Primary Care Nutrition Pathway for Adults Aged 65+
A Guide for Providing Nutrition Care to Older Adults in the Community

Medical Home
- Perform nutrition screening annually using a valid tool (e.g., SCREEN-II, MNA, and MUST)

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<th>No/ Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk/ Malnourished</th>
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<tbody>
<tr>
<td>Encourage patient to continue healthy eating habits</td>
<td>Investigate etiology, diagnostics, and risk factors</td>
<td>Refer to dietitian</td>
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<tr>
<td></td>
<td>Initiate basic care plan</td>
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<td>Monitor weight and appetite</td>
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Resources
- Healthy diet factsheets, trusted websites, etc.

Community Services
- Meal-based programs
- Assisted shopping and cooking
- Transportation
- Financial subsidy and assistance
- Day programs and respite care
- Home support agencies

Primary Care/ Community Dietitian
- Complete nutrition assessment
- Develop individualized treatment and nutrition care plan
- Reassess nutrition status
- Coordinate care

Footnotes:
- A medical home refers to a team-based healthcare delivery model led by the patient’s most responsible primary healthcare provider (e.g., MD, NP, RN, social worker, pharmacist, RD, OT, PT, SLP, mental health worker, etc.). RDs may be internal to the medical home or an external resource (i.e., private practice).
- Community services may also include: telehealth, system navigation, mental health resources, Veterans Affairs, and addiction services.
- Solid arrows indicate prioritized actions.
- Refer to the guidance document for more information.

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