disparities and inequities by citing the example that “people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity—and even lowers life expectancy relative to people who do have access to healthy foods.”¹ Furthermore, the Healthy People 2030 objectives emphasize the importance of impacting “upstream” factors that may not even be directly related to health care delivery. These could include transportation factors,

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Nutrition can interface with social determinants of health (SDOH)



Figure 1. Healthy People 2030's five domains of social determinants of health.¹²

which impact access to nutrition care services and grocery stores, or language and literacy skills that can impact the ability to learn about a healthy diet. Yet, although some Healthy People 2030 objectives are specific to reducing household food insecurity and hunger and increasing fruit and vegetable consumption in the general population, no objectives are specific to nutrition security or malnutrition for older adults.

The Academy of Nutrition and Dietetics (Academy) has outlined recommendations for addressing health disparities specifically tied to SDOH and supports investigating the root causes of health disparities by examining the SDOH that play a role in the causes and amplification of chronic health disparities disease.¹³ The Academy is poised to work with the Biden administration on food assistance, vaccination and health care, schools and childcare, and aid to families and struggling communities. The Food Environment Atlas, developed by the USDA Economic Research Service, is a tool that could help identify some of these root causes of health disparities.¹⁴ The Atlas offers statistics on food environment indicators to stimulate research on determinants of food choices and diet quality. It also provides a spatial overview of community abilities and

successes in accessing healthy food,¹² which could be useful for credentialed nutrition and dietetics practitioners working with community-based organizations.

Multiple federal programs exist for older adults that target SDOH related to nutritional health and economic stability. Older Americans Act (OAA) nutrition programs provide congregate and home-delivered meals through local agencies, and the Supplemental Nutrition Assistance Program (SNAP) provides benefits to purchase food and education (SNAP-Ed) to help promote the purchase of healthy food. OAA nutrition programs are funded at a set budget, meaning they are not entitlement programs and therefore not all who qualify will receive services if adequate funding is not available in their area. Adequate funding to meet OAA program demand has long been an issue because both program and food costs and the size of the older adult population have continued to grow without commensurate increases in funding. Ujvari et al¹⁵ found that “when adjusted for inflation, total funding appropriated for OAA nutrition services over the past 18 years fell by 8 percent, a decline of \$80 million in 2019.”¹³ In addition, although OAA program

eligibility includes all adults over age 60, the OAA specifically prioritizes services to those with the greatest social/economic needs, including racial and ethnic minorities.¹⁶ One study has documented that although 36 states effectively enroll racial and ethnic minorities in OAA programs, only 16 states effectively enroll Hispanic older adults, and thus many states have opportunities to expand their outreach efforts to more diverse groups.¹⁵

The SNAP program is an entitlement program, meaning all Americans who qualify (ie, meet income or resource limits and other requirements) are “entitled” to receive SNAP benefits.^{17,18} However, compared with all eligible people, older adults have a lower SNAP participation rate, 42% participation for those aged 60+ vs 82% participation for all eligible people.¹⁶ SNAP participation can benefit health outcomes; longitudinal data suggest food-insecure older adults who participate in SNAP are 46% less likely to be hospitalized than nonparticipating older adults.¹⁹ Yet, the issue remains that nine of 10 SNAP participants face barriers in providing their household with a healthy diet throughout the month, with the most common barrier being the cost of healthy foods.²⁰

The Academy has long supported a reevaluation of the Thrifty Food Plan (used to calculate SNAP benefits) to help ensure access to nutritious, affordable food.²¹ Progress occurred when the Biden Administration released a reevaluation of the Thrifty Food Plan in Fall 2021.²² The Administration subsequently approved a significant and permanent increase in SNAP benefits (average SNAP benefit increased by 21%), the single largest increase in the program's history.²¹ Other long-term solutions are required because OAA funding (in particular) will continue to fall short with the burgeoning older adult population.^{21,23} Specific health equity policy opportunities for credentialed nutrition and dietetics practitioners to help address these issues are outlined in [Figure 2](#).

NUTRITION SECURITY AND QUALITY HEALTH CARE

The National Quality Strategy (NQS), created by the Agency for Healthcare Research and Quality to guide local,

Policy opportunity	Examples
Advance need for specific federal public health goals targeting increased nutrition security for older adults	Develop a specific Healthy People 2030 objective on reducing malnutrition in older adults
Support increased Older Americans Act (OAA) nutrition program appropriation levels, and providing permanent flexibilities during emergencies	Allow OAA nutrition programs to quickly pivot during an emergency from congregate to grab-and-go or home-delivered meals or to help older adults who may become homebound because of health or other issues impacting access
Advocate for development of programs beyond Supplemental Nutrition Assistance Program (SNAP), specifically tailored to populations with very low food security to help lift them out of poverty	Integrate OAA and Senior Farmers' Market Nutrition Programs to allow distribution of food boxes through congregate feeding sites or home-delivered meals Expand and make permanent the Elderly Simplified Application Project ²⁴ aimed at streamlining enrollment of low-income older adults in SNAP

Figure 2. Health equity policy-related opportunities for nutrition and dietetics professional engagement

state, and national efforts to measure and improve health care quality, can offer a framework for considering how nutrition security for older adults is linked with health care quality.²⁵ The NQS has three aims, targeting:

- **Better Care**—improve quality by making health care patient-centered, reliable, accessible, and safe
- **Better Health**—improve health by supporting proven interventions to address behavioral, social, and environmental determinants of health
- **Lower Costs**—reduce cost of quality health care for individuals, families, employers, and government (Figure 3).

A focus on nutrition security in federal policies and programs can help inform each of these three areas.

Linking Nutrition Security to the NQS Aim of Better Care

Better care starts with the hospital, where health issues are documented but malnutrition or undernutrition is often not identified or treated. This is evidenced by statistics that indicate 20% to 50% of overall patients (excluding maternal and neonatal patients) are at risk of becoming or are malnourished on hospital admission,²⁶ yet fewer than 9% are diagnosed with malnutrition.²⁷ Reasons for the gap can include hospital resource and information technology system constraints, such as limited tracking of nutrition care information in electronic medical record systems and lack of knowledge among various

clinical staff because of inadequate training or education in nutrition.²⁸

For Medicare beneficiaries, this gap could be addressed by the Centers for Medicare & Medicaid Services (CMS) recent adoption of the Global Malnutrition Composite Score (GMCS) measure into the Hospital Inpatient Quality Reporting Program.²⁹ The GMCS is a composite measure that represents hospitals' performance based on the summation of the key steps in the nutrition care process and workflow (malnutrition screening, nutrition assessment, and development of a nutrition care plan by a registered dietitian nutritionist [RDN], and documentation of diagnosis).³⁰ These steps address nutrition security by helping to identify and intervene for specific causes of malnutrition, whether related to disease or medical condition or limited access to nutritious food. The GMCS is already endorsed by the National Quality Forum and is supported by more than 100 hospitals nationwide that have adopted malnutrition quality measures as part of the Malnutrition Quality Improvement Initiative Learning Collaborative.³¹ Furthermore, upholding use of this measure is a multidisciplinary, open-access toolkit for helping educate clinical staff on how to implement a quality improvement program to advance malnutrition care.³²

Linking Nutrition Security to the NQS Aim of Better Health

Prioritizing nutrition security promotes better health for at-risk individuals and communities across the continuum of

care. The burden of malnutrition is not distributed equally.³³ A recent analysis of data from the Malnutrition Quality Improvement Initiative Learning Collaborative found substantial disparities in hospital malnutrition diagnoses and readmissions. Specifically, RDNs identified malnutrition/undernutrition more often in adult non-Hispanic Black patients compared with other racial/ethnic groups, and adult non-Hispanic Black patients with malnutrition had a readmission rate of over 26%, whereas the rate was less than 19% for non-Hispanic White patients.³⁴ Similarly, Guenter et al²⁷ identified that malnutrition is more prevalent among hospital patients who are Black, from lower-income communities, and older. These same groups also have higher risk for food insecurity; as identified earlier in this paper, non-Hispanic Blacks and Hispanics experience higher rates of food insecurity and very low food security than do other populations.^{4,5} In addition, results of the 2021 Household Pulse Survey indicate that 2 million adults aged 65+ reported their household sometimes or often did not have enough food to eat during the past 7 days.³⁵

Better health is also a concern because 80% of older adults have one or more chronic conditions, and half have a least two chronic conditions.³⁶ Nutrition is an integral part of management and care for these chronic conditions. In addition, nearly one third of Medicare beneficiaries have functional limitations in activities of daily living,³³ which can impact their ability to buy, prepare, and consume food. The higher prevalence of chronic conditions and functional limitations underscores why the

There are multiple intersections among the National Quality Strategy (NQS) aims



Figure 3. The Agency for Healthcare Research and Quality's NQS concurrently pursues three aims to provide better, more affordable health care for individuals and communities.²⁵

Government Accountability Office has recommended that the Administration on Community Living (the agency with oversight of OAA programs) should “centralize information on promising approaches for making meal accommodations to meet the nutritional needs of older adult participants in the congregate and home-delivered meal programs.”³⁷

High rates of chronic conditions and functional limitations also reinforce the need for better integrating nutrition into care transitions and the role for medically tailored meals (meals prepared under the supervision of RDNs to meet the specific nutritional needs of individuals with chronic diseases).³⁸ A national dialogue on Advancing Patient-Centered Malnutrition Care Transitions identified that as patients transition from one point of care to another, their nutrition status is often not evaluated, documented, or even addressed in patient health conversations.³⁹ The Dialogue recommended this need could be met by better integrating nutrition status into existing discharge protocols, pathways, and models as well as aligning incentives (eg, policy and financial) with clinical malnutrition care delivery beyond the hospital to improve prevention, identification, and management. Medically tailored meals are beneficial, and participation in a medically tailored meals program has been associated with fewer hospital and skilled nursing admissions and less overall medical spending.⁴⁰

Further building the research base on older adult nutrition needs and the

impact of nutrition security and malnutrition on health equity and health outcomes will help inform future efforts to better the health of the older adult population. The 2020-2025 *Dietary Guidelines for Americans* for the first time included recommendations for the older adult population and recognized that heightened risk of malnutrition occurs with age.⁴¹ However, the Dietary Guidelines Advisory Committee identified multiple areas in which the science on older adult nutrition was inconclusive. Indeed, the Government Accountability Office has identified that before the 2025-2030 *Dietary Guidelines for Americans* are published, more evidence is needed on the specific nutritional needs of older adults.³⁷ Furthermore, Roberts et al⁴² have argued that “improved public health messaging about nutrition and aging, combined with routine screening and medical referrals for age-related conditions that can be treated with a nutrition prescription, should form core components of a national nutrition roadmap to reduce the epidemic of unhealthy aging.”⁴²

Linking Nutrition Security to the NQS Aim of Lower Costs

Improved nutrition security helps reduce health care costs. Malnourished hospitalized patients have a 54% higher likelihood of hospital 30-day readmissions, compared with non-malnourished patients, based on a study of non-maternal and non-neonatal US hospital stays. The

resulting cost per readmission is nearly \$17,000 per patient, depending on the specific type of malnutrition.⁴³ It is estimated that for older adults, disease-associated malnutrition costs \$51.3 billion annually.⁴⁴ For the general adult population, food insecurity is associated with higher health care use and costs, even when controlling for other socioeconomic factors.⁴⁵

Medical nutrition therapy (MNT) is an important and cost-effective intervention for many chronic diseases. MNT is the nutritional diagnostic, therapy, and counseling services for disease management provided by an RDN.⁴⁶ For older adults, access to MNT can help prevent, manage, and treat a wide range of chronic conditions, including those that have disproportionately impacted communities of color.⁴⁷ However, currently Medicare coverage for MNT is restricted to only three conditions: diabetes, chronic kidney disease, and kidney transplantation.⁴⁸

In response, the Academy has worked closely with a bipartisan group of lawmakers to support introduction of The Medical Nutrition Therapy Act of 2021 (MNT Act).^{49,50} The bill expands access through Medicare Part B coverage of outpatient MNT for malnutrition, pre-diabetes, obesity, high blood pressure, high cholesterol, eating disorders, cancer, celiac disease, human immunodeficiency virus or acquired immune deficiency syndrome, and any other disease or condition causing unintentional weight loss, with authority granted to the Secretary of Health and Human Services to include other diseases based on medical necessity. The Academy has compiled the MNT evidence base for each condition that is part of the MNT Act.⁵¹ Health care policy opportunities for the MNT Act and other quality-related areas are detailed in Figure 4. Further definitions are provided in Figure 5.

SUMMARY

A focus on nutrition security and the recommended opportunities for credentialed nutrition and dietetics practitioners presented here support improved quality care as well as health equity and benefit older adults. Adoption of the GMCS measure in the hospital supports more thorough malnutrition care and earlier malnutrition interventions. This measure

Policy opportunity	Examples
Build on increased hospital attention to nutrition security and carry nutrition risk identification and intervention forward into the community	Lead exploration of unique partnerships between Medicare/Medicare Advantage programs and OAA nutrition programs
Help operationalize the Supporting Older Americans Act of 2020, ⁵² which reauthorized and provided continued funding for Older Americans Act (OAA) programs and made several updates, including adding malnutrition to the OAA program’s purpose and participant screening	Help support a greater focus on malnutrition in OAA programs, which could include adding questions related to malnutrition and food insecurity risk to national surveys of the OAA program
Advocate for inclusion of malnutrition and food insecurity risk identification in older adult surveys and Medicare-related examinations	Add malnutrition and food insecurity risk questions to national surveys of older adult health and to Medicare new patient and annual wellness visit examinations, thus providing opportunities to better target “upstream” interventions that increase nutrition security
Advocate for more funding for older adult nutrition research to build the evidentiary base on older adult nutrition security for the 2025-2030 Dietary Guidelines for Americans	Lead and publish clinical studies related to nutrition security and malnutrition quality of care across the care continuum Advocate creating a separate Office of Nutrition Research within the National Institutes of Health, to help garner more federal focus and resources on older adult nutrition
Advocate Congress pass the Health Equity and Accountability Act, which includes the Medical Nutrition Therapy Act of 2021(MNT Act)	Provide examples of how passing the MNT Act will help increase access to cost-effective MNT for chronic diseases/ conditions, particularly for communities of color

Figure 4. Quality-related health care policy opportunities for credentialed nutrition and dietetics practitioners.

reduces complications and health care costs, improves patient outcomes, and contributes to continuity of malnutrition care as patients transition home or to other care settings. Increased funding and expanded programming and resources to intervene for nutrition security at the community level help

address health equity and lessen the impact of malnutrition on health outcomes at the health care institutional level. Monitoring of nutrition security and malnutrition quality of care through increased research, and inclusion in national surveys, help improve programs and provide the foundation

for evidenced-based recommendations on the role and impact of nutrition security for older adults. Passage of the Health Equity and Accountability Act, which includes the Medical Nutrition Therapy Act of 2021, will improve access to evidence-based nutrition care for vulnerable populations to better

Term	Definition
Food insecurity	The economic and social condition of limited or uncertain access to adequate food ⁵⁴
Food security	Access by all people at all times to enough food for an active, healthy life ⁵³
Health disparity	Preventable differences among individuals and communities, usually in disease burden, access to care, and outcomes ⁵⁴
Health equity	The state in which all individuals have the opportunity to achieve their full health potential ⁵⁴
Medical nutrition therapy (MNT)	Evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay, or management of diseases or conditions. ⁵⁵
Medically tailored meals	Meals prepared under the supervision of RDNs to meet the specific nutritional needs of individuals with chronic diseases ³⁸
Nutrition security	The condition in which all Americans have consistent access to the safe, healthy, affordable foods essential to optimal health and well-being ^{54,56}
Very low food security	Multiple indications of disrupted eating patterns and reduced food intake ⁵⁷

Figure 5. Terms and definitions.

manage chronic diseases. These proactive public health and health care policy actions are needed to address nutrition security and malnutrition care, thereby helping to support improved access to quality and affordable health care for all older Americans.

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STATEMENT OF POTENTIAL CONFLICT OF INTEREST

The Malnutrition Quality Improvement Initiative (MQii) is a project of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders who participated in and provided guidance and expertise in this collaborative partnership. J. Blankenship is an employee of the Academy of Nutrition and Dietetics. R. Blancato is the national coordinator for the Defeat Malnutrition Today coalition.

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