A proposed model for effective nutrition care

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The American Dietetic Association formed the Health Services Research (HSR) Task Force in 1998 to explore research on the effectiveness and outcomes of medical nutrition therapy (MNT). The task force identified several barriers to the development of a body of research in this area including inadequate specification of the nutrition care process and the lack of common definitions for nutrition care and its outcomes. A subgroup was formed to develop a model of nutrition care and create a core set of outcome measures with operational definitions that could be used in outcomes research. The importance of this effort is underscored by other recent policy developments related to MNT.

In its study of Medicare beneficiaries, the Institute of Medicine noted that nutrition services are commonly provided as a part of a team approach to care, but the roles of various health care team members are infrequently defined. Further, the exact nature of nutrition care provided is often not described by researchers (1). After many years of work, MNT was approved for inclusion as a covered service by Medicare Part B. The legislation (HR 5661, Section 105) defined MNT services as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional." (2) In another recent development, MNT codes were added to the American Medical Association's Current Procedural Terminology (CPT) 2001. (Figure 1) MNT is described as either initial assessment and intervention or reassessment and intervention in 15 minute sessions with an individual patient, or 30 minute group sessions (3).

These definitions fail to reflect the type, level, and complexity of nutrition care provided by dietetics personnel. If the profession is to move forward, expanding the body of evidence linking nutrition care to positive outcomes, a detailed model of the nutrition care process with standard definitions, including measurable outcomes, is necessary. The nutrition care model described here reflects the work of the HSR subgroup and is presented as a stimulus for discussion and debate about the crucial aspects of nutrition care as a framework for standardized definitions of essential nutrition care processes and outcomes.

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804 Group (2 or more individual(s)), each 30 minutes

(For medical nutrition therapy assessment and/or intervention performed by a physician, see Evaluation and Management or Preventive Medicine service codes)

FIG. 1 Medical Nutrition Therapy CPT Codes (American Medical Association Current Procedural Terminology CPT 2001, pg. 300.)

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BACKGROUND

Gates and Meyer identified the need for development of an effective disease-specific nutrition care process in dietetics that articulated the relationship between data collection and care planning (4). Medical Nutrition Therapy Across the Continuum of Care (MNTACC) is an invaluable resource in defining the course of disease-specific nutrition therapy including the number of sessions; clinical, functional, and behavioral outcome assessment factors; documentation guidelines; and session process (5). However, MNTACC does not provide a conceptual model that addresses all the facets of the environment. Client-provider interaction and protocols have had varying degrees of validation (6).

Other allied health professions offer a parallel to our search for a clearly defined model of care. The nursing profession adopted a common "nursing process" in the 1960s that serves many functions (7). The nursing process is the core and essence of nursing; is central to all nursing actions; is applicable in any setting and within any theoretical conceptual reference; unifies, standardizes, and directs nursing practice; and forms the basis of documentation and continuity of care (8, 9). In 1970 the nursing diagnosis was officially recognized as an element of nursing practice (10). Mason and Mattree summarize the nursing process as a theory with five principal, interrelated components in a cyclical pattern: assessment, diagnosis, planning, implementing, and evaluating care (11). The nursing process model is complemented by conceptual models to fully describe nursing practice in political, educational, and clinical practice.

Both physical and occupational therapy also have explicit definitions of the care process. The *Guide to Physical Therapist Practice* identified five elements of patient/client management: examination, evaluation, diagnosis, prognosis (including plan of care) and intervention which lead to outcomes (12). Occupational therapy defines four elements: referral, evaluation, intervention/reevaluation, and discharge/follow-up (13).

DEVELOPMENT OF A MODEL FOR NUTRITION CARE

The HSR subgroup accepted the challenge of developing this model in 1999. The Nutrition Care Model represents a synthesis of the deliberations of approximately 40 registered dietitians and other health care professionals in five think tank sessions held in different locations (Boston, Kansas City, Los Angeles, and Minneapolis) or by conference call (including Department of Defense personnel in several states).

Participating were six to ten "forward-thinkers" with a depth of experience in nutrition care delivery, education or research. Through facilitated discussions lasting three to six hours, they answered a series of questions: "What precisely is nutrition care in therapeutic settings?" "What activities are essential to produce behavior change and other outcomes?" "How can this