Guidance for the Primary Care Nutrition Pathway for Adults Aged 65+

The Primary Care Nutrition Pathway for Adults Aged 65+ is…

- an evidence-based algorithm for the prevention, detection, treatment, and monitoring of malnutrition
- designed for community-dwelling older adults aged ≥ 65 years
- designed to detect nutrition risk and malnutrition using regular screening by the medical home and/or community services, but not other conditions that require nutrition expertise
- a minimum standard for nutrition care; medical homes and community services providing care above this minimum are encouraged to continue their high quality practice
- dependent on the entire healthcare team, the patient, and their family for optimal nutrition care

To ensure successful implementation and sustainability, it is recommended that the medical home and community services establish champions and an interdisciplinary team to implement the Primary Care Nutrition Pathway for Adults Aged 65+.

MEDICAL HOME: PERFORMS NUTRITION SCREENING AND INTERVENTION

Perform nutrition screening at least once a year using a valid tool

- Screening should occur upon initial registration with the medical home, during annual health checks and existing medical clinics (e.g., flu shot, diabetes, mobility, etc.), and if there is clinical concern (e.g., weight loss, low appetite, or hospitalization)
- The following tools are valid and reliable for community-dwelling older adults:
  1. Seniors in the Community Risk Evaluation for Eating and Nutrition (SCREEN)
     - Self- or interviewer-administered
  2. Mini Nutritional Assessment (MNA)
     - Administered by a trained interviewer
  3. Malnutrition Universal Screening Tool (MUST)
     - Administered by a trained interviewer
- For SCREEN and MNA, the lower the score, the greater the risk/malnutrition; lower cut-points can be used to focus dietitian referrals on patients who have the greatest need

Patient has NO OR LOW nutrition risk:

No/Low Risk Nutrition Care Plan

- The “No/Low Risk Nutrition Care Plan” promotes healthy eating habits and patient education so that malnutrition can be prevented
- Encourage patient to continue pre-existing healthy eating habits
- Provide resources, such as healthy diet factsheets, trusted online websites, and tele-dietetic numbers
- Recommend and provide contact information for community services based on needs (e.g., financial assistance for low income patients)
- Offer dietitian-led group education supports within the primary care model if available

Patient is AT MODERATE nutrition risk:

Moderate Risk Nutrition Care Plan

- The “Moderate Risk Nutrition Care Plan” promotes patient education, lifestyle changes, and weight and appetite monitoring so that nutrition status can be improved and malnutrition can be prevented
- Provide basic nutrition care:
  - Educate on the importance of nutrition
  - Recommend strategies that promote food intake and weight gain (see CMTF strategies)
  - Investigate etiology, diagnostics, and risk factors for malnutrition[a]; refer to other team members or specialist(s) based on discovery
- Provide resources, such as healthy diet factsheets, trusted online websites, and tele-dietetic numbers
- Recommend and provide contact information for community services based on needs (e.g., financial assistance for low income patients)
- Schedule, at minimum, a 3-month follow-up visit:
  - Monitor weight and appetite
  - Determine if resources and community services were used; if not, suggest alternatives
- Refer moderate risk patients to a dietitian[b] for further examination and nutrition care if weight loss and/or low appetite do not resolve

Patient is <u>AT HIGH</u> nutrition risk or malnourished:

High Risk/Malnourished Nutrition Care Plan

- The "High Risk/Malnourished Nutrition Care Plan" promotes patient education, lifestyle changes, weight and appetite monitoring, and dietitian intervention so that malnutrition can be treated
- Medical home continues the "Moderate Risk Nutrition Care Plan"
- Medical home refers patient to primary care or community dietitian[b] who:
  - Conducts a minimum of 3 follow-up visits within 3 months to assess and provide individualized treatment
  - Coordinates nutrition care with the patient's medical home
- Medical home schedules, at minimum, a 1-month follow-up visit to:
  - Monitor weight and appetite
  - Determine if resources and community services were used; if not, suggest alternatives

COMMUNITY SERVICES: PERFORMS NUTRITION SCREENING

Perform nutrition screening using a valid tool

- Screening can occur during existing programs (e.g., Meals on Wheels, home care services, congregate dining, etc.)
- SCREEN is a screening tool that can be easily administered by an older adult or a community service provider
- Report nutrition screening results to the older adult's medical home
- Refer high risk and malnourished older adults to medical home and/or a primary care or community dietitian[b]

FOOTNOTES:

[a] Risk factors for malnutrition:

- Risk factors for malnutrition include, but are not limited to, gastrointestinal conditions, cancer, age-related declines in appetite, metabolism and mobility, socioeconomic status, access to food and care services, social isolation, mental health, and comorbidities
- Perform supplementary screening (e.g., poverty, depression, frailty, etc.) to identify and address modifiable risk factors for malnutrition

[b] When there is no dietitian to refer to:

- Monitor the efficacy of the therapeutic diet plan (e.g., monitor body weight at every visit, or at least monthly)
- Recommend high protein and calorie foods, as well as oral nutritional supplements (ONS) or enteral nutrition (EN) if appropriate[c]

[c] When to recommend ONS and EN:

- ONS can be considered when the patient has challenges with food access, preparation and intake, and/or poor absorptive capacity
- Recommend 30 g of protein from supplements per day, which should include ≥ 355 mL of calorie- and protein-enriched liquid supplement (Volkert et al., *Clin Nutr* 2019):
  - Determine efficacy after 1 month (e.g., weight gain)
  - Assess acceptance and use
- If ONS does not improve nutrition status:
  - Refer to a dietitian
  - Dietitian-prescribed EN may be needed
  - Investigate the risk factors of malnutrition, and consider referring to a specialist for an outpatient consult

GLOSSARY:

- A medical home refers to a team-based healthcare delivery model led by the patient's most responsible primary healthcare provider (e.g., doctor, nurse practitioner, social worker, pharmacist, registered dietitian, occupational therapist, physiotherapist, speech language pathologist, mental health worker, etc.). RDs may be internal to the medical home or an external resource (i.e., private practice)
- Community services may include meal-based programs, assisted shopping and cooking, transportation services, financial subsidy or assistance, day programs and respite care, home support agencies, telehealth, system navigation, mental health services, Veterans Affairs, addiction services, etc.

Funded by the Canadian Malnutrition Task Force, a standing committee of the Canadian Nutrition Society. For more information, and details regarding how to implement the pathway, please visit: https://nutritioncareincanada.ca/

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