

The Effectiveness of Medical Nutrition Therapy in Prevention and Treatment of Chronic Disease: A Position Paper of the Academy of Nutrition and Dietetics



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ABSTRACT

It is the position of the Academy of Nutrition and Dietetics that all individuals with nutrition-related health conditions or risk factors should have access to medical nutrition therapy (MNT) provided by a registered dietitian nutritionist (RDN). MNT provided by RDNs is effective in improving health outcomes for many chronic conditions that are leading drivers of morbidity, mortality, and health care costs in the United States. Widespread access to MNT using an individualized, client-centered, and evidence-based approach has the potential to improve population health, reduce health disparities, and reduce health care costs associated with nutrition-related health conditions. This Academy of Nutrition and Dietetics position paper summarizes recent evidence from systematic reviews on the effectiveness of MNT provided by an RDN for the prevention and treatment of nutrition-related health conditions. A total of 25 systematic reviews published between 2017 and 2024 were summarized and assessed for certainty of evidence. Systematic reviews with high or moderate certainty of evidence demonstrate that MNT is likely effective in improving a range of health outcomes in adults with pre-diabetes, type 1 diabetes, type 2 diabetes, obesity, pre-hypertension, hypertension, dyslipidemia, chronic kidney disease, head and neck cancer, and chronic obstructive pulmonary disease compared with no MNT or standard care. Barriers exist to accessing MNT, including inadequate staffing of RDNs in some areas, a lack of provider referrals to an RDN for MNT, and a lack of payer coverage and reimbursement. This position was approved in September 2025 and will remain in effect until December 31, 2032.

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POSITION STATEMENT

IT IS THE POSITION OF THE Academy of Nutrition and Dietetics that all individuals with nutrition-related health conditions or risk factors should have access to Medical Nutrition Therapy (MNT) provided by a registered dietitian nutritionist (RDN). MNT provided by RDNs is effective in improving health outcomes for many chronic conditions that are leading drivers of morbidity, mortality, rising health care costs in the United States. Widespread access to MNT using an individualized, client-centered, and evidence-based approach has the potential to improve population health, reduce health disparities, and reduce health care costs associated with nutrition-related health conditions. This position was approved in September 2025 and will remain in effect until December 31, 2032.

Dietary intake has a significant impact on morbidity and mortality from noncommunicable diseases, yet only an estimated 10% of the population meets dietary recommendations.¹ Nutrition-related health conditions, including type 2 diabetes mellitus (DM), cardiovascular disease, obesity, and some cancers, are the leading causes of illness, disability, and death in the United States. Most Americans have at least 1 chronic health condition, and over a quarter have multiple chronic health conditions.² The health burden and cost of these chronic conditions is substantial. The Centers for Disease Control and Prevention estimates that 90% of health care expenditures, or about \$4.9 trillion annually, are for individuals with chronic conditions.³ Health care costs are often higher for individuals who have chronic conditions and lower household incomes, low education or employment, or poor-quality housing.^{4,5} Failure to effectively prevent and treat nutrition-related health conditions and associated risk factors

is expected to lead to increased mortality, increased health care costs, and reduced quality of life (QoL).^{6,7}

Implementation of effective nutrition care for disease prevention and treatment has the potential to lower health care costs and improve population health, life expectancy, and workforce productivity.^{8,9} Health care policies that ensure access to high-quality nutrition care services for all patients have the potential to reduce health disparities.¹⁰ Improving access to medical nutrition therapy (MNT) provided by a registered dietitian nutritionist (RDN) for individuals with nutrition-related health conditions should be part of a national strategy to address the burden of chronic disease in the United States.

MNT, as defined by the Commission on Dietetic Registration, is an evidence-based application of the Nutrition Care Process.¹¹ The Nutrition Care Process consists of 4 interconnected steps, including nutrition assessment and reassessment, nutrition diagnosis, nutrition intervention,

and nutrition monitoring and evaluation. The goal of MNT is to prevent, delay, or manage an individual's disease and enhance their well-being through nutrition. RDNs often provide MNT to individuals as part of a medical care team for the treatment and prevention of diseases such as DM, cardiovascular disease, chronic kidney disease (CKD), obesity, and eating disorders. Although MNT has been shown to be effective in improving health outcomes for a wide range of nutrition-related health conditions, many individuals lack adequate access to MNT provided by an RDN. Potential reasons for this include lack of insurance coverage and inadequate reimbursement, lack of nutrition screening and referrals¹² to RDNs, and RDN shortages in some areas.¹³

The objective of this position paper is to describe current evidence regarding the efficacy of MNT provided by an RDN for nutrition-related health conditions and outcomes and to advocate for improved access to effective nutrition care provided by RDNs.

POSITION PAPER DEVELOPMENT PROCESS

Academy of Nutrition and Dietetics' position papers are based on systematic reviews with high or moderate certainty evidence.¹⁴ The literature was searched for systematic reviews published from January 2018 through October 2024 that examined the research question: In adults with health conditions, what is the impact of MNT interventions provided by an RDN, compared with no MNT or standard care, on outcomes of interest? A broad search was conducted for systematic reviews related to MNT provided by an RDN with outcomes of interest (QoL, cost, disease events, nutritional status, and disease-specific outcomes such as fasting blood glucose) in Medline, CINAHL Database, Cochrane Database of Systematic Reviews, Food Science Source, and the Evidence Analysis Library website.¹⁵ To be included in this evidence summary, systematic reviews were required to:

1. Search at least 2 databases
2. Assess risk of bias of individual studies
3. Conduct meta-analysis or grade the certainty of the evidence

Systematic reviews were restricted to those published in English and were focused on adults aged 18 years or older. Few current systematic reviews examining the impact of MNT in adults with type 2 DM or type 1 DM were found, so a systematic review conducted for the Evidence Analysis Library and published in 2017 was also included.¹⁶

For systematic reviews that conducted meta-analysis but did not grade the certainty of evidence, outcomes were graded using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method.¹⁷ This method considers the number of studies and participants included and study design, risk of bias in included studies, inconsistency in results between studies, indirectness of the research, imprecision of the findings, and other factors.^{17,18} Conclusion statements were developed based on the results of the included systematic reviews and the certainty of the supporting evidence.¹⁹ Results from the systematic reviews were used to guide considerations for improving access to effective nutrition care to improve population health and health equity.

EVIDENCE ON THE CLINICAL EFFECTIVENESS OF MNT

Twenty-five systematic reviews were identified that examined the impact of MNT provided by an RDN for adults with a wide variety of nutrition-related health conditions.^{16,20-43} In support of this position statement and paper, included systematic reviews reported beneficial effects of MNT for several key outcomes in a wide variety of populations with moderate to high certainty evidence as described in the following sections. Conclusions based on recent systematic reviews are described in [Figure 1](#), and supporting evidence can be found in [Figure 2](#). No evidence indicated that MNT resulted in negative impacts for any of the outcomes examined ([Figs 1 and 2](#)).

In adults with type 1 and 2 DM, MNT likely decreases hemoglobin A1c and glucose concentrations compared with no MNT.¹⁶ In adults with pre-diabetes, MNT likely decreases fasting blood glucose and total cholesterol concentrations as well as blood pressure (BP) and waist circumference compared

with no MNT.²⁵ In adults with overweight or obesity, MNT likely improves weight loss, body mass index (BMI), and systolic BP, as well as mental QoL compared with no MNT.²³ In adults with hypertension or pre-hypertension, MNT likely decreases BP, risk of stroke, and weight or BMI compared with no MNT.²⁷ In adults with dyslipidemia, MNT decreases total and low-density lipoprotein cholesterol and triglyceride concentrations ([Figs 1 and 2](#)).²²

In adults with CKD, MNT improves BP compared with no MNT when that is the aim of the intervention.²⁸ In older adults with malnutrition discharged from acute care, MNT likely improves weight and BMI, but not mortality, compared with no MNT.³⁵ In adults with head and neck cancer, MNT likely improves QoL, nutritional status (patient-generated subjective global assessment score), percent weight change, and unplanned hospital visits compared with no MNT.³⁷ In adults with chronic obstructive pulmonary disease (COPD), MNT likely improves QoL, weight, and body composition, but it has an unclear effect on lung function, compared with no MNT ([Figs 1 and 2](#)).⁴¹

Available evidence indicates that MNT may improve several additional outcomes, yet the certainty of evidence was low or very low because of the risk of bias (how the study was conducted) and imprecision of results (because of small sample size or because results were inconsistent) ([Fig 1](#)). For example, there was low-certainty evidence that in adults with overweight or obesity, MNT may improve diastolic BP, improve physical QoL, and be cost-effective.²³ In adults with malnutrition, MNT may improve mortality, hospital length of stay, and cost-savings.³³ In individuals with eating disorders, MNT may improve eating disorder psychopathology and behaviors but has an uncertain effect on weight.⁴⁰ Many other benefits of MNT were seen, for which the available evidence was of low certainty.

EVIDENCE ON THE COST-EFFECTIVENESS OF MNT

Little research exists on the cost-effectiveness of MNT interventions provided by an RDN. Evidence from current systematic reviews

Condition	Conclusion	Evidence certainty
Type 1 diabetes mellitus (DM) (adults) ¹⁶	In adults with type 1 DM, medical nutrition therapy (MNT) decreases hemoglobin A1c (HbA1c) and glucose concentrations (high certainty), but likely has mixed effects on anthropometric and lipid profile outcomes and blood pressure (BP) (moderate certainty).	Moderate/high
Type 2 DM ^{16,30,31}	In adults with type 2 DM, MNT likely reduces HbA1c and glucose concentrations but may have mixed effects on anthropometric and lipid profile outcomes and BP compared with no MNT.	Moderate
Pre-diabetes ²⁵	In adults with pre-diabetes, MNT likely reduces fasting blood glucose, waist circumference, BP, and total cholesterol concentrations compared with no MNT.	Moderate
	In adults with pre-diabetes, MNT may improve HbA1c, body mass index (BMI), and low-density and high-density lipoprotein cholesterol concentrations compared with no MNT.	Low
Overweight and obesity ^{23,42,43}	In adults with overweight or obesity, MNT likely improves weight loss, BMI, systolic BP, and mental quality of life (QoL) compared with no MNT.	Moderate
	In adults with overweight or obesity, MNT may improve diastolic BP, physical QoL, and may be cost-effective compared with no MNT.	Low
Cardiovascular risk factors ²⁰⁻²²	In adults with cardiovascular risk factors, MNT likely decreases BP and weight compared with no MNT. In adults with dyslipidemia, MNT likely decreases total and low-density lipoprotein cholesterol and triglyceride concentrations.	Moderate
Hypertension or pre-hypertension ^{26,27}	In adults with hypertension or pre-hypertension, MNT likely reduces BP, risk of stroke, weight, and BMI compared with no MNT.	Moderate
	In adults with hypertension or pre-hypertension, MNT may reduce waist circumference and hypertension incidence for those with pre-hypertension compared with no MNT.	Low
Chronic kidney disease (CKD) ^{28,29}	In adults with CKD, MNT interventions aiming to reduce BP likely do so compared with no MNT.	Moderate
	In adults with CKD, MNT interventions aiming to reduce serum phosphate may do so compared with no MNT.	Low
Celiac disease ³²	In adults with celiac disease, MNT may improve QoL and gastrointestinal symptoms.	Very low
Malnutrition ³³⁻³⁵	In older adults with malnutrition discharged from acute care, MNT likely improves weight and BMI, but not mortality, compared with no MNT.	Moderate
	In adults with malnutrition, MNT may improve mortality, length of stay, and cost-savings.	Low
Cancer ³⁶⁻³⁹	In adults with head and neck cancer, MNT likely improves QoL, nutritional status, percent weight change, and unplanned hospital visits compared with no MNT.	Moderate
	MNT may improve dietary intake in some settings and may improve weight outcomes in cancer survivors.	Low
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Figure 1. Overall conclusions from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

Condition	Conclusion	Evidence certainty
Chronic obstructive pulmonary disease (COPD) ⁴¹	In adults with COPD, MNT likely improves QoL, weight, and body composition, but has an unclear effect on lung function compared with no MNT.	Moderate
Eating disorders ⁴⁰	In individuals with eating disorders, MNT may improve eating disorder psychopathology and behaviors but has an uncertain effect on weight.	Low

Figure 1. (continued) Overall conclusions from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

demonstrates that MNT interventions provided by RDNs may be cost-effective for adults with overweight or obesity,²³ malnutrition (including older adults with malnutrition),^{33,35} and COPD.⁴¹

Although MNT interventions do incur cost for RDN time and space, assessment and intervention tools, and resources, MNT interventions have relatively low costs. Recent evidence suggests that adding access to an RDN resulted in cost savings because of optimization of medication management.⁴⁴ In collaboration with other health care providers, RDNs have initiated medication adjustments after dietary interventions, often leading to the reduction or discontinuation of medications such as insulin and oral hypoglycemic agents. Evidence has shown MNT to demonstrate cost-savings of US \$638 to \$1450 per patient per year because of reductions in medications and an increase in quality-adjusted life years by 0.75 years.²²

WHY IS MNT PROVIDED BY AN RDN EFFECTIVE?

Current systematic reviews indicate that MNT provided by an RDN can be an effective treatment for many health conditions. A potential key to the success of MNT is the individualized approach. RDNs are comprehensively trained in nutrition science, client counseling, and behavior change, equipping them to adapt and tailor nutrition care to address an endless combination of individual needs. Thus, interventions provided by an RDN do not test a 1-size-fits-all approach but rather test the efficacy of tailored interventions provided by trained nutrition practitioners. This explanation is supported by recent literature, which demonstrates that personalized interventions are more effective than

generalized advice.^{12,41} MNT is a flexible, relatively low-cost treatment option that can be modified to a wide variety of individuals and circumstances and in a wide variety of settings.⁴ MNT provided by an RDN is also effective because it is evidence-based, ensuring delivery of proven methods in combination with clinical expertise and client values. Although other practitioners recognize the importance of providing nutrition education and counseling, they most often do not have the training, education, time, knowledge, or confidence to provide high-quality nutrition care.⁴²

INCREASING ACCESS TO MNT

Individuals with nutrition-related health conditions or risk factors may not have adequate access to MNT for a variety of reasons, including a lack of RDNs available in some settings, a lack of referral networks, and a lack of payer coverage for nutrition services. Lack of access to nutrition care provided by an RDN can lead clients to seek care options that may ultimately have higher costs or more side effects, such as medications, if they are covered by payers.⁴⁵

Key approaches to increasing access to MNT include:

- Addressing MNT policy, licensure, and adequate reimbursement for MNT
- Increasing screening for nutrition-related health conditions and referral to an RDN, if indicated
- Ensuring adequate RDN staffing in health care facilities to support the provision of evidence-based MNT practices to all individuals with nutrition-related health conditions
- Participating in and disseminating findings from research

studies on the efficacy of MNT broadly to increase providers, policymakers, and public awareness of RDN services

These approaches are discussed further in this paper and are summarized in [Figure 3](#).

MNT Payment and Policy

Despite the robust evidence of the efficacy of MNT for a variety of conditions, currently, there is only consistent nutrition care coverage from public and private payers for adults with type 2 DM and CKD in outpatient settings. Although the evidence supports that MNT provided by RDNs improves outcomes, practitioners may hesitate to refer clients and clients may be reluctant to participate because of out-of-pocket costs. Lack of coverage for MNT may be of particular detriment to clients with lower incomes or from socially disadvantaged groups, who may have more health issues but less income to cover nutrition care. Lack of access to health care is a major cause of health disparities.

Policy makers and decision makers for public and private health plans should increase access to evidence-based nutrition care to drive population health improvements.⁹ There are currently 2 crucial pieces of federal legislation aiming to improve access to MNT services. The first is the MNT Act, which advocates increased coverage of MNT provided by RDNs for a range of conditions such as obesity, eating disorders, cancer, human immunodeficiency virus/acquired immune deficiency syndrome, malnutrition, gastrointestinal disorders, and other cardiometabolic conditions.⁴⁶ The second, the Treat and Reduce Obesity Act, specifically targets comprehensive care for obesity, including behavioral

Condition	Systematic Review	High or Moderate Certainty Evidence Effect size reported as mean difference and 95% CI unless otherwise noted	Low or Very Low Certainty Evidence Effect size reported as mean difference and 95% CI unless otherwise noted
Cardiovascular risk factors	Cross et al, 2024 ^{20ab}	<i>Moderate</i> - Systolic blood pressure (SBP) (mmHg): -2.11 (-3.97, -0.25)^b - Diastolic blood pressure (DBP) (mmHg): -1.46 (-2.67, -0.25) - Triglycerides (mmol/L): -0.18 (-0.34, -0.03) - Weight (kg): -1.71 (-3.13, -0.29)	<i>Low</i> - Total cholesterol (TC) (mmol/L): -0.16 (-0.35, 0.04) - Low-density lipoprotein (LDL) cholesterol (mmol/L): 0 (-0.15, 0.15) - High-density lipoprotein (HDL) cholesterol (mmol/L): 0.03 (-0.03, 0.1) - Body mass index (BMI): -0.49 (-1.0, 0.02) - Waist circumference (WC) (cm): -0.4 (-0.4, 0.13)
	Ross et al, 2019 ^{21b}	—	<i>Low</i> - TC (mmol/L): -0.12 (-0.30, 0.05) - HDL cholesterol (mmol/L): (-0.05, 0.06) - LDL cholesterol (mmol/L): -0.04 (-0.16, 0.08) - Triglycerides (mmol/L): -0.22 (-0.43, -0.02)
	Mohr et al, 2022 ^{22b}	<i>Moderate</i> - TC (mg/dL): -20.84 (-40.60, -1.07) - LDL cholesterol (mg/dL): -11.56 (-21.10, -2.03) - Triglycerides (mg/dL): -32.55 (-57.78, -7.32)	<i>Low</i> - SBP: -8.76 (-14.06, -3.45) - DBP: -2.90 (-7.89, 2.09) - HDL cholesterol (mg/dL): 1.75 (-4.43, 4.92)
	Conclusion for cardiovascular risk factors	In adults with cardiovascular risk factors, medical nutrition therapy (MNT) likely decreases blood pressure (BP) and weight compared with no MNT (<i>moderate</i>). In adults with dyslipidemia, MNT likely decreases total and LDL cholesterol and triglyceride concentrations (<i>moderate</i>).	
Overweight/obesity	Hartmann et al, 2022 ^{42ab}	<i>Moderate</i> Weight (kg): -1.31 (-2.4, -0.24)	-
	Machado et al, 2022 ^{43a}	-	<i>Low</i> Weight (kg): -9.17 (-8.08, -10.41)
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Figure 2. Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

	Morgan-Bathke et al, 2023 ^{23b}	<i>High</i> • % Weight loss: -4.01 (-5.26, -2.75) • WC (cm): -3.45 (-4.39, -2.51) • SBP (mmHg): -2.91 (-4.9, -0.92) • Fasting blood glucose (FBG) (mg/dL): -1.37 (-2.75, 0.01) <i>Moderate</i> • Mental quality of life (QoL): 2.4 (1.55, 3.23) • BMI: -1.5 (-1.74, -1.26)	<i>Low</i> • Physical QoL: (2.3, 9.4) • DBP: -1.99 (-3.02, -0.96) • May be cost-effective^c
	Williams et al, 2019 ^{24ab}	<i>Moderate</i> • BMI: -0.43 (-0.59, -0.26)	<i>Low</i> • Weight (kg): -1.03: (-1.4, -0.66)
	Conclusion for overweight/obesity	In adults with overweight or obesity, MNT likely improves weight loss, BMI, SBP, and mental QoL (<i>moderate</i>) and may improve DBP, physical QoL, and may be cost-effective (<i>low</i>) compared with no MNT.	
Pre-diabetes	Dudzik et al, 2023 ^{25b}	<i>Moderate</i> • FBG (mg/dL): -4.97 (-6.24, -3.71) • Weight (kg): -3.23 (-3.97, -2.50) • WC (cm): -2.93 (-3.58, -2.28) • SBP: -2.91 (-4.59, -1.24) • DBP: -2.34 (-3.45, -1.24) • TC (mmol/L): -0.11 (-0.19, -0.04) • TG (mg/dL): -5.89 (-12.55, 0.78)	<i>Low</i> • T2DM incidence: No effect^c • Glycosylated hemoglobin (HbA1c) (%): -0.30 (-0.49, -0.12) • BMI: -1.49 (-2.17, -0.82) • HDL cholesterol (mmol/L): 0.08 (0.02, 0.14) • LDL cholesterol (mmol/L): -0.14 (-0.27, -0.02)
	Conclusion for pre-diabetes	In adults with pre-diabetes, MNT likely reduces FBG, WC, BP and total cholesterol concentrations (<i>moderate</i>) and may improve HbA1c, BMI, and LDL and HDL concentrations (<i>low</i>) compared with no MNT.	
Hypertension or pre-hypertension	Riegel et al 2018 ^{26ab}	<i>Moderate</i> • SBP (mmHg): -3.28 (-4.67, -1.88) • DBP (mmHg): -1.14 (-2.07, -0.21)	-
	Senkus et al 2024 ^{27b}	<i>Moderate</i> • SBP (mmHg): -3.63 (-4.69, -2.56) • DBP (mmHg): -1.99 (-2.59, -1.39) • Stroke (RR): 0.34 (0.14, 0.81)	<i>Low</i> • WC (cm): -1.04 (-2.04, -0.04) • Hypertension incidence relative risk (RR): 0.46 (0.22, 0.97)
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Figure 2. (continued) Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

		• Weight (kg): -1.93 (-2.64, -1.21) • BMI: -0.25 (-0.45, -0.04)	• Myocardial infarction: 0.83 (0.48, 1.42) Very low • QoL^c: unclear
	Conclusion for Hypertension	In adults with hypertension or pre-hypertension, MNT likely reduces BP, risk of stroke, weight and BMI (<i>moderate</i>), and may reduce WC and hypertension incidence for those with pre-hypertension (<i>low</i>) compared with MNT.	
Chronic kidney disease	Rozga et al, 2022 ^{28b}	Moderate • SBP: -6.7 (-11.0, -2.4) • DBP: -4.5 (-6.6, -2.4)	Low Physical health related (Hr) QoL (SMD): -0.04, (-0.3, 0.2) Mental HrQoL (SMD): 0.2 (-0.3, 0.64)
	St-Jules et al, 2020 ^{29b}	—	Low Serum phosphate (mg/dL): -0.76 (-1.12, -0.41)
	Conclusion for CKD	In adults with CKD, MNT interventions aiming to reduce BP likely do so (<i>moderate</i>) and those aiming to reduce serum phosphate may do so (<i>low</i>) compared with no MNT.	
Type 2 diabetes	Franz et al, 2017 ^{16c}	High • HbA1c: decreased 0.3% to 2.0% at 3 months • Glucose: decreased Moderate • Weight, BMI, WC: mixed effects with significant reduction in some studies • BP and total, LDL cholesterol, and triglyceride concentrations: mixed effects with significant reduction in some studies • HDL cholesterol: mixed effects with significant increase in some studies	—
	Razaz et al, 2019 ^{30ab}	—	Very low • HbA1c : -0.42 (-0.69, -0.17) • FBG (mg/dL): -8.85 (-14.41, -3.28) • Weight (kg): -1.54 (-2.44, -0.64) • BMI: -0.34 (-0.52, -0.17) • WC (cm): -2.16 (-4.09, -0.23)
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Figure 2. (continued) Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

			• SBP (mmHg): -7.9 (-13.03, -2.77) • DBP (mmHg): -2.6 (-4.27, 0.94) • TC (mg/dL): -4.06 (-7.31, -0.81) • Triglycerides (mg/dL): -8.82 (-20.10, 2.45) • LDL cholesterol (mg/dL): -4.43 (-13.66, 4.8) • HDL cholesterol (mg/dL): -0.4 (-3.2, 2.4)
	Siopis et al, 2021 ³¹	—	Very low • SBP (mmHg): -0.75 (-2.45, 0.96) • DBP (mmHg): -1.17 (-4.52, 2.17) • LDL cholesterol (mmol/L): -0.15 (-0.33, 0.04)
	Conclusion for type 2 diabetes	In adults with type 2 diabetes, MNT likely reduces HbA1c and glucose concentrations but may have mixed effects on anthropometric and lipid profile outcomes and BP compared with no MNT (<i>moderate</i>).	
Type 1 diabetes (T1DM)	Franz et al, 2017 (adults) ^{16c}	High • HbA1c: decreased 1.0% to 1.9% at 6 months • Glucose: decreased Moderate • Weight, BMI, WC: mixed effects but decreased in some studies • BP, total, and HDL cholesterol and triglyceride concentrations: no significant effect • LDL cholesterol concentrations: mixed findings, but may decrease	—
	Conclusion for T1DM	In adults with T1DM, MNT decreases HbA1c and glucose concentrations (<i>high</i>), but likely has mixed effects on anthropometric and lipid profile outcomes and BP (<i>moderate</i>).	
Celiac disease	Almond et al, 2021 ^{32c}	—	Very low • QoL: may Improve^c • BMI: unclear^c • Gastrointestinal symptoms: may improve
	Conclusion for celiac disease	In adults with celiac disease, MNT may improve QoL and gastrointestinal symptoms (<i>very low</i>).	
Malnutrition	Kaegi-Braun et al, 2022 ^{34ab}	—	Low • Mortality odds ratio (OR): 0.66 (0.47, 0.94) • Length of stay (LOS) (days): -1.57 (-2.79, -0.35)
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Figure 2. (continued) Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

	Scheutz et al, 2021 ^{33ac}	—	Very low • Cost savings: \$2, 912.47
	Munoz et al, 2023 (older adults) ^{35b}	Moderate Post-discharge • Weight (kg): 2.02 (0.23, 3.81) • BMI: 1.2 (0.3, 2.4) • Mortality OR: 1.09 (0.60, 1.96)	Low Community: • Weight (kg): 0.88 kg (0.06, 1.71) • Calorie intake (kcal): 125.76 (61.97, 189.55) • Protein intake (g): 15.56 (11.91, 19.21) • May be cost-effective ^c Post-discharge: • Mini Nutritional Assessment (MNA) Score: 0.96 (0.37, 1.55) • Readmissions (OR): 0.93 (0.47, 1.84) • May be cost-effective ^c Very low Post-discharge • Calorie intake (kcal): 769.6 (-164.2, 1, 703.5) • Protein intake (g): 36.88 (-7.32, 81.06)
	Conclusion for malnutrition	In older adults with malnutrition discharged from acute care, MNT likely improves weight and BMI, but not mortality, compared with no MNT (<i>moderate</i>). In adults with malnutrition, MNT may improve mortality, LOS, and cost-savings (<i>low</i>).	
Oncology	Ryding et al, 2024 ^{36ab} (cancer survivors)	—	Low Body fat (%):-2.29 (-3.26, -1.32) Weight (kg): -3.72 (-4.51, -2.93)
	Tunzi et al, 2022 (head and neck cancer) ^{37c}	High • QoL: improved • PG-SGA score: improved • % weight change: reduced • Unplanned hospital admissions: reduced	Low Protein and energy intake: no effect
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Figure 2. (continued) Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.

	Ueshima et al, 2023 ³⁸ (incurable cancer) ^b	—	Low • Energy intake (kcal): 392.82 (170.04, 615.50) • Protein intake (g): 10.67 (1.83, 19.51) Very low • Patient-generated subjective global assessment (PG-SGA) score: -1.52 (-4.18, 1.15) • Body weight (kg): -0.45 (-3.68, 2.78)
	Zhang et al, 2020 ^{39ab} (malnutrition in cancer)	—	Low Mortality RR: 1.11 (0.95, 1.29) Very low • QoL (score): 37.92 (23.14, 52.7) • Weight (kg): 4.28 (-0.21, 8.76) • Energy intake (kcal): 230.23 (171.49, 88.98)
	Conclusion for oncology	In adults with head and neck cancer, MNT likely improves QoL, PG-SGA score, % weight change, and unplanned hospital visits compared with no MNT (<i>moderate</i>). MNT may improve dietary intake in some settings and may improve weight outcomes in cancer survivors (<i>low</i>).	
Chronic obstructive pulmonary disease (COPD)	Hanson et al 2019 ^{41c}	High • QoL: improved • Weight: improved • Body composition: improved Moderate • Lung function: unclear effect	Low • Hospital admissions: improved • Hospitalization costs: improved
	Conclusion for COPD	In adults with COPD, MNT likely improves QoL, weight and body composition but has an unclear effect on lung function compared to no MNT (<i>moderate</i>).	
Eating disorders	McMaster et al, 2021 ^{40c}	Moderate • Weight gain: unclear (bulimia/binge eating disorder [BED])	Very low Weight gain: Unclear (anorexia) • Eating disorder psychopathology and behaviors: improved (anorexia and bulimia/BED)
	Conclusion for eating disorders	In individuals with eating disorders, MNT may improve eating disorder psychopathology and behaviors, but has an uncertain effect on weight (<i>low</i>).	
^a Authors of systematic reviews did not grade certainty of evidence. Certainty of evidence was determined by Academy staff, using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method.			
^b Bolded results were statistically significant in meta-analysis.			
^c No meta-analysis was conducted.			

Figure 2. (continued) Results from systematic reviews (2017–2024) examining the impact of medical nutrition therapy interventions provided by registered dietitian nutritionists.



Policy

- Support legislation that reduces barriers to payment for MNT provided by a registered dietitian nutritionist (RDN), including the MNT Act and the Treat and Reduce Obesity Act.



Network

- Cultivate referral networks with interprofessional colleagues to provide comprehensive care.
- Health care agencies should implement electronically integrated policies and procedures for screening nutrition risk factors and referring to an RDN.



Staffing

- Advance adequacy of RDN staffing to improve payment for services.
- Mandate adequate RDN-to-patient ratios.
- Strengthen recruitment and training opportunities.



Research

- Support and participate in research to assess the efficacy and cost-effectiveness of MNT provided by an RDN.

Figure 3. Calls to action for partners for improving access to medical nutrition therapy (MNT).

therapy provided by an RDN.⁴⁷ Both pieces of legislation have the potential to increase access to effective nutrition care on a national level. RDNs should take action to contact their legislators about the importance of these acts.

RDNs also need to be aware of billing practices and codes to receive payment for services in outpatient settings when possible. Effective January 1, 2025, RDNs can bill Medicare for Direct Training Caregiver Services, which involves training unpaid caregivers to support a patient's treatment plan through tasks such as diet preparation and wound care. These services aim to enhance caregiver effectiveness and improve patient outcomes, whereas MNT focuses on individualized nutrition care. This development comes as a result of the new Healthcare Common Procedure Coding System codes approved in the 2025 Physician Fee Schedule, as confirmed by the Centers for Medicare & Medicaid Services.⁴⁸ RDNs should have a National Provider Identifier to facilitate payment for services and should enroll as providers through private and public payers common in their area.

RDNs can use resources on billing practices through the Academy of Nutrition and Dietetics. RDNs should use the current coding and systems in place to bill for reimbursement (www.eatrightpro.org/career/payment).

Finally, licensure ensures that only qualified professionals provide MNT, protecting the public from harm and supporting safe, ethical care.⁴⁹ It also increases access to MNT by enabling insurance reimbursement and helping consumers identify competent providers. To protect and expand this access, the Academy of Nutrition and Dietetics works closely with state affiliates to advocate for strong licensure laws, advance the Dietitian Licensure Compact, and educate policymakers and the public on the importance of protecting access to qualified nutrition practitioners.⁴⁹

Screening and Referrals to RDNs for MNT

Coordination of a comprehensive care plan requires collaboration and communication between interprofessional health care practitioners. Most

nutrition-related health conditions require multi-component care from an interprofessional team, including but not limited to physicians, physical therapists, speech and language pathologists, occupational therapists, mental health practitioners, and others. Recent evidence highlights the value of RDNs on these teams, showing that their increased involvement can lead to more patient referrals, greater patient satisfaction, and cost savings.⁴⁴ Despite these benefits, referral to RDNs remains low.⁵⁰⁻⁵²

Patients should be routinely screened by health care providers for nutrition-related health conditions and risk factors using validated tools, such as the Malnutrition Screening Tool, which takes less than 5 minutes to complete.⁵³ If nutrition risk is identified, patients should be referred to RDNs for MNT. Health care facilities should establish and implement standardized, electronically integrated policies and procedures for both nutrition risk screening and referral to an RDN. These protocols should prioritize conditions for which MNT is known to be

effective, ensuring timely and appropriate intervention.

RDNs should cultivate relationships with interprofessional colleagues to create a network for referrals. Developing an interprofessional network allows for a high-quality multi-component treatment plan delivered within each practitioner's scope of practice. In addition, it creates familiarity and trust with interprofessional colleagues and allows for education regarding when an individual should be referred to an RDN, which may increase referrals.⁵² Maintaining communication about client progress and needs is essential for creating a comprehensive and cohesive plan to help clients meet health goals.

Adequacy of RDN Staffing

Shortages of health care workers, including RDNs, are a widespread concern, particularly in areas that are rural or lack sufficient resources. Lack of appropriate coverage for services may lead hospitals to have too few RDNs on staff, leading to more patients being served per RDN. For example, a survey of 215 cancer centers in the United States found a ratio of 1 RDN to 2308 clients.⁵⁴ This may cause RDNs to struggle to provide adequate time and attention to all the patients under their charge. Fewer contacts and less time for nutrition interventions provided by RDNs may lead to less effective nutrition care.²³

Staffing needs depend not only on the number of patients in a facility, but also on the malnutrition risk in the population.^{54,55} According to the Centers for Medicare & Medicaid Services, long-term care (LTC) facilities are required to employ a full-time, licensed RDN or a certified dietary manager with a consulting RDN. However, in LTC settings, the RDN or consulting RDN must maintain responsibility for MNT services, including nutrition assessment, diagnosis, and individualized nutrition care. Inadequate access to RDNs in LTC facilities can hinder at-risk residents from receiving comprehensive nutrition care. Providing adequate RDN staffing can improve the quality of care. For example, higher RDN staffing in LTC led to fewer citations related to dietary service delivery.⁵⁶

To improve RDN-to-patient ratios, a multipronged approach is needed. First, there must be improved reimbursement for RDN-led services in outpatient settings and initiation of reimbursement for inpatient settings, particularly under Medicare and Medicaid. Despite demonstrated efficacy in improving health outcomes for many chronic diseases, insufficient reimbursement remains a major barrier to integrating more RDNs into the health care field. Second, establishing minimum RDN-to-patient ratios is necessary to ensure RDNs have sufficient time to provide individualized, evidence-based care to all patients with nutrition-related health conditions. Finally, there is a need to strengthen and promote dietetics programs, with particular attention to increasing access and inclusion for communities that have been underrepresented in the field.¹³ According to the Accreditation Council for Education in Nutrition and Dietetics data, there has been a 7% decline in enrollment since the year 2000.⁵⁷ Expanding dietetic internship opportunities, strengthening communication among internship directors and preceptors, and increasing awareness of the growing demand and job outlook for RDNs among high school and college students are key strategies to enhance capacity and enrollment in dietetics programs and increase the availability of RDNs in the field.

Positioning Dietitians for the Future

To improve access to care on a population level, RDNs must promote not only improvement in coverage but also awareness of MNT effectiveness. The dietetics profession faces ongoing challenges in maintaining relevance and visibility among the public and other health care professionals. In response, the Academy of Nutrition and Dietetics has outlined 5 strategic priorities⁵⁸:

1. A clearly defined identity
2. Strong partnerships and community engagement
3. A cultural shift within the profession
4. Professional empowerment
5. Operational excellence

In parallel, dietitians from New Zealand and Australia conducted a qualitative study to identify strategies for strengthening the profession to meet future demands.⁵⁹ They outlined 5 key actions⁵⁹:

1. Embracing and leveraging diversity within the profession
2. Fostering a cohesive and well-defined professional identity
3. Decolonizing education and practice
4. Maintaining science as the foundation while integrating cross-disciplinary knowledge
5. Creating pathways for a flexible, responsive nutrition workforce

The alignment between the Academy's priorities and international insights affirms that the profession is moving in a unified, future-focused direction. Strengthening the profession and improving awareness of MNT are essential for improved patient and public access to MNT.

To advance the profession and awareness of quality care provided by RDNs, further research is needed to determine the efficacy of MNT for additional nutrition-related health conditions and to further demonstrate the cost-effectiveness of MNT in the prevention and treatment of nutrition-related health conditions. Any measure of the cost of nutrition care should analyze cost-efficacy, which examines whether the intervention is beneficial enough to be worth the cost of the intervention, based on prespecified thresholds. This type of approach recognizes that, although adding a qualified practitioner to a health care team might increase actual cost, it can be cost-effective overall, because clients are receiving tailored, evidence-based interventions that have a higher likelihood of improving behaviors and health outcomes. Studies examining cost-efficacy should incorporate measures such as disability-adjusted life years and quality-adjusted life years to provide a robust perspective on the impact of MNT on individuals' QoL. Nutrition practitioners should participate in research and quality improvement projects that collect data to determine RDN efficacy and cost-effectiveness and disseminate the findings of research to other health care providers, policymakers, and payers.

CONCLUSION

This position paper provides evidence on the efficacy of MNT by an RDN for nutrition-related health conditions and risk factors. Current systematic reviews support that MNT provided by an RDN is an effective treatment for many health conditions and may be an effective solution for reducing health care expenditures associated with nutrition-related health conditions. Increasing access to MNT for all individuals with nutrition-related health conditions has the potential to significantly improve public health and reduce chronic disease burden. To increase access, reimbursement for MNT for a broader range of conditions is essential. Without reimbursement, providers may be less likely to refer individuals for treatment, and individuals with fewer financial resources may be unable to access MNT services, resulting in health disparities. RDNs can advocate for expanded coverage of MNT, expand referral networks, stay up to date on billing practices, participate in research, and disseminate research findings broadly. Health care providers can implement simple screening practices to identify nutritional conditions and risk factors and refer to an RDN as appropriate. Although MNT has been found to be cost-effective in most studies, more research is needed to determine the cost-benefit of MNT and assess how MNT impacts client-centered outcomes such as QoL.

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AUTHOR CONTRIBUTIONS

L. M., M. R., and D. H. drafted the outline of the paper and contributed the supporting data and analyses. L. M., M. R., A. S., and D. H. provided major revisions. All authors approved the final draft.

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