Guidance for the Primary Care Nutrition Pathway for Hospital to Community Transitions

The Primary Care Nutrition Pathway for Hospital to Community Transitions is…

- an evidence-based algorithm for treating and monitoring nutrition risk and malnutrition, but not other conditions
- designed for all medical and surgical patients who are at nutrition risk or malnourished transitioning from the hospital to the community
- a minimum standard for nutrition care; hospitals, 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 each hospital, medical home, and community service establish champions and an interdisciplinary team to implement the Primary Care Nutrition Pathway for Hospital to Community Transitions.

HOSPITAL TEAM: IDENTIFIES MALNUTRITION AND CREATES DISCHARGE PLAN

Detect nutrition risk and malnutrition using the Integrated Nutrition Pathway for Acute Care
Design a hospital discharge nutrition care plan and share it with the medical home

- INPAC is recommended as it is an evidence-based, field-tested algorithm for preventing, detecting, treating, and monitoring malnutrition among medical and surgical patients in acute care
- Hospital discharge nutrition care plan:
  - Document the patient's nutritional status (e.g., body weight, Subjective Global Assessment rating, etc.) and treatment provided during hospitalization
  - Educate the patient and family on the importance of nutrition
  - Provide therapeutic diet prescription, including high calorie and protein food, as well as oral nutritional supplements (ONS) or enteral nutrition (EN) if appropriate[a]
  - Provide resources, such as healthy diet factsheets, trusted online websites, and tele-dietetic numbers
  - Follow-up with the patient's medical home and provide the discharge nutrition care plan
    - The treatment plan is to be managed by the medical home, including ongoing monitoring of the patient's weight and appetite
  - Refer to and provide contact information for primary care or community dietitian[b]
  - Recommend and provide contact information for community services based on need (e.g., financial assistance for low income patients)

MEDICAL HOME: CONTINUES NUTRITION CARE

Initiate the hospital discharge nutrition care plan recommended by the hospital team
Perform nutrition screening at least once a year using a valid tool[c] (see CMTF resources)

- Initiate the hospital discharge nutrition care plan:
  - Reassess the patient
  - Investigate etiology, diagnostics, and risk factors for malnutrition[d]; refer to other team members or specialist(s) based on discovery
  - Monitor weight and appetite at every visit
- Reinforce therapeutic diet prescription
- Reinforce the use of recommended resources
- Refer to and provide contact information for community services
- Coordinate care with the primary care or community dietitian, or refer the patient to a dietitian[b] if this was not done by the hospital team
- 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
- If following a malnourished patient who is admitted to hospital, communicate the treatment plan and efficacy to the hospital team

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 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.

PRIMARY CARE OR COMMUNITY DIETITIAN: PROVIDES NUTRITION TREATMENT

Perform a comprehensive nutrition assessment
Provide individualized nutrition treatment and monitor the patient

- Reassess nutritional status with a comprehensive assessment
- Provide individualized nutrition treatment at a minimum of 3 follow-up visits within 3 months
- Coordinate nutrition care with the patient's medical home
- Link to and provide contact information for community services based on need (e.g., financial assistance for low income patients)

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.)
- Report nutrition screening results to the patient's medical home
- Refer high risk and malnourished patients to medical home and/or a primary care or community dietitian[b]

FOOTNOTES:

[a] 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[d], and consider referring to a specialist for an outpatient consult

[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 oral nutritional supplements (ONS) or enteral nutrition (EN) if appropriate [a]

[c] Valid and reliable nutrition screening tools:

1. Seniors in the Community Risk Evaluation for Eating and Nutrition (SCREEN; adults 65+)
   - Self- or interviewer-administered
2. Mini Nutritional Assessment (MNA; adults 65+)
   - Administered by a trained interviewer
3. Malnutrition Universal Screening Tool (MUST; adults 18+)
   - 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

[d] 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

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/

Canadian Malnutrition Task Force / le Groupe de travail canadien sur la malnutrition
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