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A new model of clinical care and physician training should prioritize patient nutritional status and micronutrient remediation

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Statement of the problem: Extensive clinical experience at a US Federally qualified health center serving vulnerable populations reveals a need for social accountability in treating patients where they are: those who have poor nutrition, smoke, abuse substances and alcohol, are sedentary and/or take many common medications, are at high risk for nutrient deficiencies. These are neither routinely assessed nor related.

Methodology & theoretical orientation: Longitudinal systematic documentation of clinical assessment and care.

Findings: The speaker maintains a nutritional deficiency database to document and disseminate her case-based knowledge. One example: in 2019-2020, among 1600 patients, 326 had nutritional deficiency along with co-morbid condition(s): 96 patients had levels of Vitamin C below normal range; Vitamin B6 (66); Vitamin D (109); Vitamin A (32).

Significance: These deficiencies, if untreated, lead to serious and easily preventable health problems standard care often fails to identify and address. Data and brief case examples will reveal the need for new clinical rubrics to: query patient nutrition in initial clinical encounters; conduct micronutrient testing and supplementation; consistently document to establish if micronutrient supplementation resolves part or all of the presenting problem(s) or achieves other health aims. The speaker is developing needed curricula to train providers in: macro and micro nutrition and gut health, for prevention and overall health; routine assessment of diet; testing for micronutrient status; patient nutrition education and providing multiple resources to help patients eat well. Physicians should take their own often time-challenged nutritional habits seriously, for their own health and to credibly model patient behavior change.

Conclusion: There is a clear need to document improved outcomes and cost efficiency of routine patient nutritional assessment, education and follow-up, vs. ordering many diagnostic tests that may not improve patients' status. A new model of care should include routine, mandated nutritional status evaluation and remediation.