



NUTRITION CARE: TARGETING STRATEGIES TO ADDRESS DISEASE RELATED MALNUTRITION



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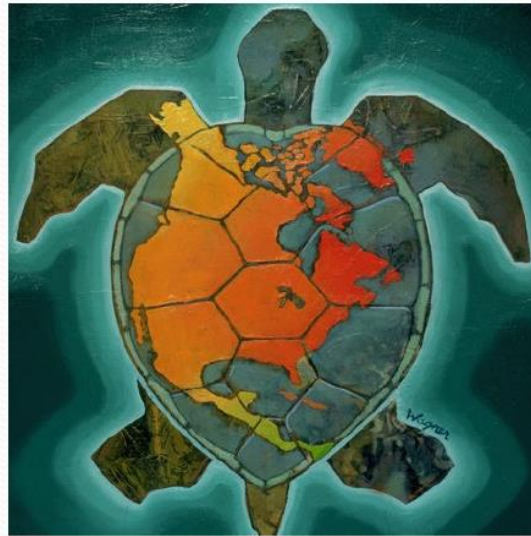
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Disclosure

- Speaker, Consultant, Research Support – Baxter, Fresenius Kabi, Abbott, Nestle

I acknowledge that the work I do is centered in Treaty 6 Territory, Canada, home to many nations including the Cree, Saulteaux, Blackfoot, Sioux and Métis People





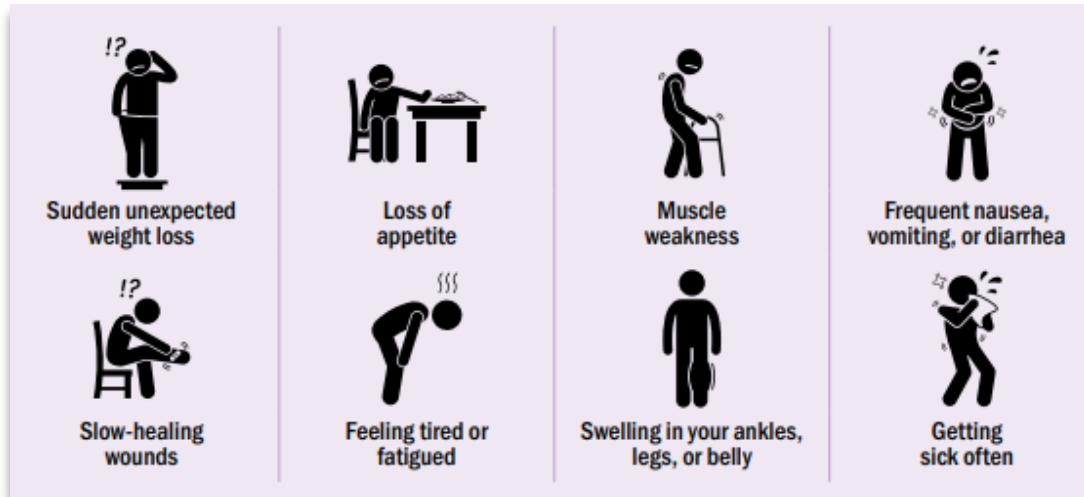
Learning Objectives

- Describe the Prevalence and Burden of Disease Related Malnutrition (DRM)
 - Discuss the Importance of prioritising and optimising nutrition delivery
 - Explore patient and provider perspectives of malnutrition
 - Identify Patient, Provider and System opportunities to address DRM
- 

What is Malnutrition?

- **Imbalance of nutrients** resulting in **functional decline**.
 - Inadequate intake
 - Impaired nutrient absorption
 - Increased energy expenditure/altered metabolism
- It's not always easy to see – but easy to screen* for.
- There are serious consequences for a patients and for health systems.

Warning Signs



Consequences



Incidence in Canadian Hospitals

On admission to hospital:



Malnutrition and Obesity: Australasian Nutrition Care Day

Ekta Agarwal, Maree Ferguson, Merrilyn Banks, Angela Vivanti, Marijka Batterham, Judy Bauer, Sandra Capra, Elisabeth Isenring,
Malnutrition, poor food intake, and adverse healthcare outcomes in non-critically ill obese acute care hospital patients. Clinical Nutrition, 2019

Characteristics of the ANCDS cohort per BMI (n=2889)

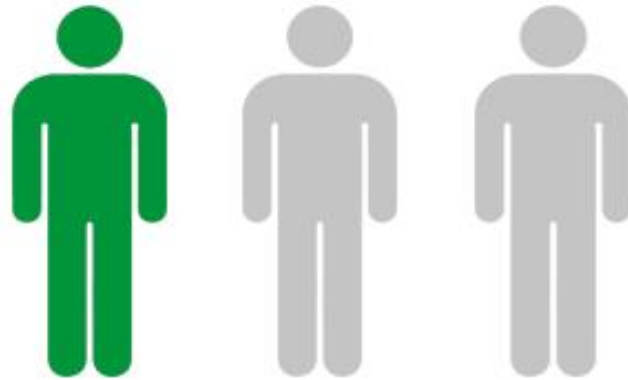
Nutritional					
Median BMI (kg/m ² , range)	17 (10–18.4)	22 (18.5–24.9)	27 (25–29.9)	34 (30–85)	0.000
Malnutrition risk ^{e,f}					
Not at risk of malnutrition	72 (32%)	516 (49%)	566 (66%)	547 (73%)	0.000
At risk of malnutrition	152 (68%)	531 (51%)	292 (34%)	201 (27%)	
SGA ^e					
A (well-nourished) ^g	10 (7%)	116 (22%)	105 (36%)	89 (12%)	0.000
B (moderately malnourished)	80 (53%)	341 (64%)	162 (55%)	101 (14%)	
C (severely malnourished)	60 (40%)	67 (14%)	19 (9%)	4 (3%)	
Overall nutritional status ^e					
Well-nourished ^g	0	632 (61%)	671 (79%)	636 (86%)	0.000
Malnourished ^h	226 (100%)	408 (39%)	181 (20%)	105 (14%)	
Food intake ^c					
0%	31 (14%)	108 (10%)	71 (8%)	31 (8%)	0.000
25%	41 (18%)	151 (15%)	110 (13%)	42 (10%)	
50%	54 (24%)	218 (21%)	162 (19%)	74 (18%)	
75%	75 (25%)	295 (28%)	231 (27%)	110 (27%)	
100%	41 (18%)	265 (26%)	286 (33%)	158 (38%)	

Poor food intake early during hospital stay predicts **prolonged LOS**

31.4%

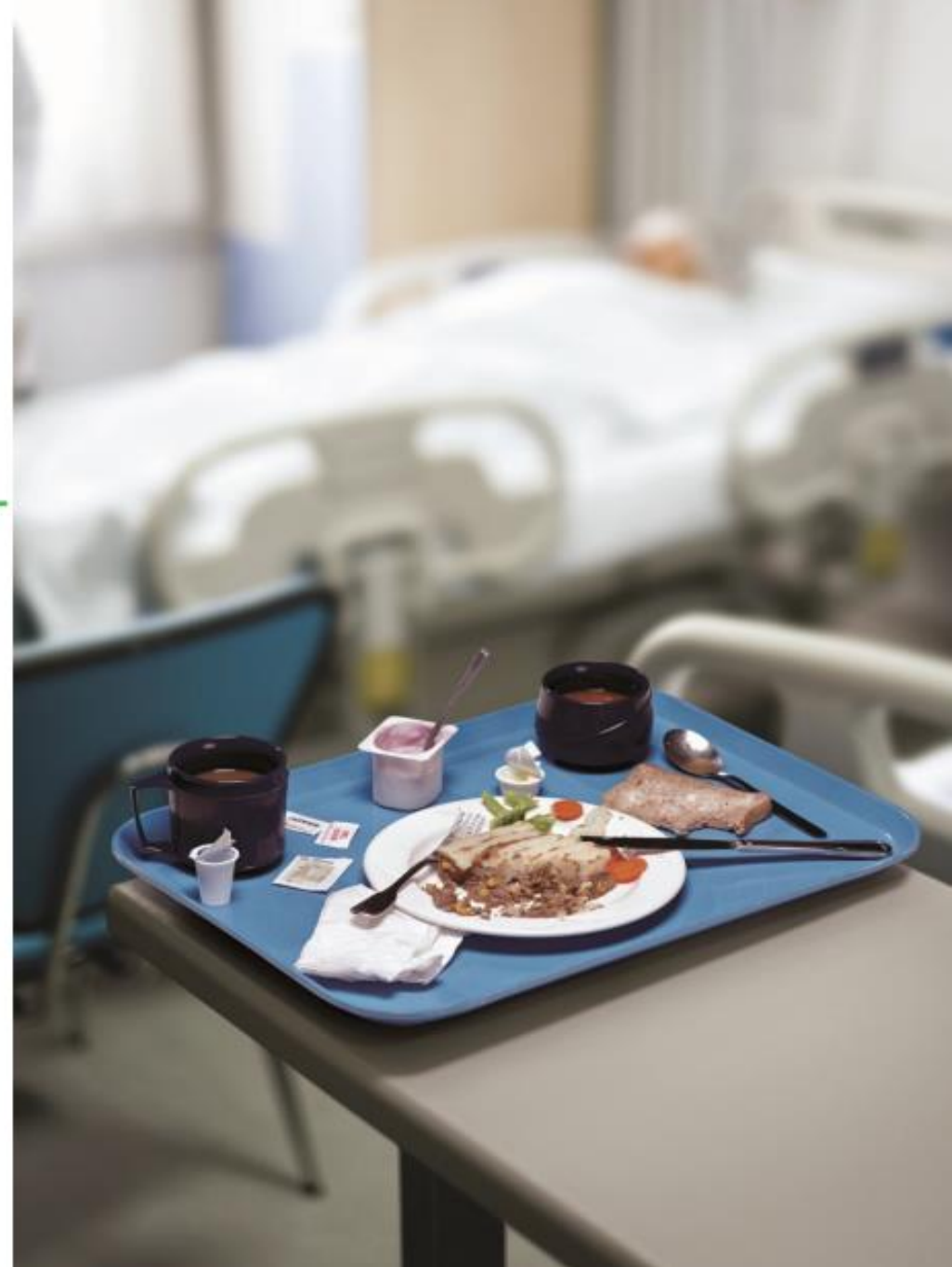
of patients
ate < 50%
of their meals

Week 1 of hospitalization (n=931)

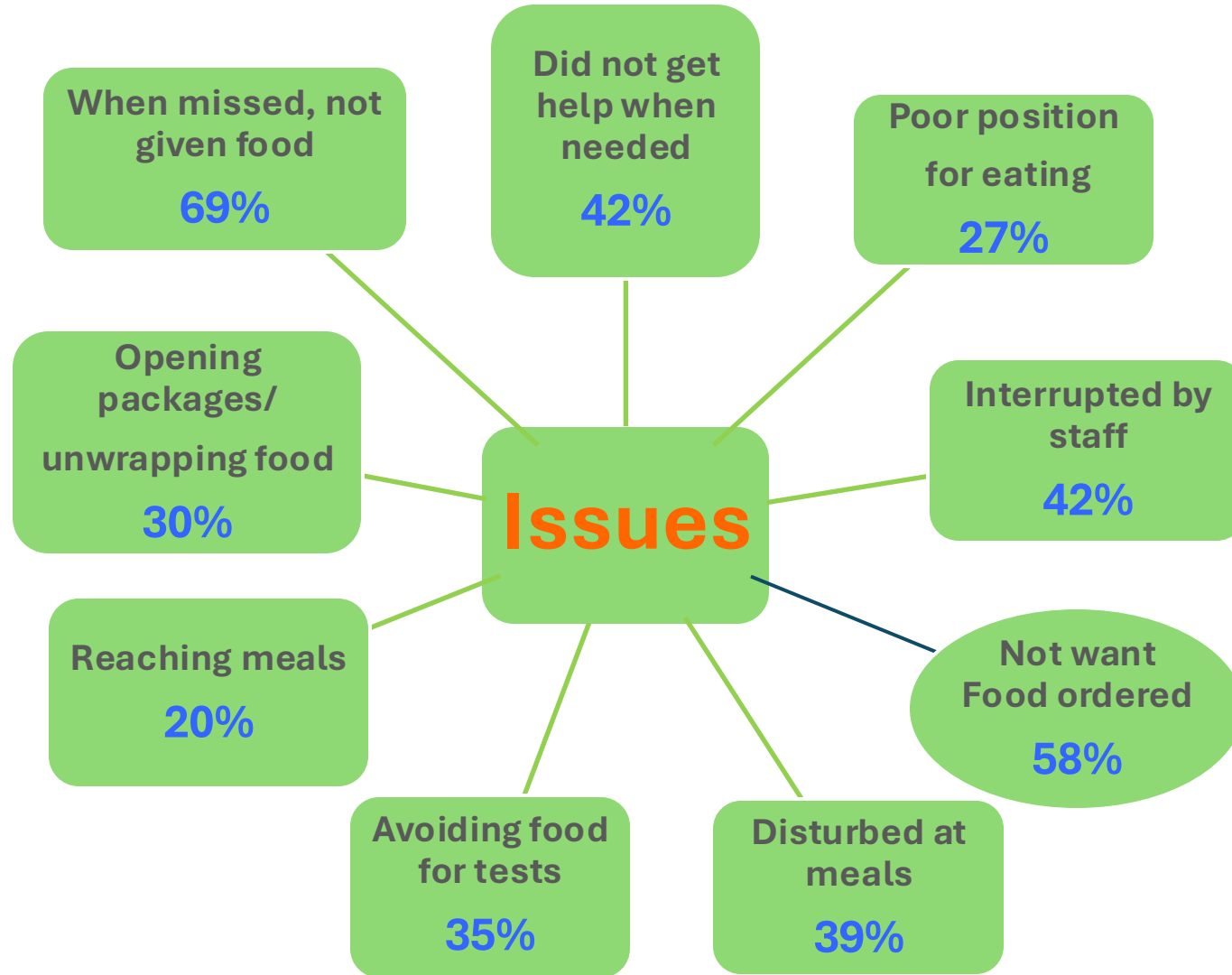


LOS: Length of stay
P < 0.001

Allard JP et al.. *JPEN* 2016;40(4):487-97.



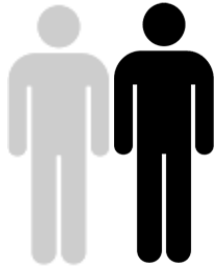
In Hospital Food Intake Barriers



Malnutrition is Costly

Hospital consequences

Up to **1** OUT OF **2**
Canadians admitted to
hospital is malnourished¹



3 days longer
stay in hospital²

\$2K Average additional
cost/patient²

x8 more likely
to die³

x2 more likely
to be readmitted⁴



\$2 billion/year
is the estimated cost
of malnutrition

What works?



- **Change in thinking:** Food is Medicine, not a budget item;
NUTRITION IS THERAPY
- **Systematic screening and early diagnosis** for malnutrition
(like systematic screening for fall risk and pressure injuries)
- **Standardized language**
- **Embedding tools** and processes into multidisciplinary team-work

CANADIAN MALNUTRITION TASK FORCE FOUNDATIONAL WORK



2010

Did not know malnutrition prevalence, cost or gaps in nutrition care



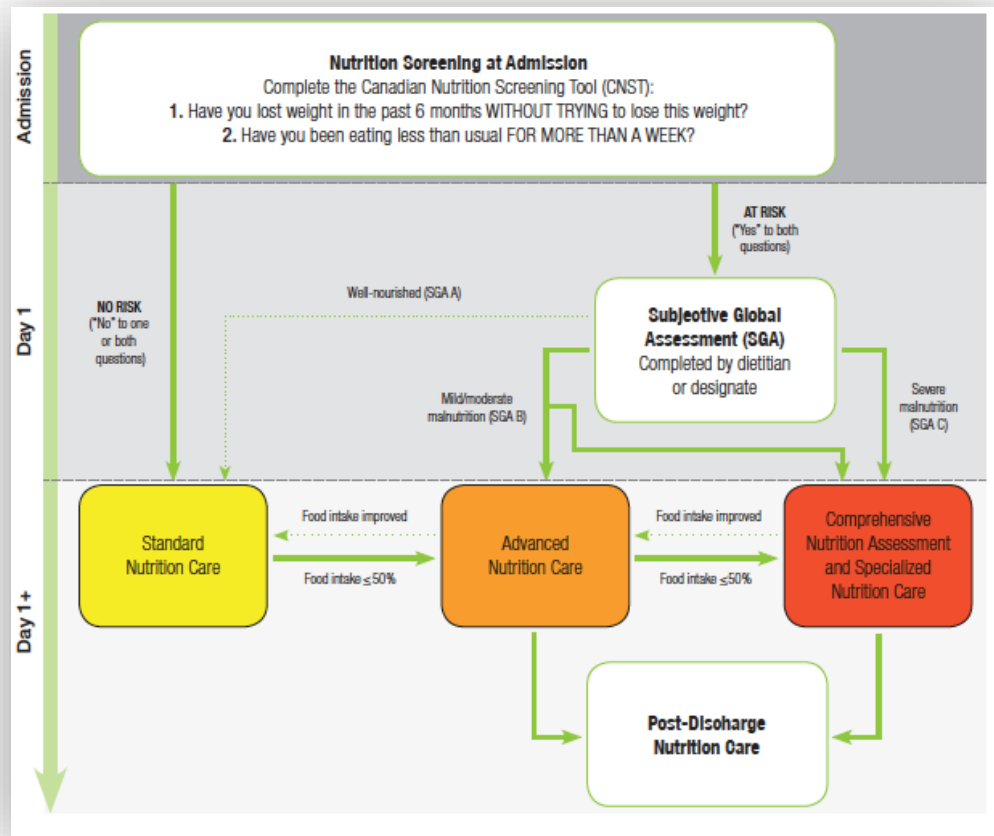
>50 peer reviewed manuscripts (direct and indirect)
>100 oral or poster presentations at research conferences
+++ Grand Rounds + other KT presentations

2025+

Changing practice nationally and internationally

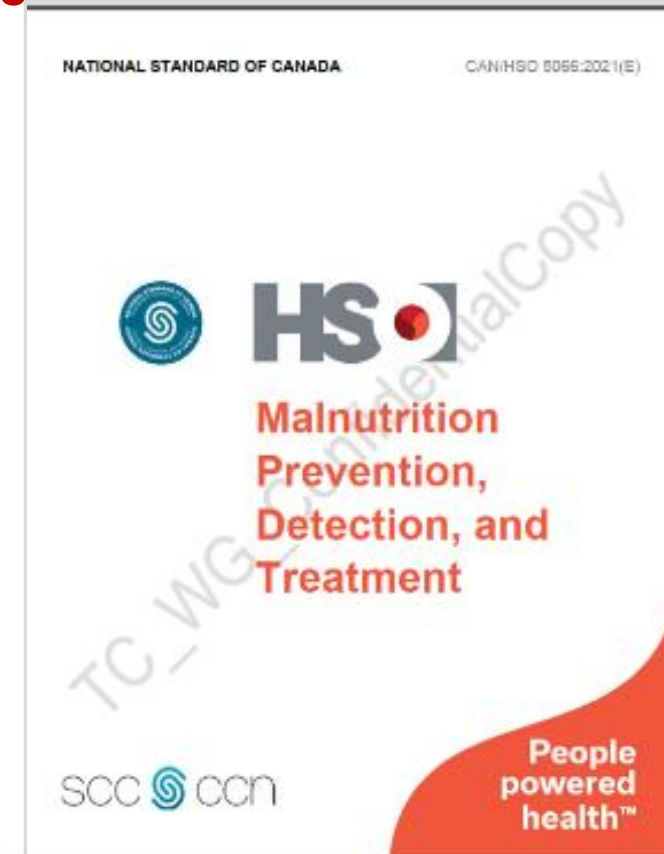
Best practices for hospital malnutrition

Integrated Nutrition Pathway for Acute Care (INPAC)



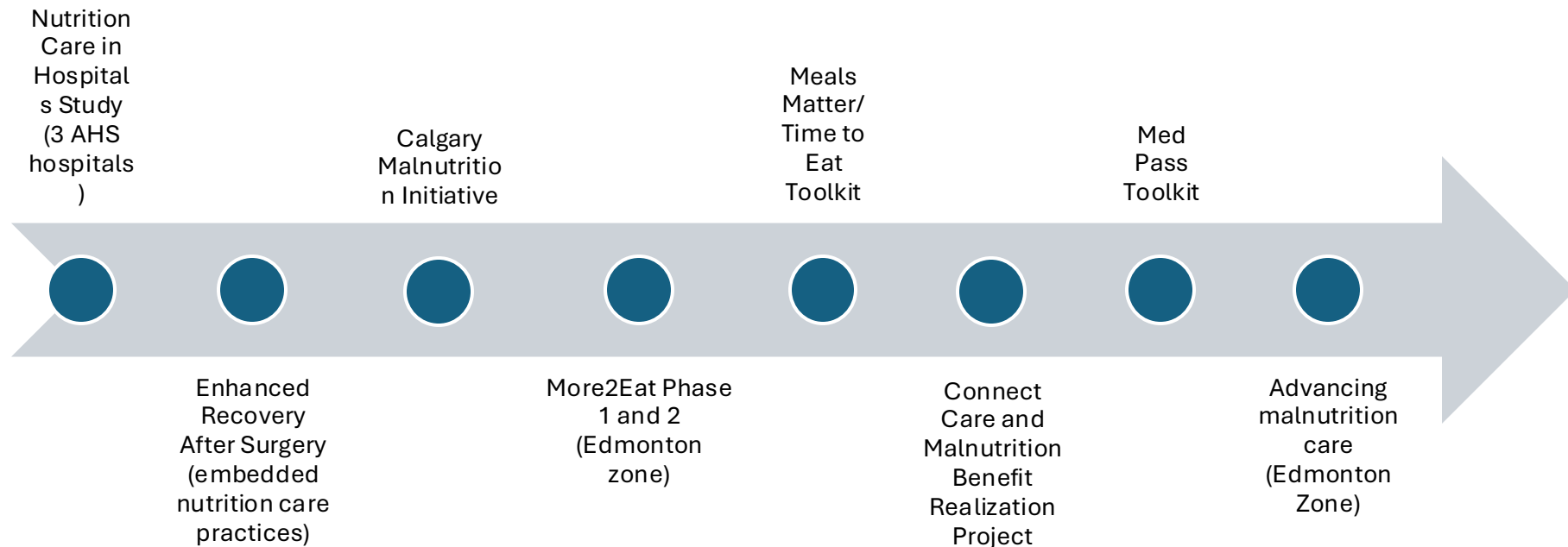
<https://nutritioncareincanada.ca/resources-and-tools/hospital-care-inpac/inpac>

Malnutrition Prevention, Detection and Treatment Standard (CAN/HSO 5066:2021)

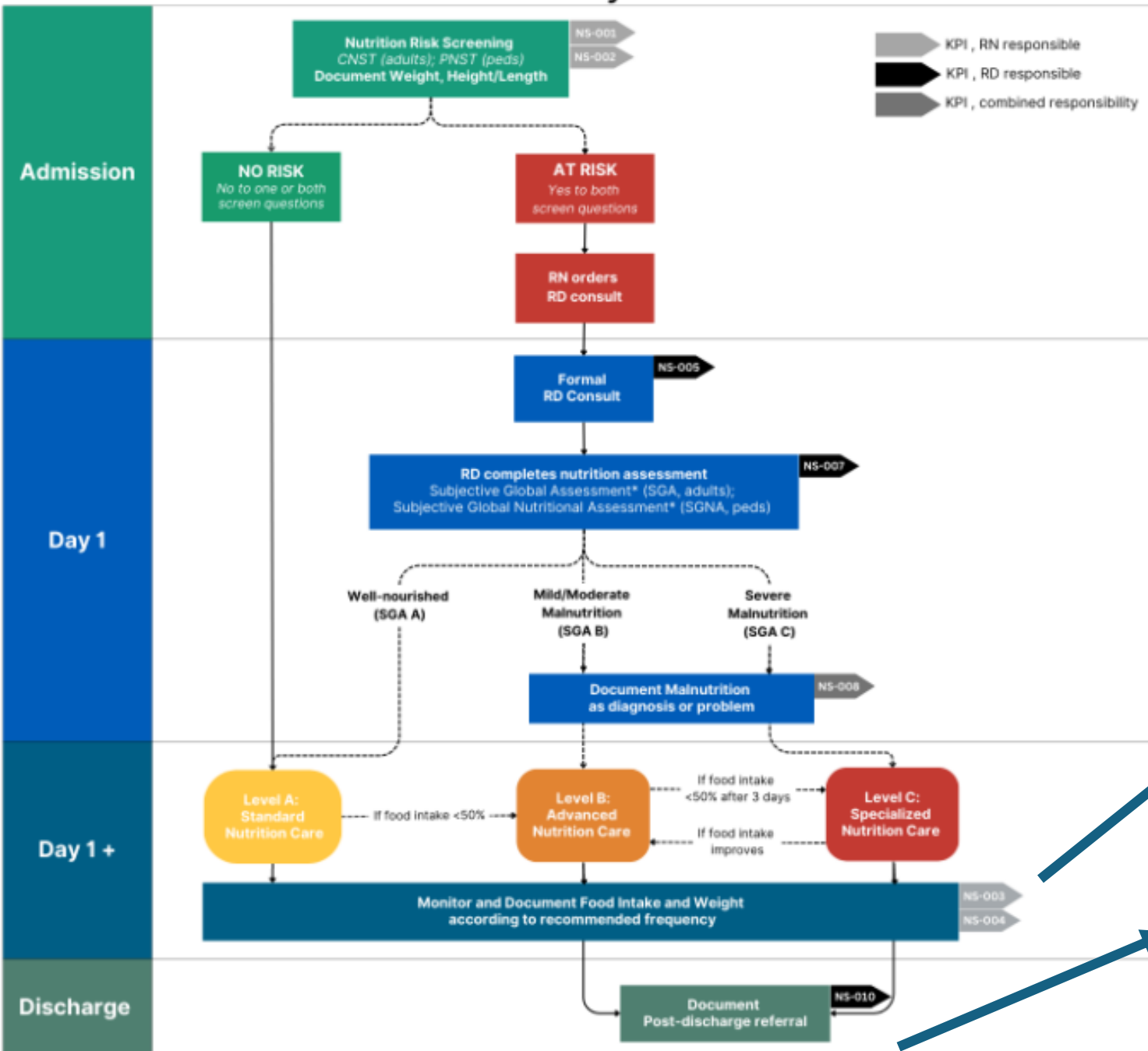


<https://healthstandards.org/standard/malnutrition-prevention-detection-and-treatment>

Acting Locally in Alberta: Key Malnutrition Initiatives over the Past 10 Years Targeting Acute Care



AHS Nutrition Services' Nutrition Care Pathway for Acute Care for Adults and Pediatrics



Nutrition Interventions:

- Diet modification
- Supplementation
- Oral Nutrition Supplement
- EN
- PN

Community based interventions/
Transitions of care

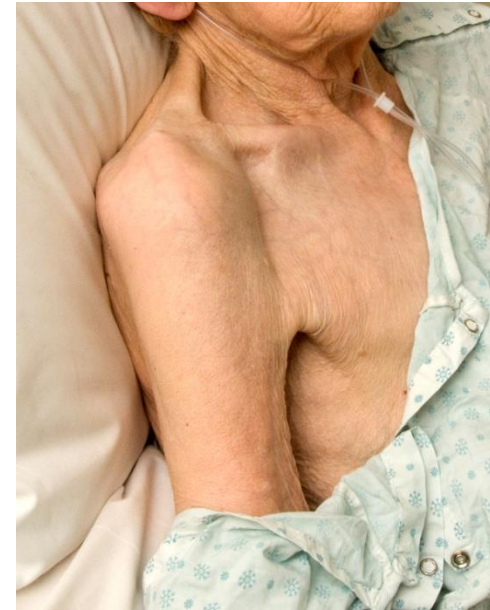
Identifying the Patient who may benefit...



SGA-A
Well Nourished



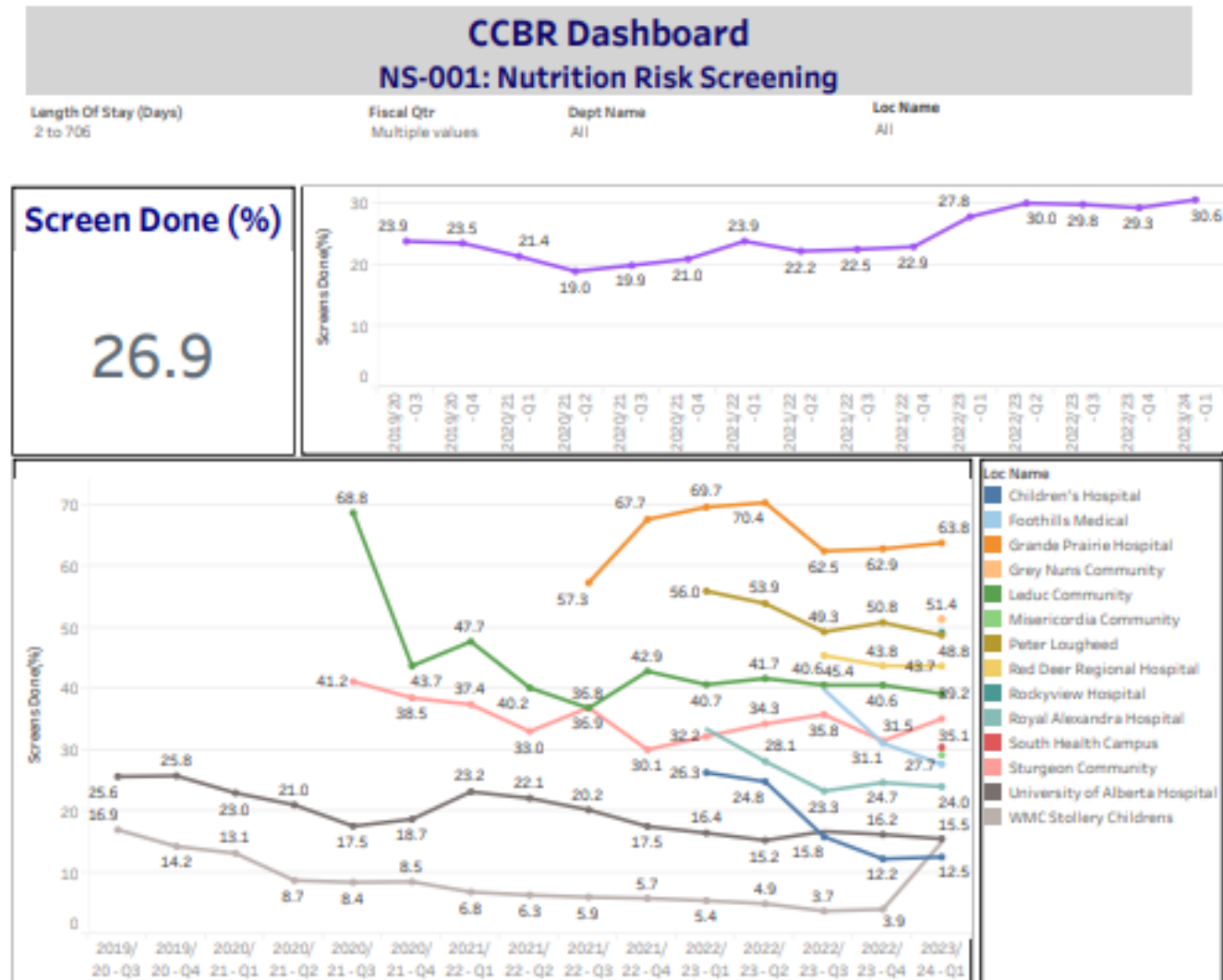
SGA-B
Moderate Malnutrition



SGA-C
Severely Malnourished

PHOTOS: Leah Gramlich

NS-001 Nutrition Risk Screening at Hospital Admission: Using the Electronic Health Record (EPIC) to Inform Nutrition Care



Malnutrition Perceptions: *Patient and Dietitian Experience*

St-Jacques M, Verdin N, Easaw J, Longmore S, Atkins M, Chan C, Gillis C. The conversation around malnutrition: a qualitative study of dietitian and patient perspectives. *Appl Physiol Nutr Metab*. 2025 Jan 1;50:1-11. doi: 10.1139/apnm-2024-0522. PMID: 40314557.

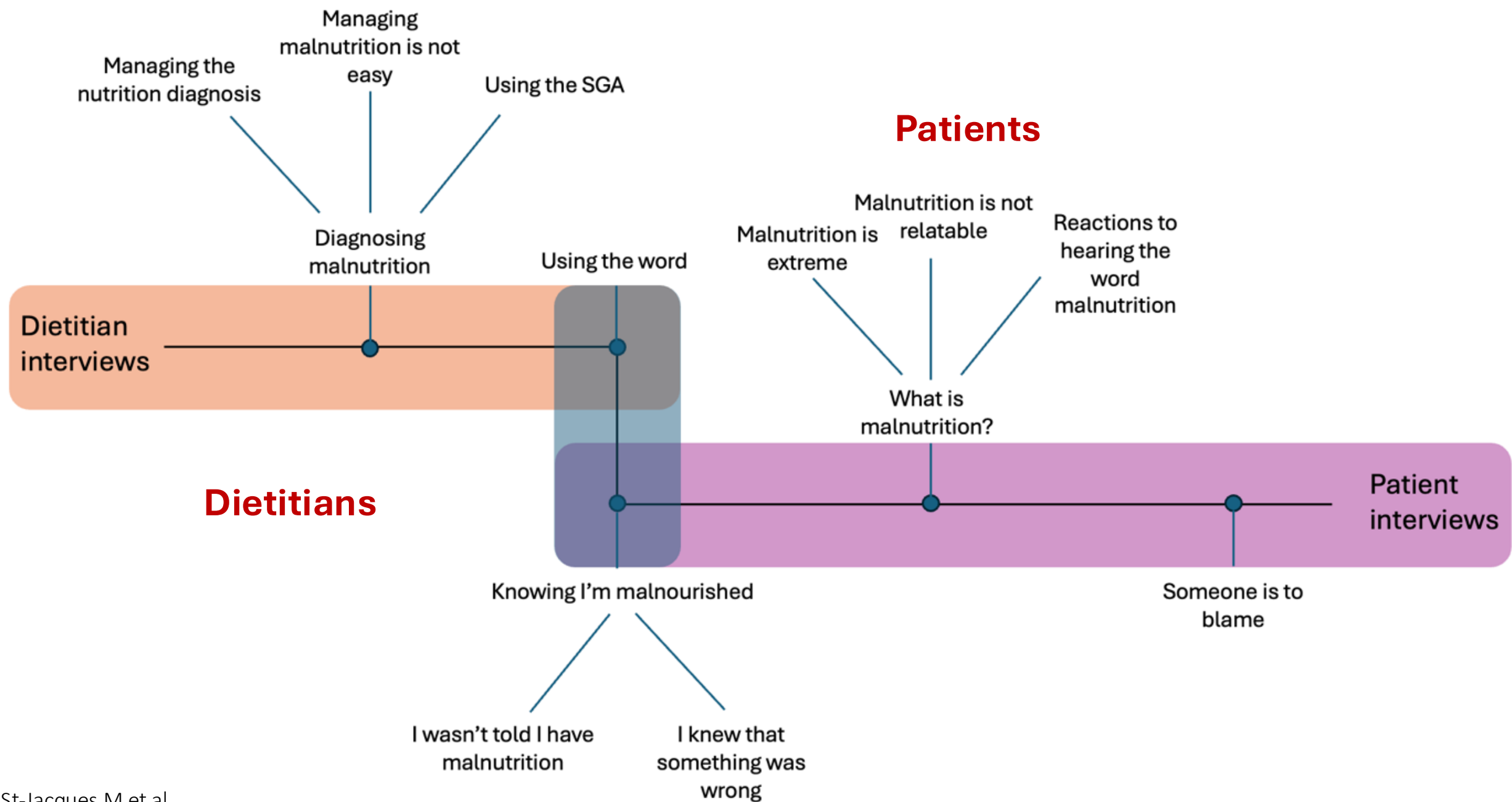


"Gee, doc, no salt, fat, or carbs?
You really put the 'die' in diet."

- **Overarching Goal:**
- Explore the discussion around malnutrition between dietitians and patients when a diagnosis and treatment plan for malnutrition is provided both in the hospital and outpatient settings.

Research Questions:

- How is the word “malnutrition” used?
- Perceptions or reactions to the word.



Dietitian results

Theme 1: Using the word

- Most dietitians do not use the word “malnutrition”
- “Soften the blow”, protect dietitian-patient relationship, fear of insulting patients
- Some will use similar words (i.e., “nutritional risk” or “worrisome nutritional status”) and others focus on issues (ie. “lack of protein”, “weight loss”)
- Regardless of word used, it must be explained

Um, yeah, it's it's kind of it's similar to the word obesity. It's a scary word. It's not a nice word, it's not a nice thing, it's not a nice way to describe somebody and people, you know, have sensitivities about how their bodies look too and to say, “Oh, you're malnourished”. It's very negative. Almost insulting. In a way.



– Dietitian in supportive living, >15 years of experience

Patient results

Theme 2: Knowing I'm malnourished

- Only 1 out of 25 patients reported being told they had malnutrition
- Some reported not even being aware they have nutrition problems
- Reported both phenotypic and etiologic signs that something is wrong (ie. weight loss, comments from loved-ones, loss of appetite)



I don't know... they never mentioned the word malnutrition, but they were uptight about me putting on some weight.

-87yo male from Alberta

Patient results

Theme 3: What is malnutrition?

- Malnutrition is **extreme**
 - “Starving African child”, very sick, very skinny (English)
 - Eating unhealthy foods, ”junk foods” (French)
- Malnutrition is **not relatable**
 - Impossible in North America
 - Impossible if overweight/obese
 - Psychological barrier related to the perception that one’s diet is healthy



Patient results

Theme 3: Blame

- Seen as “being someone’s fault”
 - *“doing it to themselves”*
- Some mentioned feeling ashamed about having malnutrition
- Some patients hesitant to seek help
- Some rationalized – “out of my control” or “low priority”

I would have to say I was a bit embarrassed when you said [I had malnutrition]. I still am.

-68yo female from
Quebec



Recommendations: Acknowledge this GAP

1) Come up with a **clear definition/guidance** for the diagnosis of Malnutrition

- Individualized
- Relatable
- Minimizing shame
- Take it seriously

2) Continue **educating health care professionals** on malnutrition

3) Develop a **public health campaign** to raise awareness, desensitize the population and destigmatize malnutrition

Medical Patients

Polymorbidity – at least 2 co-occurring chronic diseases

- CCI>1.5; Mean number of medications or diseases >1.5
- Recent large RCT shows positive impact of nutrition care on outcome

Long hospital LOS: hospital processes contribute to poor intake

Co-occurrence of Frailty, Sarcopenia, Cachexia

Recent large RCTs show impact of nutrition therapy

Surgical Patients



Undergo a planned trauma/stress



May be kept “fasting” for prolonged periods



Opportunities to enhance nutritional and functional status prior to surgery and standard approaches after surgery enhance outcomes

The ICU is a Unique Environment



ICU accounts for 14% of US hospital beds



Feeding protocols are routine



Nutrition screening not routinely done (all patients assumed to be at risk)



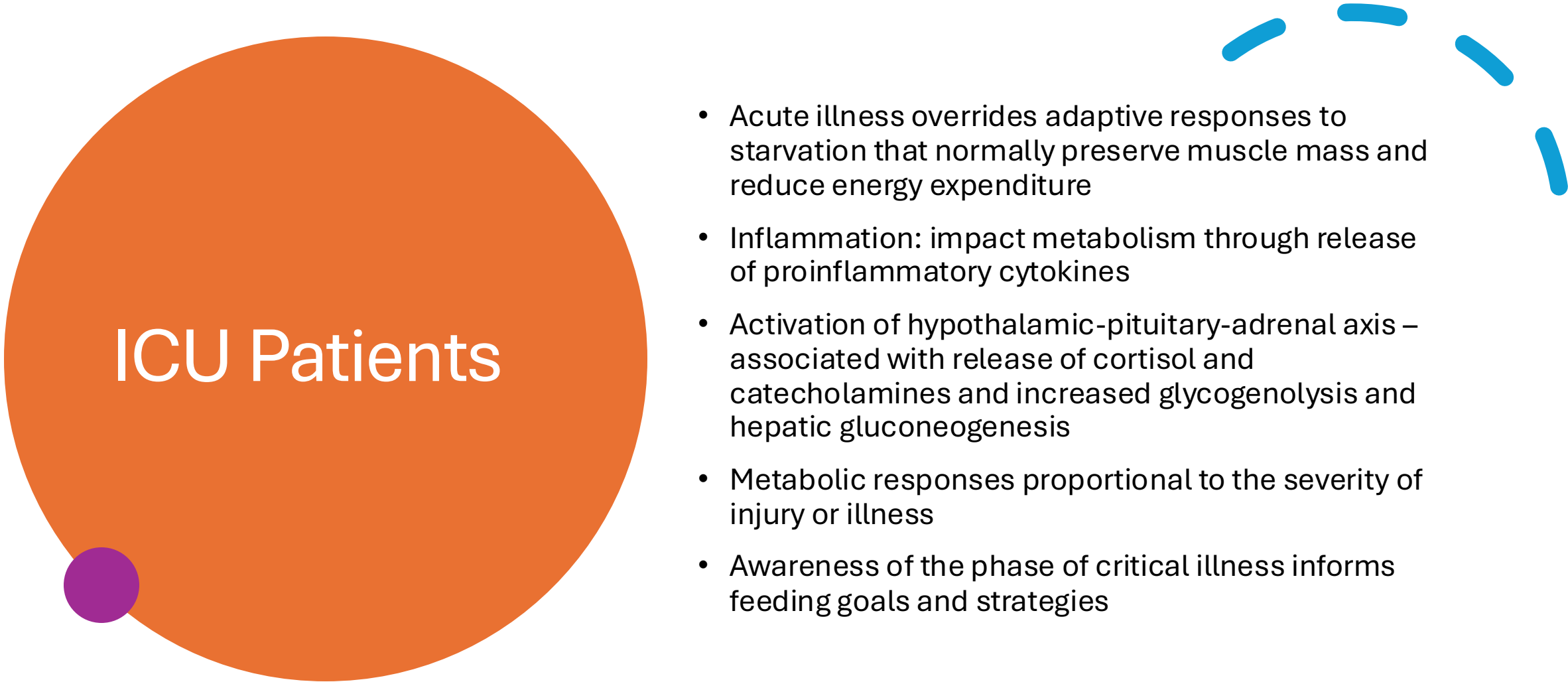
High staff:patient ratios



Nutrition care is part of the culture which is multidisciplinary



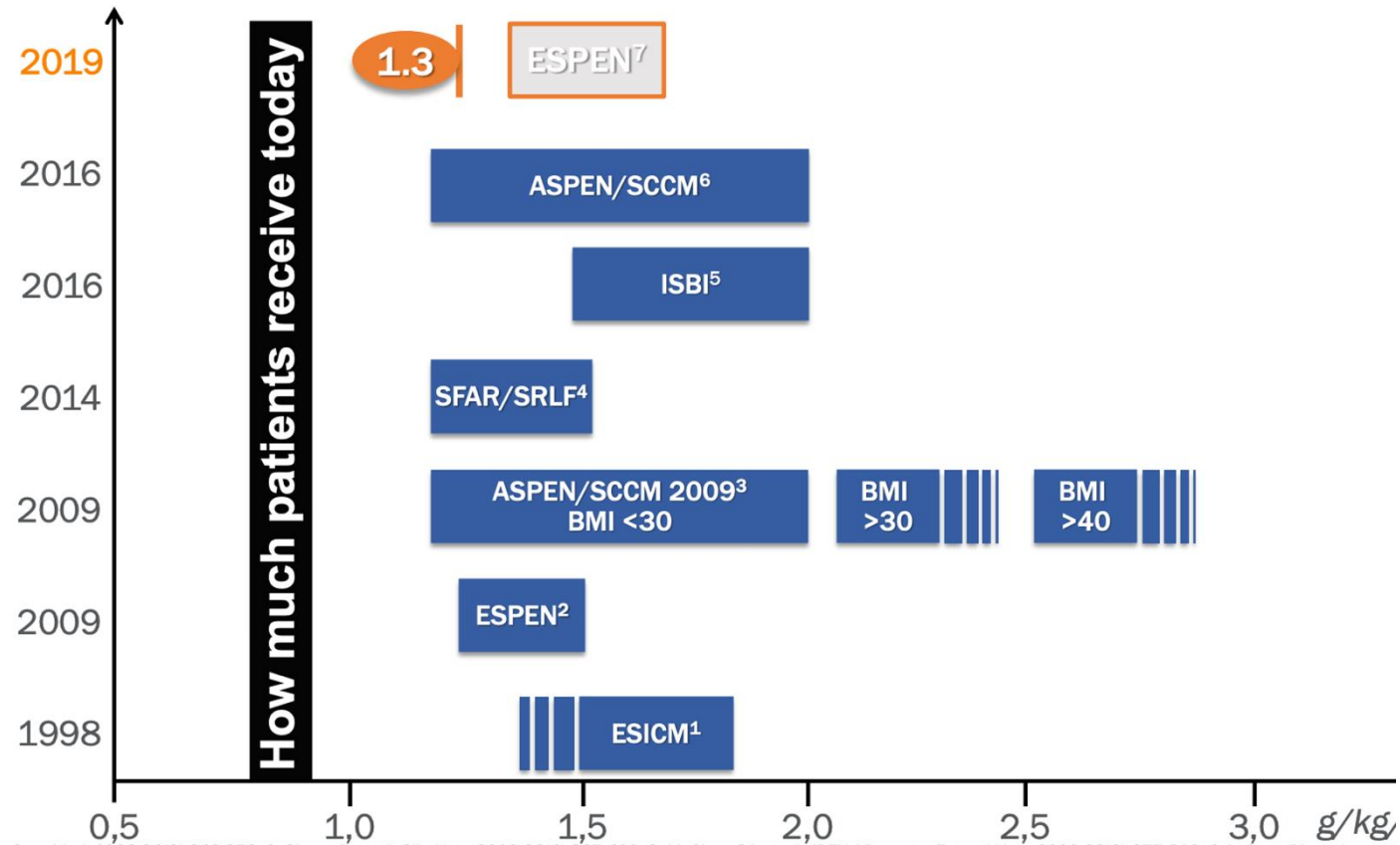
Many high-quality studies available



ICU Patients

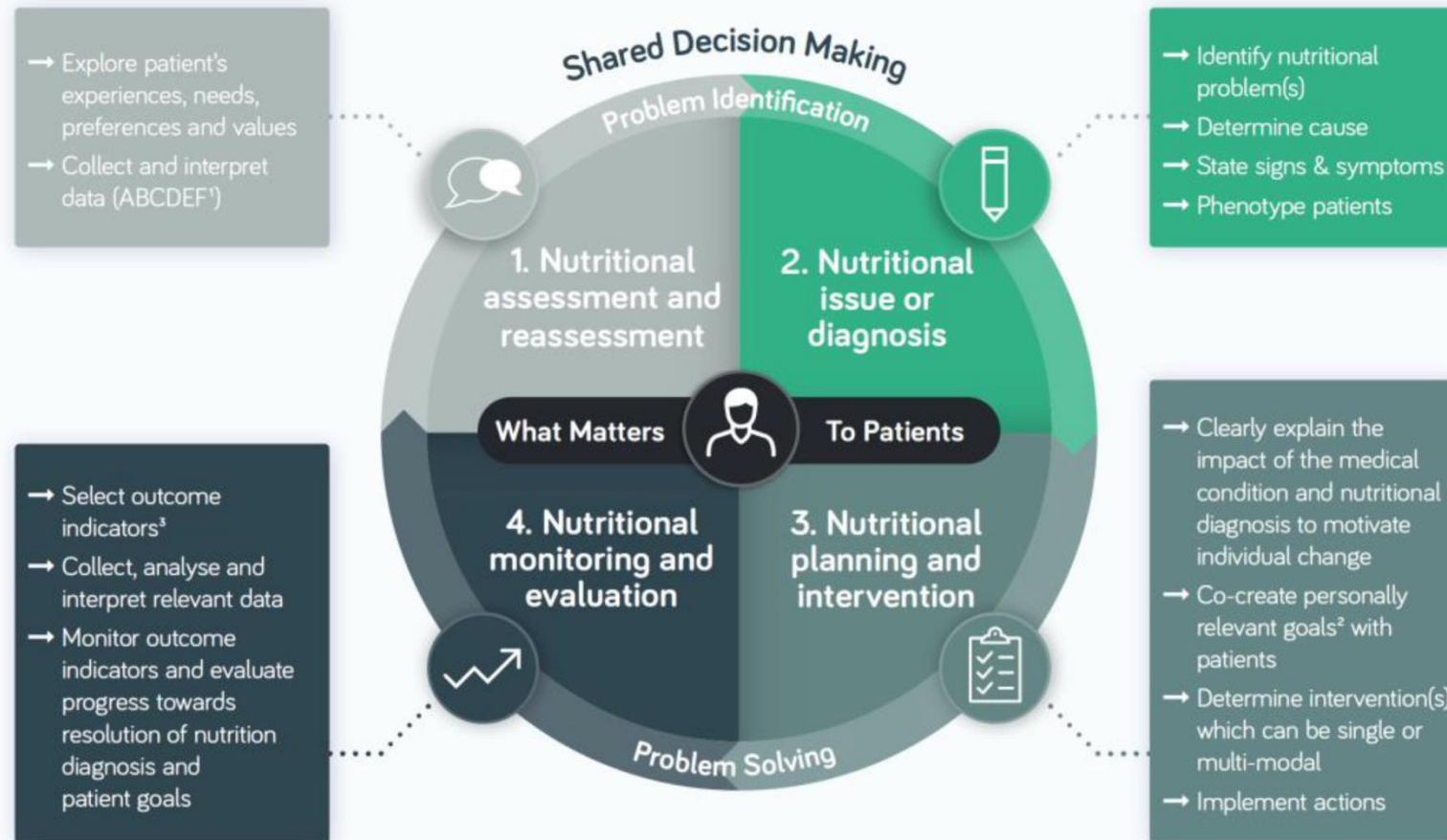
- Acute illness overrides adaptive responses to starvation that normally preserve muscle mass and reduce energy expenditure
- Inflammation: impact metabolism through release of proinflammatory cytokines
- Activation of hypothalamic-pituitary-adrenal axis – associated with release of cortisol and catecholamines and increased glycogenolysis and hepatic gluconeogenesis
- Metabolic responses proportional to the severity of injury or illness
- Awareness of the phase of critical illness informs feeding goals and strategies

ICU: Gap between Nutrition Prescribed and Received

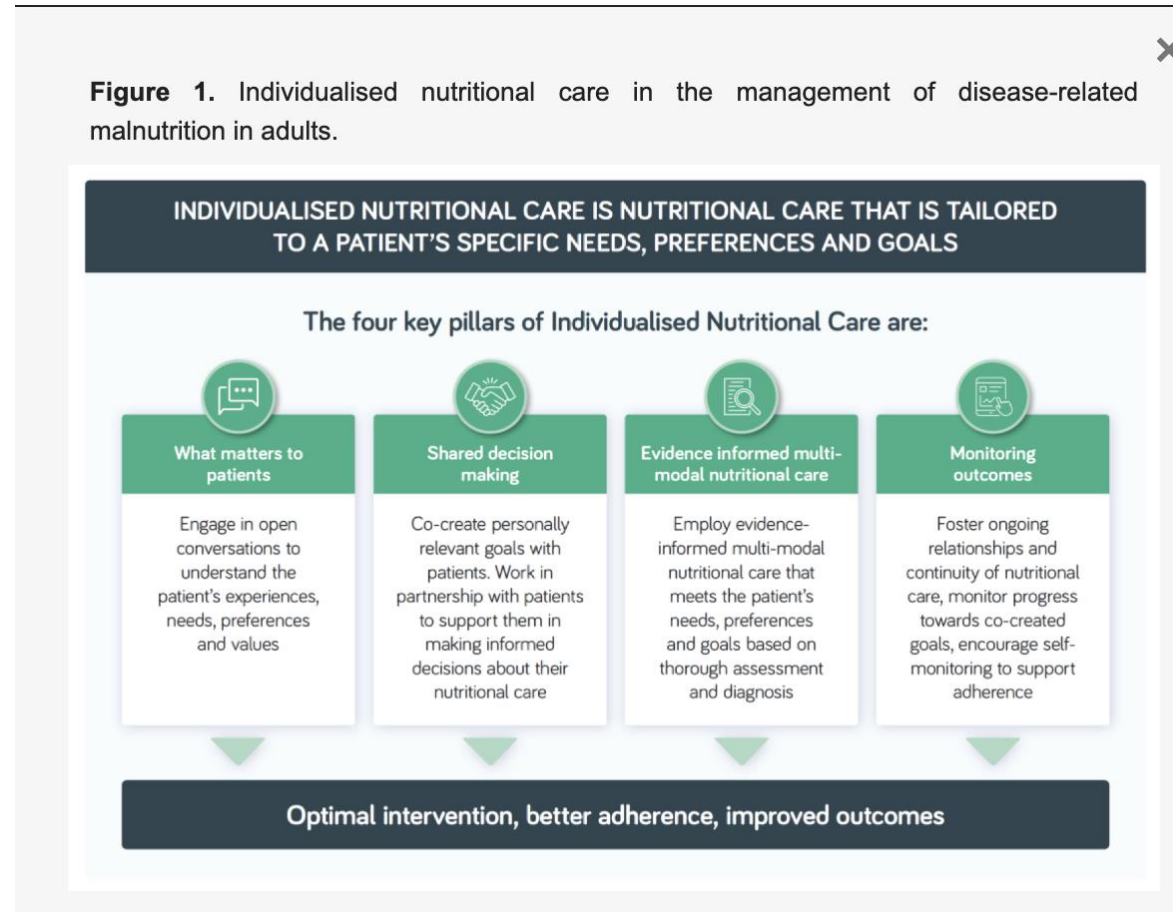


1. Jolliet P, et al. *Intensive Care Med.* 1998;24(8):848-859; 2. Singer P, et al. *Clin Nutr.* 2009;28(4):387-400; 3. McClave SA, et al. *JPEN J Parenter Enteral Nutr.* 2009;33(3):277-316; 4. Lefrant JY, et al. *Ann Fr Anesth Reanim.* 2014;33(3):202-218; 5. International Society of Burn Injuries Practice Guidelines Committee. *Burns.* 2016;42(5):953-1021; 6. McClave SA, et al. *JPEN J Parenter Enteral Nutr.* 2016;40(2):159-211; 7. Singer P, et al. *Clin Nutr.* 2019;38(1):48-79.

INDIVIDUALISING NUTRITIONAL CARE USING THE NUTRITION CARE PROCESS



Holdoway, A.; Page, F.; Bauer, J.; Dervan, N.; Maier, A.B. Individualised Nutritional Care for Disease-Related Malnutrition: Improving Outcomes by Focusing on What Matters to Patients. *Nutrients* **2022**, *14*, 3534. <https://doi.org/10.3390/nu14173534>



Undernutrition - ?*New Language*

ICD-11 amendment – submitted Nov 2020, accepted Oct 17 2025

Swedish CDC initiative supported by >40 nutrition societies globally

5B72 Undernutrition in adults

When undernutrition is confirmed by the presence of a **combination of phenotypic criteria**; e.g. weight loss, low body mass index or low muscle mass, **and etiologic criteria**; e.g. reduced food intake (e.g. poor appetite) and/or assimilation (e.g. digestive or absorption disorders) or presence of disease, injury or infection with chronic, relapsing or acute severe inflammation.

5B72.0 Undernutrition in adults related to disease with moderate to severe inflammation

5B72.1 Undernutrition in adults related to disease with non-discernible inflammation

5B72.2 Undernutrition in adults related to starvation

Post-coordination: XS0T Moderate XS25 Severe (for all codes)

Physician Perspectives on Malnutrition Screening, Diagnosis and Management

Veldhuijzen van Zanten, D., Vantomme, E., Ford, K., Cahill, L., Jin, J., Keller, H., Nasser, R., Lagendyk, L., Strickland, T., MacDonald, B., Boudreau, S., & Gramlich, L. (2024). *Nutrients*, 16(14), 2215. <https://doi.org/10.3390/nu16142215>

- Qualitative assessment using CFIR through interviews of 22 physicians in 3 provinces (GI, Primary care, surgery, geriatrics, hospitalist medicine)
- Major themes:
 - Integration of nutrition care into physician work flow
 - Barriers
 - Enablers

Integration of Nutrition Care Processes into Physician Workflow

Thematic Content	
Identifying patients with malnutrition is crucial, and physicians can play a key role	
Integration of Nutrition Care processes into physician workflow	Routine screening is rarely performed by physicians; they rely on allied healthcare, including dietitians, to identify patients with malnutrition
	Physicians do not routinely use standardized screening tools
	Common clinical markers were weight loss, BMI, muscle wasting, or visual indicators
	Common biochemical markers were albumin and prealbumin.
Intervention	Physicians viewed their role as identifying and referring patients with malnutrition, rather than treating
	Monitoring
Outpatient follow-up for nutrition is rare	

Exemplar Quotes
<i>"The physician is running what's happening, they should be pushing the rest of the team to maximize nutrition in the patients".</i> Gastroenterologist
<i>"We just sort of say, 'this patient's at risk because they have a chronic GI condition, consult a dietitian', and then we rely on them to identify the patients at risk"</i> Gastroenterologist
<i>"I've personally never used [the SGA] once in my practice. I've not seen [the SGA] used in any of my colleagues' practices".</i> Gastroenterologist
<i>"We see patients that are cachectic, obvious signs of the deltoid squaring, the muscle wasting".</i> Internal Medicine Specialist
<i>"We look at albumin, prealbumin. That's our kind of easy marker of where you're at. There's probably better ones out there".</i> General & Colorectal Surgeon
<i>"I see my role as being the preliminary point of either identifying malnutrition or screening for it".</i> Surgeon
<i>"There was very little support on the outpatient side for nutrition follow-up".</i> Gastroenterologist

Barriers to Providing Care for Patients with Malnutrition

Barriers to providing care for patients w
malnutrition

Physicians prioritize other medical problems over
malnutrition screening and management

er “Physicians are incentivized to spend as little time as
possible with patients so [malnutrition] is something
that’ll often get overlooked”.

Geriatrician

e “...this subject is not taught in undergraduate medical
school...it’s given a cursory nod”.

Gastroenterologist

Physicians feel poorly equipped with knowledge
and clinical exposure to handle malnutrition

“Lack of resources...and easy access to
dietitians...creates some barriers to referral in
follow-up”.

Primary Care

“Making sure that they have access to food, that they
can afford food. Getting social work involved if they
can’t”.

Family Medicine & Hospitalist

Inadequate number of dietitians to help meet
malnutrition goals

“I
di
fo

Rising inflation impacts affordability of healthier
food options

“I
CA
CA

Enablers: Physician Identified
Needs and Resources

Enablers: physician-identified needs and resources

Multidisciplinary

Involvement of multiple healthcare professionals to improve malnutrition care

“...it’s more of a team approach verses just a siloed approach”

Family & Emergency Medicine

Clinical

The development of standardized malnutrition pathways would improve the delivery of care

“...some sort of relatively straight forward applicable clinical decision [tool] that could be integrated into daily practice”

Internal Medicine

Evidence

Demonstrable proof that malnutrition care leads to improved patient outcomes

“...an idea of what to track metric-wise then you could try and see if what we actually did matters or actually made any difference”

Family & Emergency Medicine

Continuity

“...we could do a better job in terms of educating family doctors or at least providing direction as to what they should be measuring...”

Gastroenterologist

Financial

Improved education for physicians about how to screen for and manage malnutrition

“...there’s definitely a gap in terms of the patient’s ability to pay for [oral nutritional supplements and nutritional support] and the expense”

Gastroenterologist

Due to financial constraints and food insecurity, less expensive options for patients would assist in providing consistent care.

Is this the Perfect Storm?

- Using the word and making the diagnosis is “hard”
- Everyone wants to “dibs out” of Malnutrition and Nutrition care
- “Not my problem” problem

Is there any room for optimism?

In Hospital

Multiple studies have shown that nutrition interventions in hospital can make a difference in outcomes

EFFORT Trial 2019

Kaegi-Braun 2021

NOURISH study 2016

Gomez 2019

KANEKO 2021 to name a few.....

Interventions

- Dietitian protein and calorie goals vs. standard diet
- Dietary advice
- Oral nutrition supplements
- Enteral/parenteral nutrition
- Early feeding

EFFORT Trial

Effect of early nutritional support on Frailty, Functional Outcomes and Recovery of malnourished medical inpatients

Pragmatic, unblinded, multicenter RCT
n = 2088 medical inpatients at nutritional risk

Intervention: protocol-guided **individualised nutrition** support to reach protein and caloric goals (defined by dietitians); Received 22 kcal/kg, 0.8 gm pro/kg

Control: standard hospital food (no dietary consultation)

Received 18 kcal/kg, 0.7 gm pro/kg/d

% Meeting Energy Targets

% Meeting Protein Targets

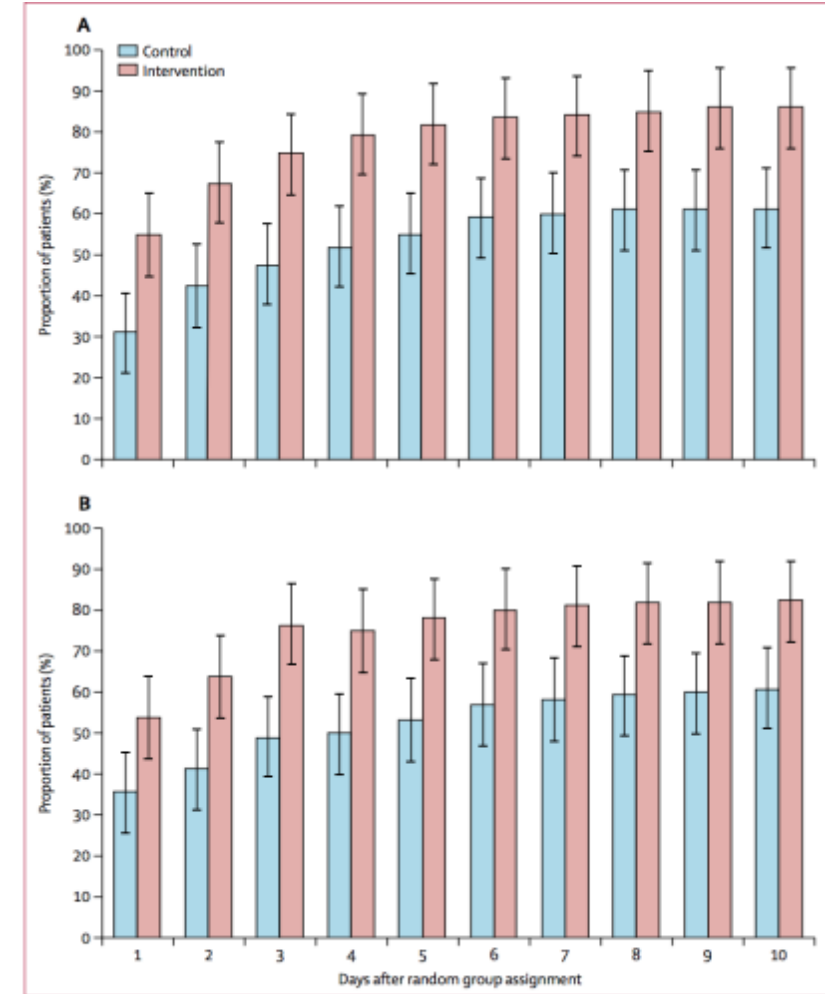


Figure 3: Proportion of patients reaching caloric (A) and protein (B) requirements during the first 10 days after random group assignment

EFFORT Trial

More control patients:

- had an adverse outcome within 30 days of admission
- died within 30 days of admission

No differences in side effects due to nutritional support

No benefit in patients with CRP >100

- Evidence translates into cost savings

Adverse
Outcome

Survival

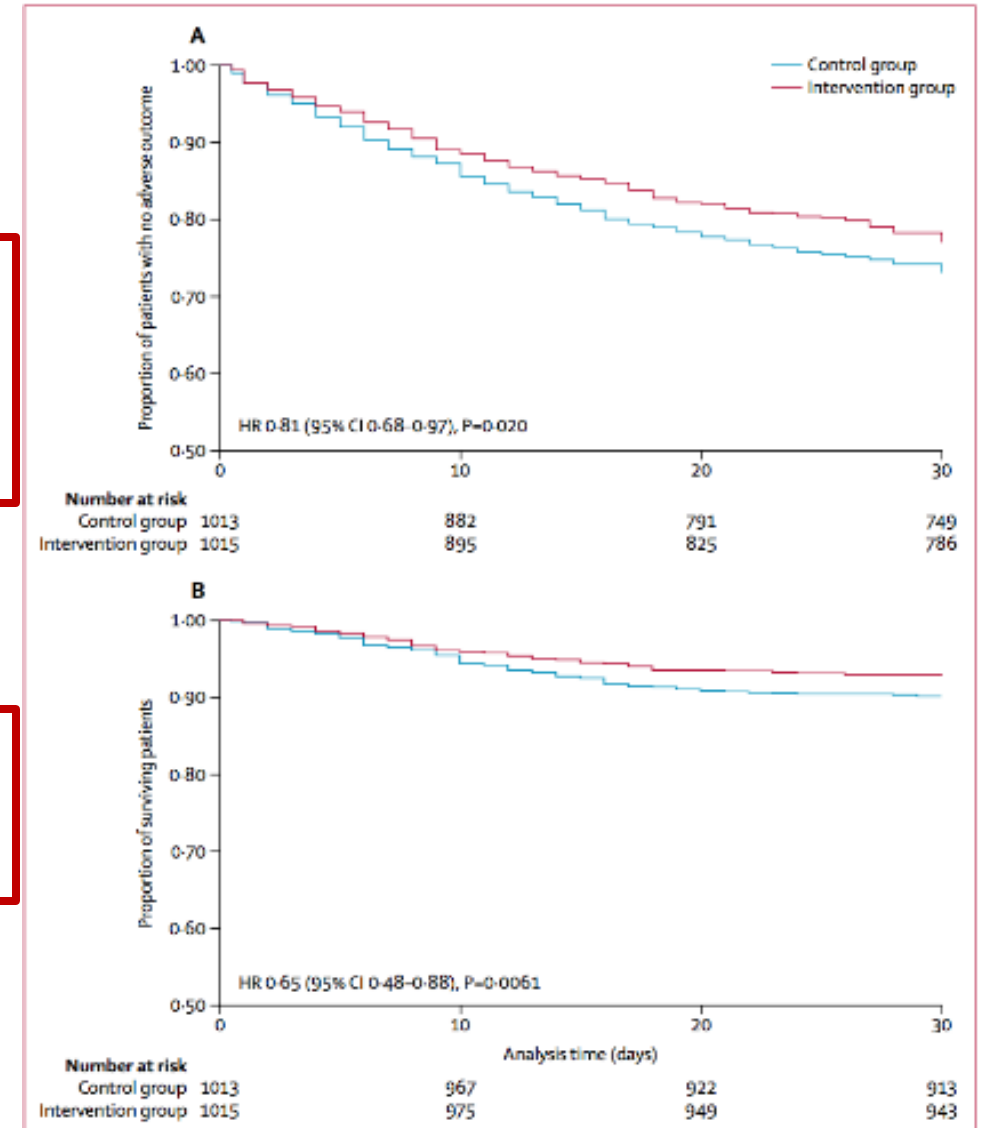


Figure 4: Kaplan-Meier estimates of the cumulative incidence of the primary endpoint and all-cause mortality (A) Time to the first event of the composite primary endpoint (log-rank p value=0.035). (B) Time to death (log-rank p value=0.031).

Schuetz P et al. Lancet 2019



Health System Perspectives

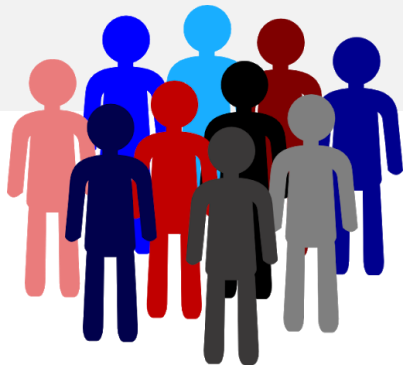
Advancing Malnutrition Care: wide scale implementation 2021-2025

Ford KL, Laur C, Dhaliwal R, Nasser R, Gramlich L, Allard JP, Keller H; AMC Core Team. Spread and Scale of the Integrated Nutrition Pathway for Acute Care Across Canada: Protocol for the Advancing Malnutrition Care Program. JMIR Res Protoc. 2024 Dec 31;13:e62764. doi: 10.2196/62764. PMID: 39740211

Feb 2021 to Dec 2022

Deliverables by end of Dec 2022

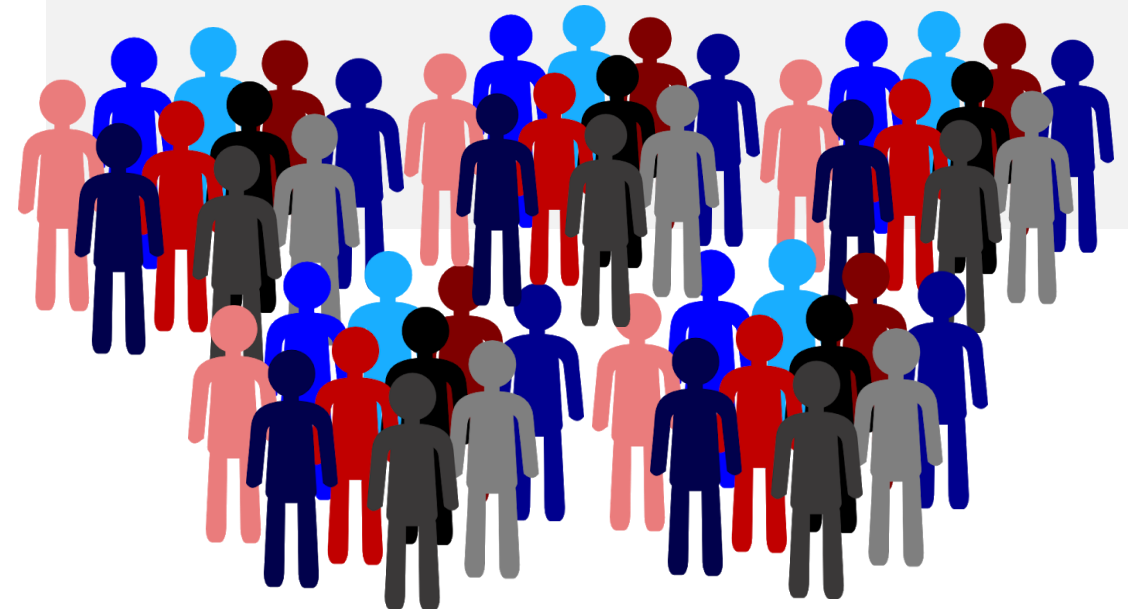
- CMTF Regional Champions Program in place
- 10 Regional champions
 - implemented INPAC screening and assessment in their settings
 - have metrics on practices
 - started mentoring for other settings in their region



January 2023 to December 2025

Deliverables by end of Dec 2025:

- CMTF Regional Champions Program expansion has resulted in
- 50 hospital sites that have
 - implemented INPAC activities
 - have metrics on practices



Hospital Leaders Engagement



Health Professionals' Roundtable for Strategy (HPRS)

Nov 2023

April 2024

November 2024

CMTF engaged with Hospital Health Leaders in 4-hour sessions on how to raise awareness of malnutrition and to accelerate the adoption of best nutrition care practices in hospitals.

Upcoming Concurrent Session at CWHL Conference

November 14, 2024

“Starving for collaboration: Addressing hospital-based malnutrition and the power of teams”

Developing,
Supporting and
Inspiring Canadian
Health Leaders.

Canada West Health Leaders Conference

CCHL is pleased to present the Canada West Health Leaders Conference (CWHLC). This conference, themed “Synergies in action: The power of collaboration” will take place in Saskatoon, SK from November 13 to 15, 2024.

|| Pause Slideshow

← 2 / 3 →



Policy to address Disease-Related Malnutrition

ISSUE

Disease-related malnutrition is under recognized and undertreated in Canada; it affects up to 1 in 2 patients in hospital. Disease-related malnutrition leads to negative health outcomes for Canadians and incurs increased health care expenditures, ranging from approximately \$1.6B - \$2.1B annually¹. Nutrition care pathways that optimize nutrition by focusing on nutrition risk screening, assessment, and intervention exist, but are not routinely implemented across Canadian hospitals. To compound this unresolved issue, disease-related malnutrition is not acknowledged or addressed in health policy. The issue of disease-related malnutrition is a shared responsibility across all levels of governance (i.e., federal, provincial/territorial, organizational).

The Canadian Nutrition Society and the Canadian Malnutrition Task Force commit to the Nutrition Decade

31 October 2022 | ROME – The formal commitment recently submitted by the Canadian Nutrition Society and its standing committee, the Canadian Malnutrition Task Force, will support two action areas of the UN Decade of Action on Nutrition.

Supporting two action areas

The commitment submitted today by the Canadian Nutrition Society (CNS) and its standing committee, the Canadian Malnutrition Task Force (CMTF), is related to the establishment of evidence-based practices and advocacy for policies to address Disease Related Malnutrition (DRM).

The generation of new evidence and guidance on effective nutrition programmes and policies is one of the modalities of implementation of the Nutrition Decade as described in its [Work Programme](#). The CNS/CMTF commitment is aligned with this modality of implementation and will be a valuable contribution to the Nutrition Decade's vision of a world where all people, at all times, and at all stages of life have access to affordable, diversified, safe and healthy diets.

In support of the Nutrition Decade's action area 2 "Aligned health systems providing universal coverage of essential nutrition actions", the CNS/CMTF commitment will strengthen and enable more resilient health systems, and support the development of policies that will ultimately improve nutrition for the health of both Canadians and all global citizens.

In support of the Nutrition Decade's action area 6 "Strengthened governance and accountability for nutrition", the CNS/CMTF commitment will allow for greater attention to governance and coordination mechanisms for food security and nutrition, and the establishment of policies and programmes related to nutrition.



The Australasian Society of Parenteral and Enteral Nutrition commits to the Nutrition Decade

4 March 2024 | ROME – The commitment submitted today by the Australasian Society of Parenteral and Enteral Nutrition will focus on two action areas of the UN Decade of Action on Nutrition.

An initiative on Disease Related Malnutrition

The initiative CAN DReaM (Creating Alliances Nationally to address Disease Related Malnutrition (DRM)) has been created to overcome the lack of a coordinated approach to address DRM.

The Australasian Society of Parenteral and Enteral Nutrition (AuSPEN) has joined this initiative, which will support the establishment of evidence-based practices and the advocacy for policies to address DRM.

Support to the Nutrition Decade

The AuSPEN commitment will be a valuable contribution to the Nutrition Decade's vision of a world where all people, at all times, have access to affordable, diversified, safe and healthy diets.

In support of the Nutrition Decade's action area 2 "Aligned health systems providing universal coverage of essential nutrition actions", the AuSPEN commitment will strengthen and enable more resilient health systems and will support the development of policies that will ultimately improve nutrition for the health of Australians and citizens globally.

In support of the Nutrition Decade's action area 6 "Strengthened governance and accountability for nutrition", the AuSPEN commitment will allow more attention towards governance and coordination mechanisms for food security and nutrition and the establishment of policies and programs related to nutrition. It will also support multisectoral information systems related to food and nutrition.

More information about the AuSPEN commitment can be found [here](#).



Scoping Review

Background

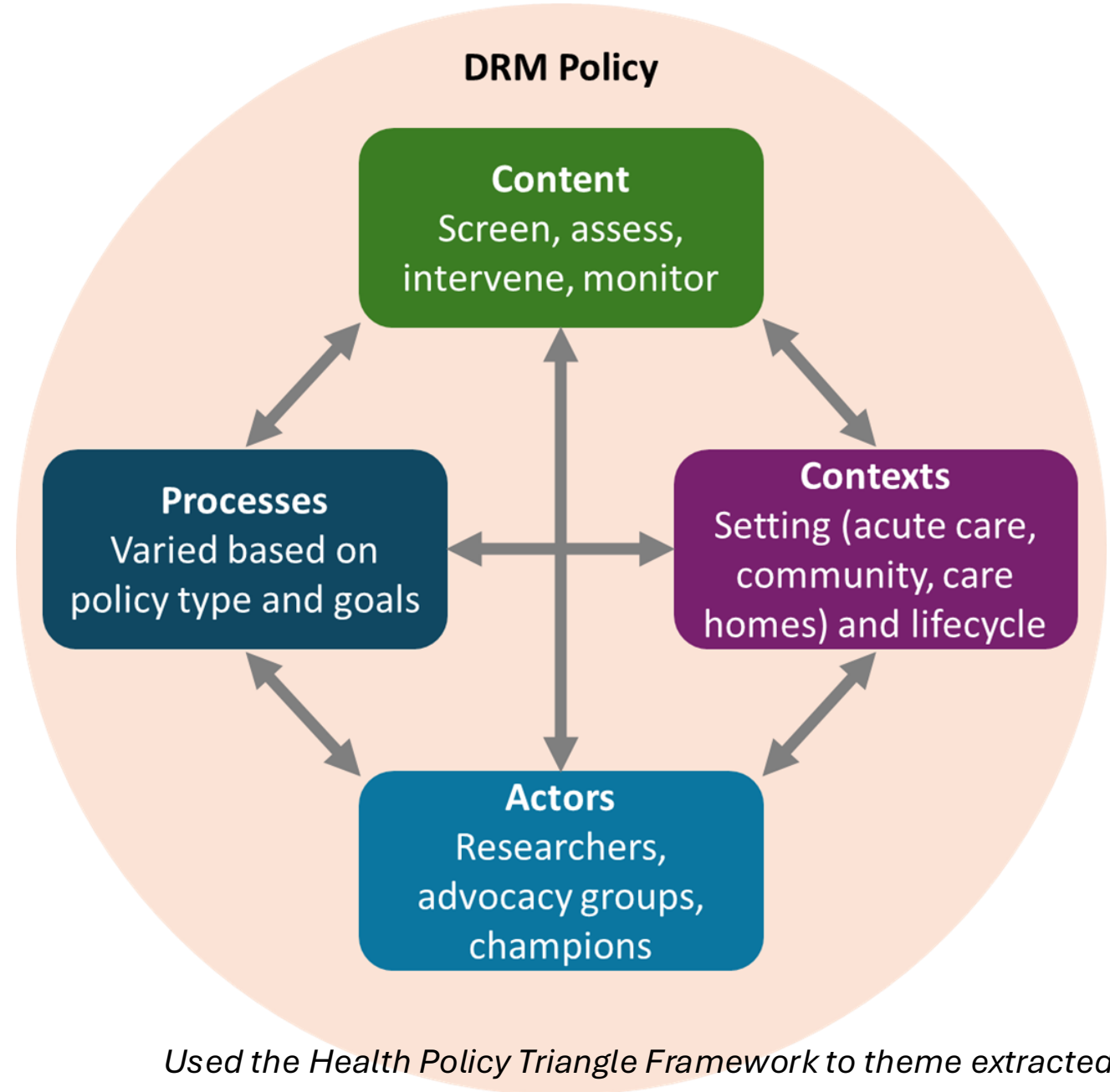
- Conducted a scoping review to gain an understanding of policies-related work in the area of DRM

Research Questions

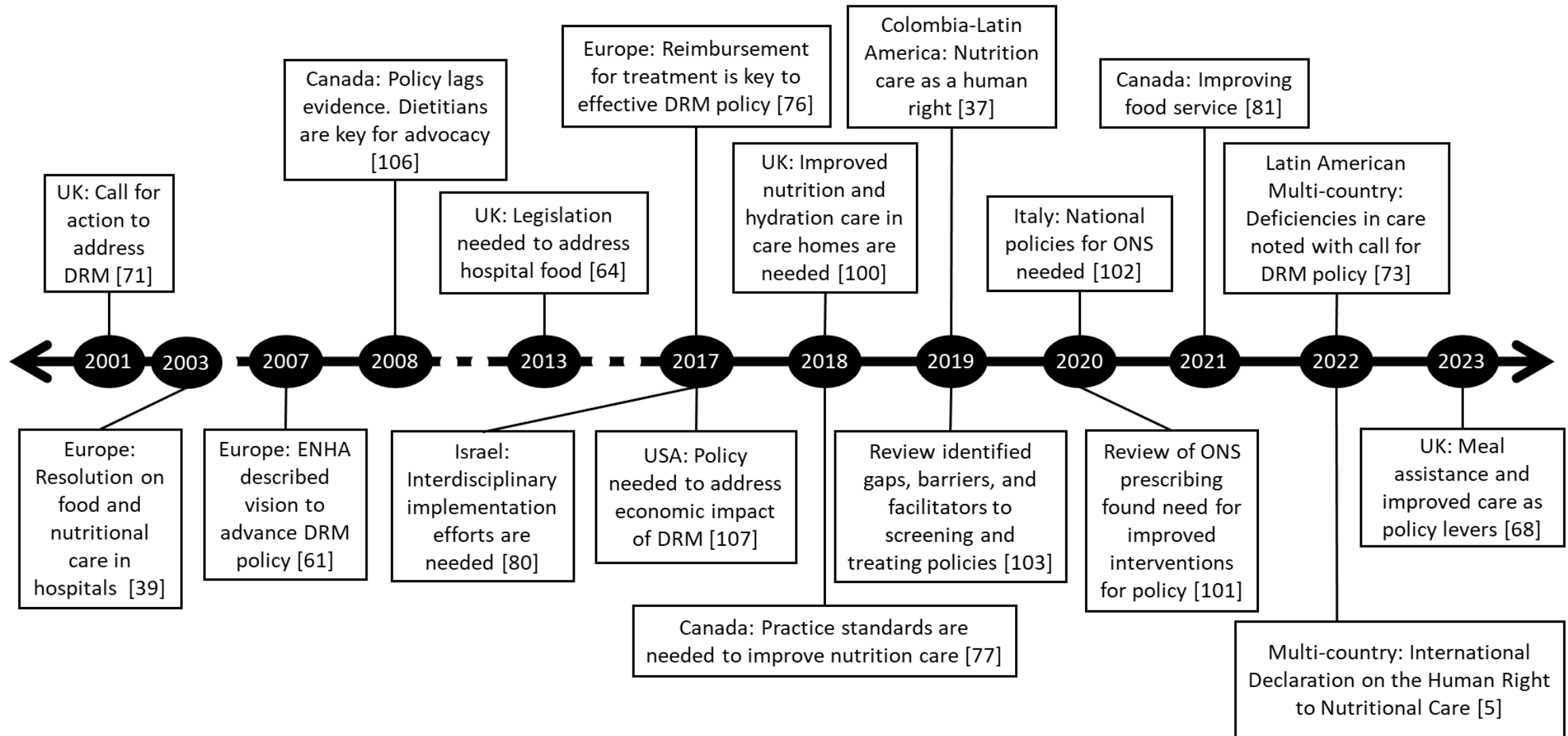
1. What current policies exist that address or influence DRM in Canada and other countries?
2. What measures/performance indicators are used in the policies?
3. What impact has been reported on outcomes for patients, populations and health systems relative to the health policies?

Scoping Review - Findings

- Screened >37,000 articles
- Assessed 275 articles for eligibility
- Included 67 articles in the review

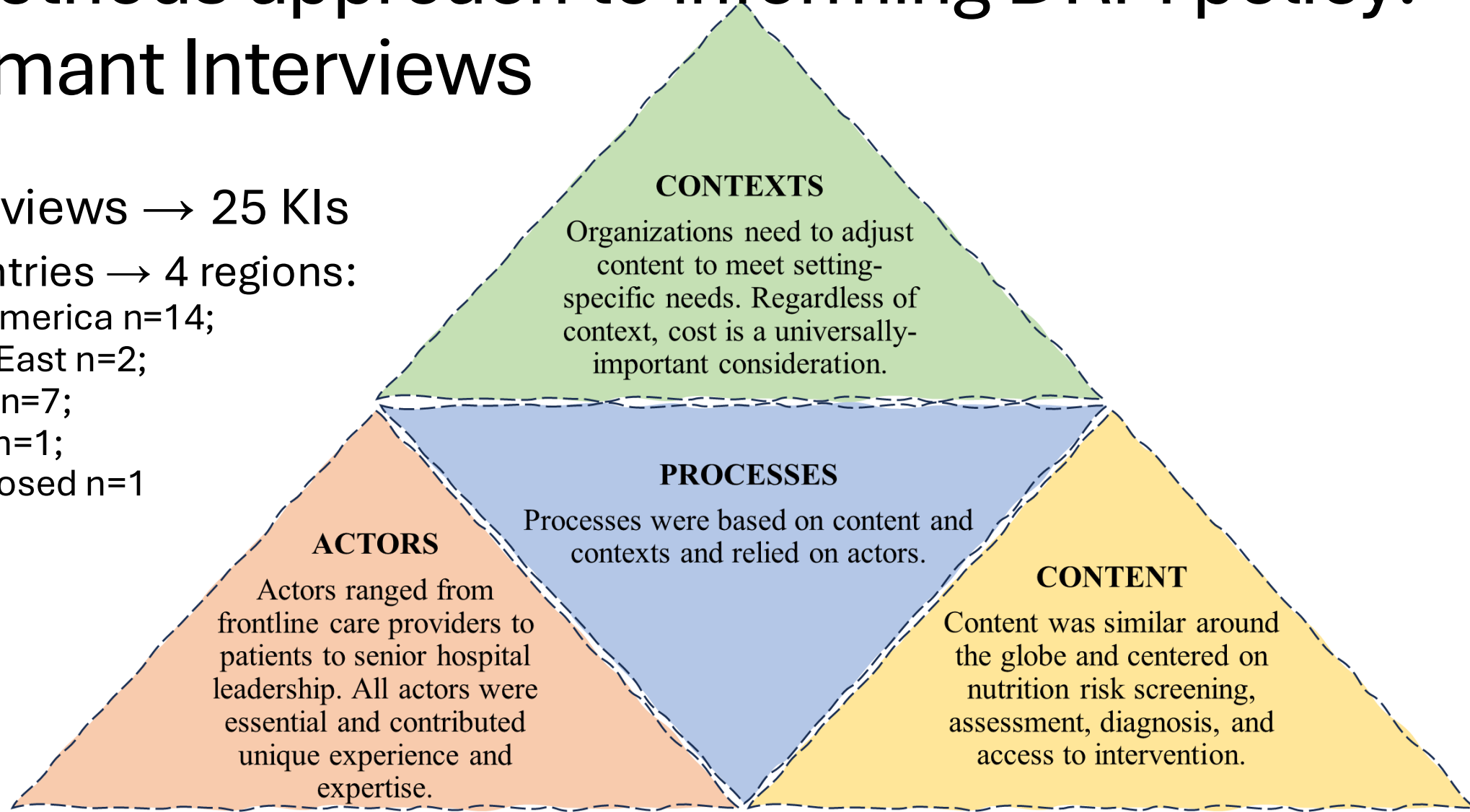


Timeline of advocacy efforts for disease-related malnutrition policy advancement: **a Global Issue**



Mixed-methods approach to informing DRM policy: Key Informant Interviews

- 22 interviews → 25 KIs
 - 7 countries → 4 regions:
North America n=14;
Middle East n=2;
Europe n=7;
Global n=1;
undisclosed n=1



POLICY ACTION FOR DISEASE-RELATED MALNUTRITION

NATIONAL/FEDERAL

- Acknowledge disease-related malnutrition, nutrition care as a human right, and the need for widespread nutrition risk screening.
- Facilitate data collection and evaluation of disease-related malnutrition metrics.
- Facilitate national standard for addressing disease-related malnutrition and include accreditation for adoption of health standards to support quality nutrition care.



PROVINCIAL/TERRITORIAL

- Requirements for improved nutrition education in medical education and amongst other health care professionals.
- Policy for medical nutrition therapy (e.g., home enteral and parenteral nutrition, oral nutritional supplements).
- Expand diagnosing (e.g., disease-related malnutrition) and prescribing (e.g., medical foods) capabilities to registered dietitians.



ORGANIZATIONAL

- Develop and implement policy that aligns with provincial/territorial and national/federal aims, and organizational needs/culture.
- Standardize nutrition care processes.

COMMUNITY

- Ensure that the medical home supports access to nutrition care.
- Focus on nutrition risk screening for older adults and at-risk populations.
- Assess access to food (i.e., food security) and address any barriers.



HOSPITAL

- Provide each patient with nutrition care.
- Implement and sustain food services policy (e.g., mealtime assistance).
- Transfer care at time of discharge



CARE HOMES

- Provide each resident with nutrition care.
- Implement and sustain food services policy (e.g., mealtime assistance and experience).

Government Advocacy Efforts

Launched Oct 3 2024



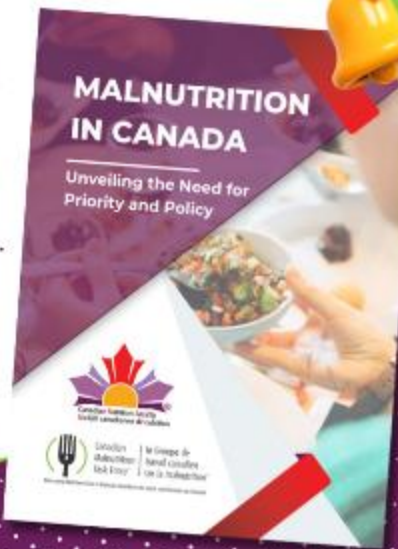
Canadian Malnutrition Society
Société canadienne de nutrition

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

New Whitepaper Released!

Malnutrition in Canada - Unveiling the Need for Priority and Policy

This Whitepaper delves into the overlooked prevalence and impact of malnutrition on our Canadian healthcare system and highlights calls for action for governments, decision-makers, and stakeholders.



DOWNLOAD THE WHITEPAPER

Scan the QR code or visit:
<https://shorturl.at/owM9p>

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Canadian Malnutrition Society
Société canadienne de nutrition

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

Publication d'un nouveau livre blanc

La malnutrition au Canada : dévoiler les besoins pour établir les priorités et les politiques

Ce livre blanc examine la prévalence et l'impact négligés de la malnutrition sur notre système de santé canadien et met en évidence les appels à l'action pour les gouvernements, les décideurs et les parties prenantes.



Téléchargez le Livre blanc ici

Scannez le code QR ou visitez le site:
<https://shorturl.at/hMS64>

#NutritionCare

Conclusions: There is Room for Optimism!

Disease related malnutrition is prevalent and impactful

Targeted strategies are required to advance malnutrition care

- Patient – engagement, language, empowerment
- provider – awareness, education and training
- health system level - awareness, advocacy, health policy for DRM

Learn from other jurisdictions and build on best practices

Act Locally, think Globally

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Global community of
practice in DRM