Nutrition Basket of Services for Family Medicine

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Over 70% of patients that present in family medicine clinics everyday have one or more chronic diseases. Evidence-based guidelines from the US Preventive Services Task Force, The American Diabetes Association, The American Heart Association, and others, recommend intensive self-management support for these patients to engage them in self-care activities. However, most family medicine practices lack the time, staff, and resources to fully provide self-management support services to their patients. This is reflected in a recent report from the Centers for Disease Control (MMWR 2014;63:1045-9), which found that only 6.8% of insured patients with a new diagnosis of diabetes participated in self-management education within the first year of diagnosis.

Several of the new payment models and primary care initiatives are emphasizing the need for robust self-management support services that are provided within the family medicine practice. For example, the Patient-Centered Medical Home (PCMH) has as one of the primary tenants to engage patients and families into their care. The new strategic effort from the family medicine community, "Health is Primary: Family Medicine for America's Health" will focus the first year of its campaign on actionable information about how to improve health through exercise, nutrition, prevention, and chronic disease management. Payment initiatives, such as Meaningful Use, Pay 4 Performance, and value-based-purchasing are tying payments to practices based on improvements in quality metrics, including demonstration of coordinated patient care plans.

Registered Dietitians Nutritionists (RDNs) are one of the recognized experts in providing Medical Nutrition Therapy (MNT) and patient self-management support. Nutrition counseling provided by a RDN has been shown to improve health outcomes for type 2 diabetes, weight management, disorders of lipid metabolism, and hypertension. Primary care physicians report seeing the benefit of including RDNs on their health care teams to provide MNT and patient self-management support, yet typical fee-for-service has limited the ability to fully integrate RDNs into family medicine. The good news is through the Affordable Car Act, there is a renewed emphasis on prevention and wellness services making it easier for RDNs to provide comprehensive MNT and patient self-management support within a family medicine practice. For example, Medicare considers RDNs a "qualified medical professional" for performing the Annual Wellness Visit, the Subsequent Annual Wellness Visit, the Initial Personal Prevention Exam, Chronic Care Management, and Intensive Behavioral Therapy for Obesity. Providing these services, in addition to MNT for patients throughout the life cycle including pediatrics, can make it financially feasible for family medicine practices to hire RDNs as integrated members of their health care team.

The PCMH and Per-Member-Per-Month payments are also mechanisms for family medicine practices to provide nutrition and self-management support to their patients. For example, meet Janette Neel, MS, RDN, CDE, who works at the St. Anthony Family Medicine Residency Practice in Westminster, Colorado. Janette provides traditional nutrition services, such as nutrition counseling and diabetes education; and she is also a member of the integrated health team, which includes behavioral health professionals, care managers, and volunteer health coaches. Janette also has a defined role for population management within the practice, specifically managing the diabetes registry. She assists the health coaches in identifying high-risk patients for outreach, and data from the registry is also used by their integrated team and the clinic's Diabetes Quality Improvement Team to identify gaps in care and opportunities for improvement.

Janette experiences first-hand how RDNs can enhance the work of family medicine practices, and states, "I think dietitians are well-suited to working in a PCMH. RDNs have excellent clinical training and patient-engagement skills that are an ideal fit for this model of care. PCMH emphasizes disease prevention, self-management support, and collaborative population management, and RDNs have been addressing these aims for many years. Our training underscores the importance of whole-person and patient-centered care and we are invested in helping patients attain positive health outcomes. Rather than accepting referrals as an outside consultant, being physically located in the primary care clinic is ideal for patient access, provides the RDN with full access to the patients' medical records, and allows for immediate communication amongst the team members."

To find a RDN in your area, check out the following resources:

- Colorado Academy of Nutrition and Dietetics Linkedin Group page: https://www.linkedin.com/groups?home=&gid=4784920&trk=anet_ug_hm
- Academy of Nutrition and Dietetics "Find a Registered Dietitian": www.eatright.org
- Contact Kristy Bates, RDN: bateskri@gmail.com

January 26th, 2015

Re: "Basket of Nutrition Services for Family Medicine"

Written by Bonnie, Jortberg, PhD, RD for the Colorado Academy of Family Physicians and published in the January magazine and online version in February 2015

Dear Member Leaders,

What do we want you to know?

We are sharing an article that promotes the services and roles RDNs provide to promote strong primary care, and more specifically, in the family medicine practice. The article, written by Bonnie Jortberg, PhD, RD, identifies RDNs as health professionals who contribute to improved health outcomes not only through MNT, but by providing a range of services that improve overall population health, and by performing other key roles as a member of an integrated health team in the family medicine practice setting and in Patient Centered Medical Homes (PCMH). The article appears in the print edition of the January magazine of the Colorado Academy of Family Physicians and will be available online in the February and March electronic newsletters found at http://coloradoafp.org/publications/. The article will also be published by the Arkansas, Maryland and Ohio chapters of the American Academy of Family Physicians (AAFP).

What do we want you to do?

We hope that you will take the time to read the article, circulate the article to membership, share it in conversations with physicians, practice managers, and related audiences, and use it as a conversation starter to initiate or strengthen relationships with your state or local chapter of the AAFP. While the article has been shared with all of the state chapters of the AAFP, it does not mean that chapters will publish the article. We ask that you consider follow up with your state chapter to encourage publication of the article. If you have an existing relationship with a physician member of AAFP in your state, please consider asking him/her to encourage publication.

How does this work fit into overall Academy efforts?

In October 2013 Academy members of the House of Delegates (HOD) identified the integration of nutrition services into evolving health care delivery and payment models (e.g., Accountable Care Organizations [ACO], and PCMH) as a mega-issue, an issue highly important to the profession. The result of the meeting included a request that the Coding and Coverage Committee and the Legislative and Public Policy Committee collaborate to create a Nutrition Services Delivery and Payment Action Plan to guide member efforts on this front. For more information on the HOD mega-issue and the resultant plan, visit www.eatright.org/hod.

Simultaneous to the HOD discussion, the Academy Coding and Coverage Committee's PCMH/ACO Workgroup was developing a set of recommendations for the Academy for engaging members to seize opportunities presented with these and other population health models of care and assess member resource and educational needs. The Workgroup's Report and recommendations is posted on the Academy website at www.eatright.org/coverage (under Health Care Reform, Academy's Efforts to Integrate RDNs into Emerging Health Care Delivery and Payment Models).

While the Academy efforts were underway, the Centers for Medicare and Medicaid Services (CMS) launched the Comprehensive Primary Care (CPC) initiative in 2012, a 4-year multi-payer initiative intended to strengthen primary care in seven states and regions. The initiative was identified by the Academy as an opportunity to promote the integration of the RDN into primary care and PCMHs. The Nutrition Services Coverage team at the Academy underwent efforts to

educate member leaders and members about the CPC, which included webinars and the creation of a toolkit: "Integration of RDNs into Primary Care" (available at www.eatright.org/shop). More recently, professional alliances in a CPC initiative state facilitated collaboration that resulted in this article about nutrition services for family medicine.

Thank you for reading this communication that contains background information, the article, and suggested ways to use the article to promote the integration of the RDN in the primary care setting. Please contact me if you have any questions about the article and related content. And thank you, in advance, for sharing it with your members.

Sincerely,

Michelle Kuppich, RD

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