Innovation in an Emerging Field: Integrated Nutrition Services

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Rosewood Family Health Center
Yakima Valley Farm Workers Clinic

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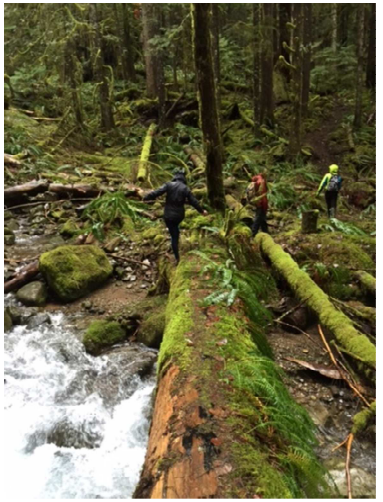
Objectives

- Describe value added by RDNs in Primary Care and PCPCH settings.
- Describe a successful, integrated primary care nutrition services model.
- List strategies for initiating and promoting an integrated nutrition services model in a PCPCH/FQHC/CHC.

A little about me



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About 1 billion physician visits are made a year.

55.5% of these are in primary care settings.

What do you think?: What % of RDNs work in Primary Care?

a) 50%

b) 25%

c) 10%

d) 5%

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Answer: Very Few

- 23% of RDNs work in acute care inpatient facilities
- 15% work in “ambulatory/outpatient facilities”
- Estimate 4% work in primary care

New health care delivery models and initiatives are changing the landscape of primary care to improve health outcomes and contain costs.

What is Healthcare Transformation, and what does it have to do with me?

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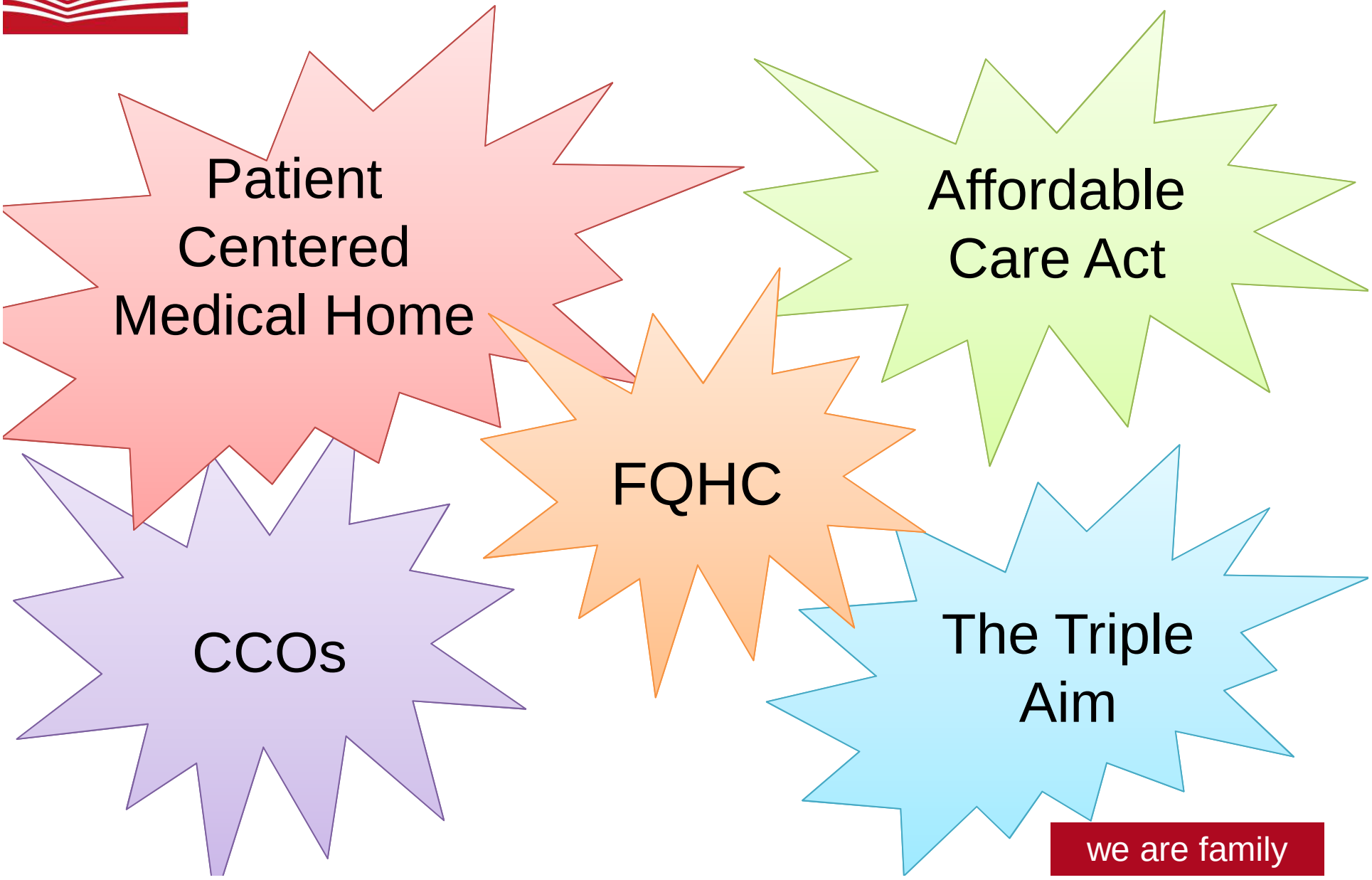
Buzz Words to Know



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The Affordable Care Act

- The ACA created new healthcare delivery structures for Medicaid and Medicare (like CCOs)
- In states that expanded Medicaid (Oregon and Washington did), decreased uninsured population
- For RDNs: created environment for transformation and innovation, including alternative healthcare delivery and payment models

Coordinated Care Organizations

Jackson Care Connect

UHA Umpqua Health Alliance

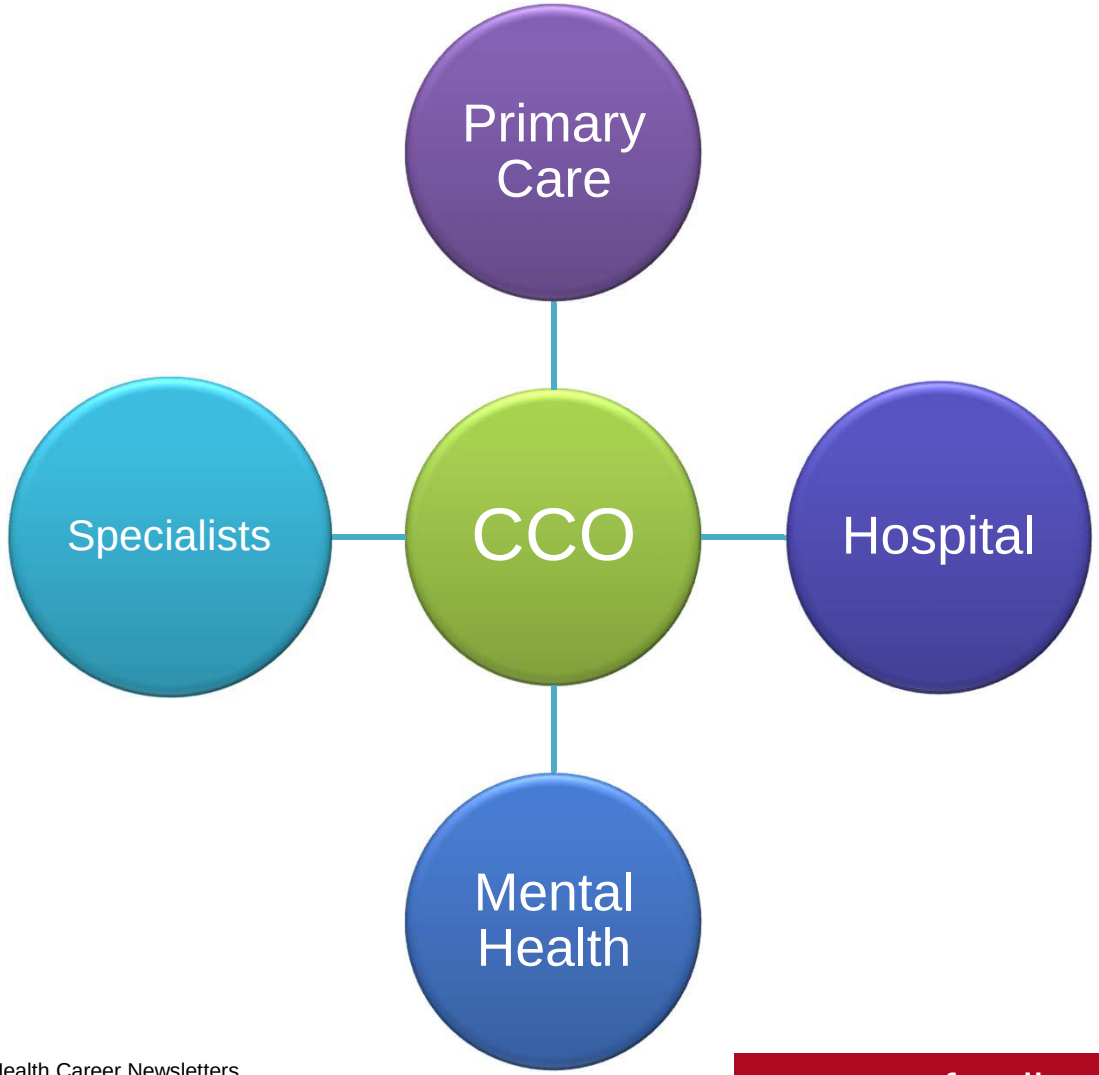
FamilyCare health plans

health share Health Share of Oregon

CareOregon

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION

PacificSource Community Solutions



Resources: Clackamas County Health, Housing, and Human Services; Health Career Newsletters

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Payment Models

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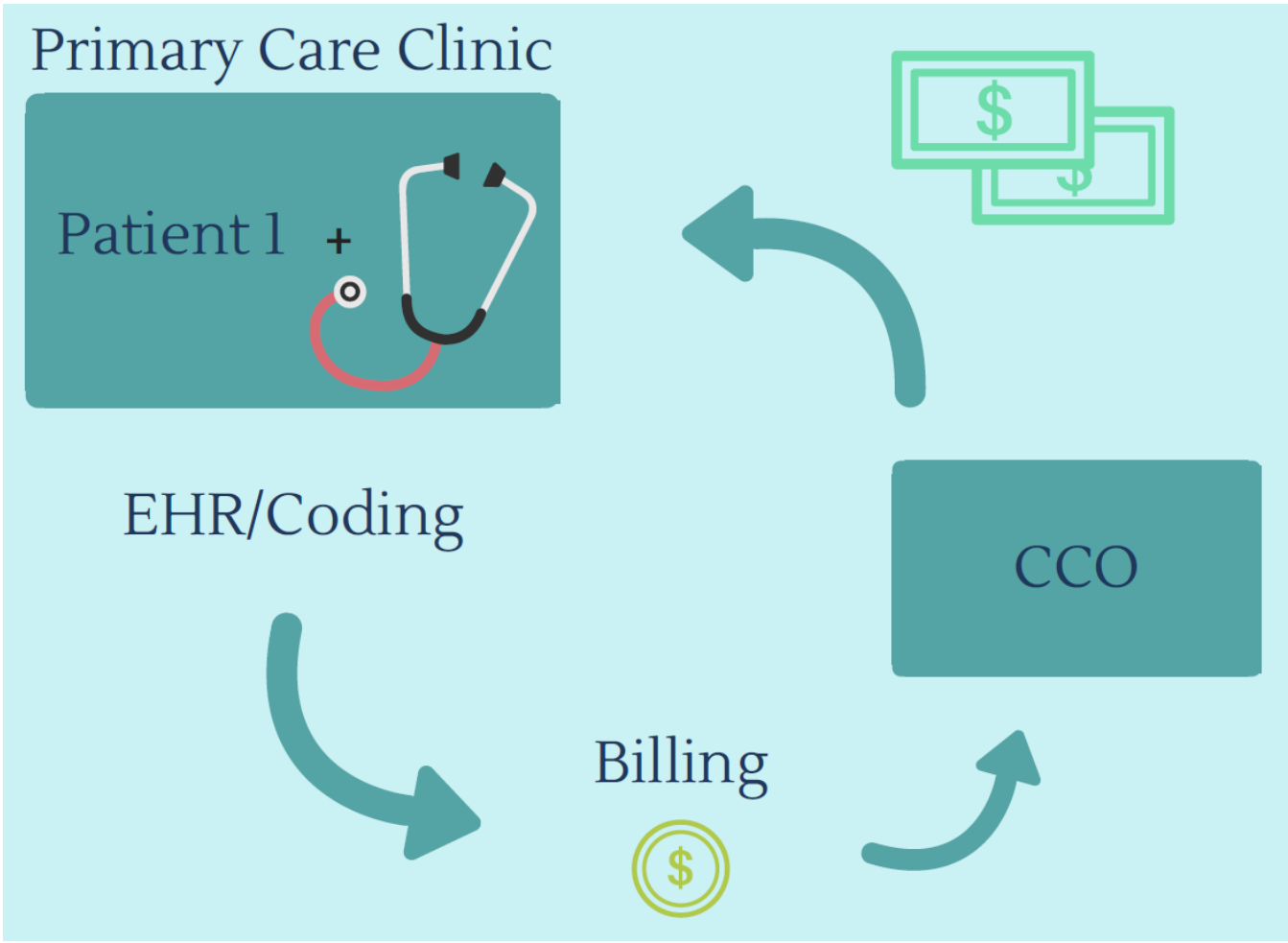
Fee for Service



Resources: Oregon Primary Care Association, Jortberg White Paper,

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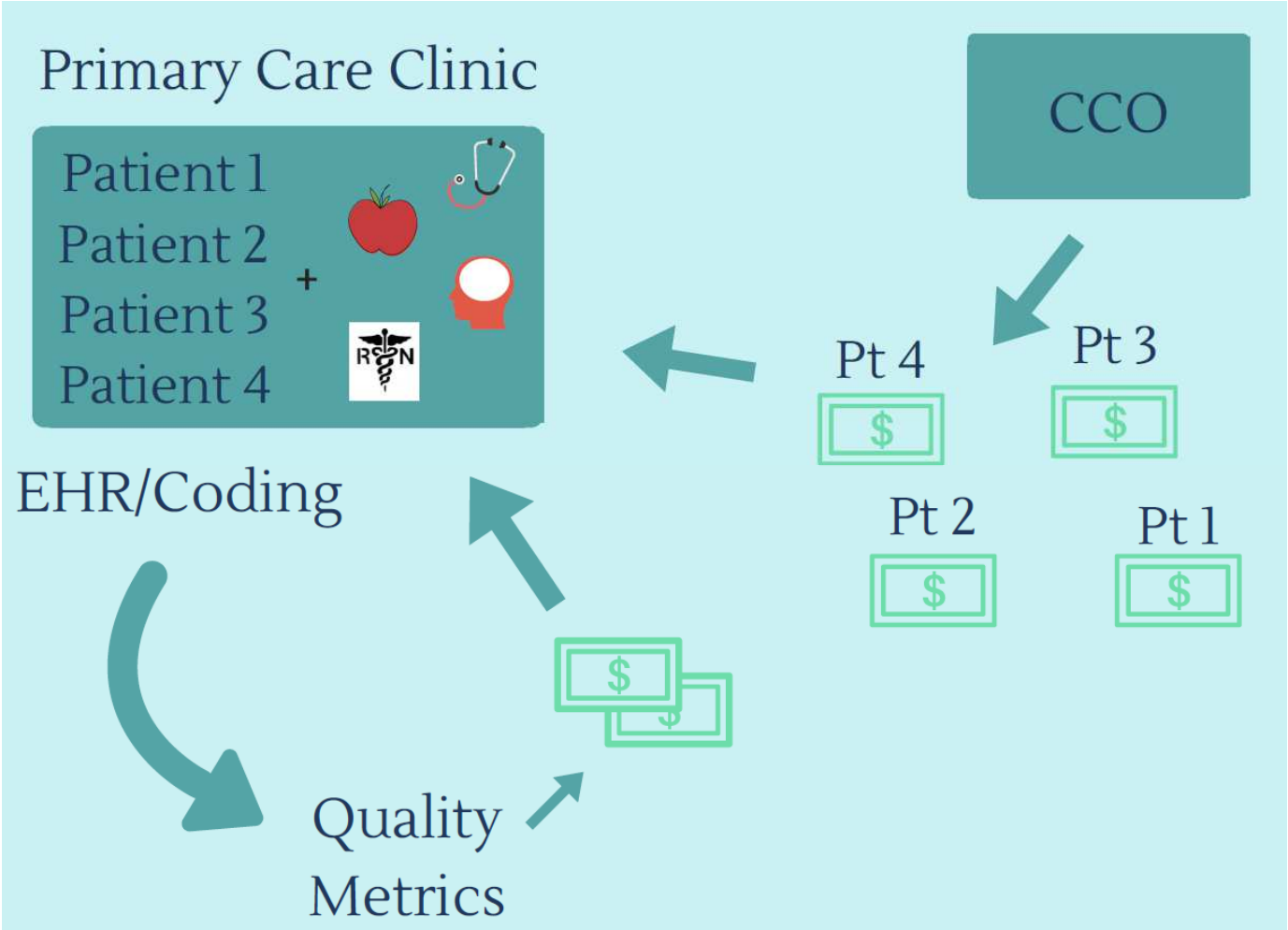
Alternative Payment Methodology



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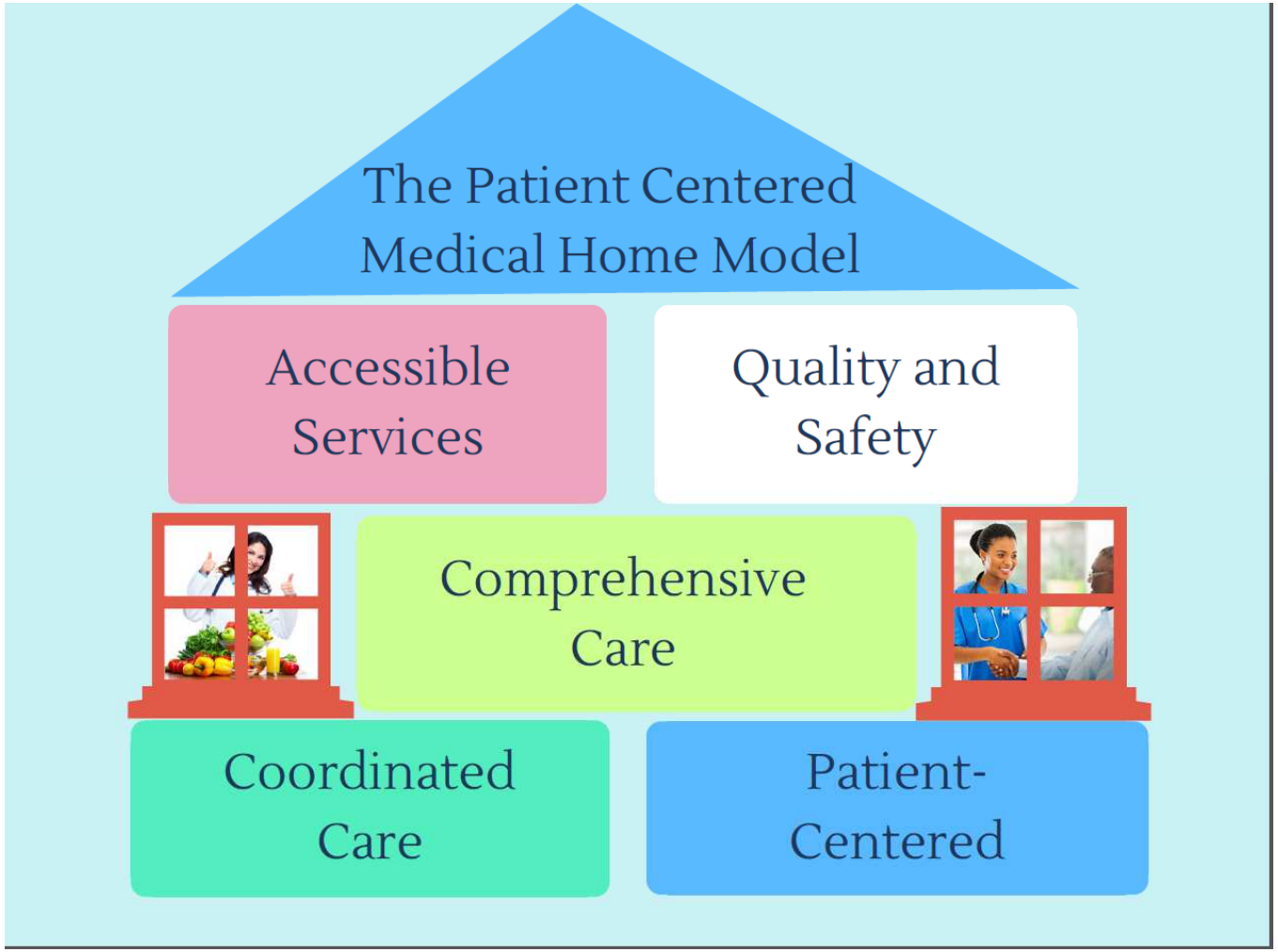
What is Primary Care?

Making Primary Care Better: Experiments in Front Line Medicine

The Patient Centered Medical Home Model



Resources: AHRQ Patient Centered Medical Home Resource Center

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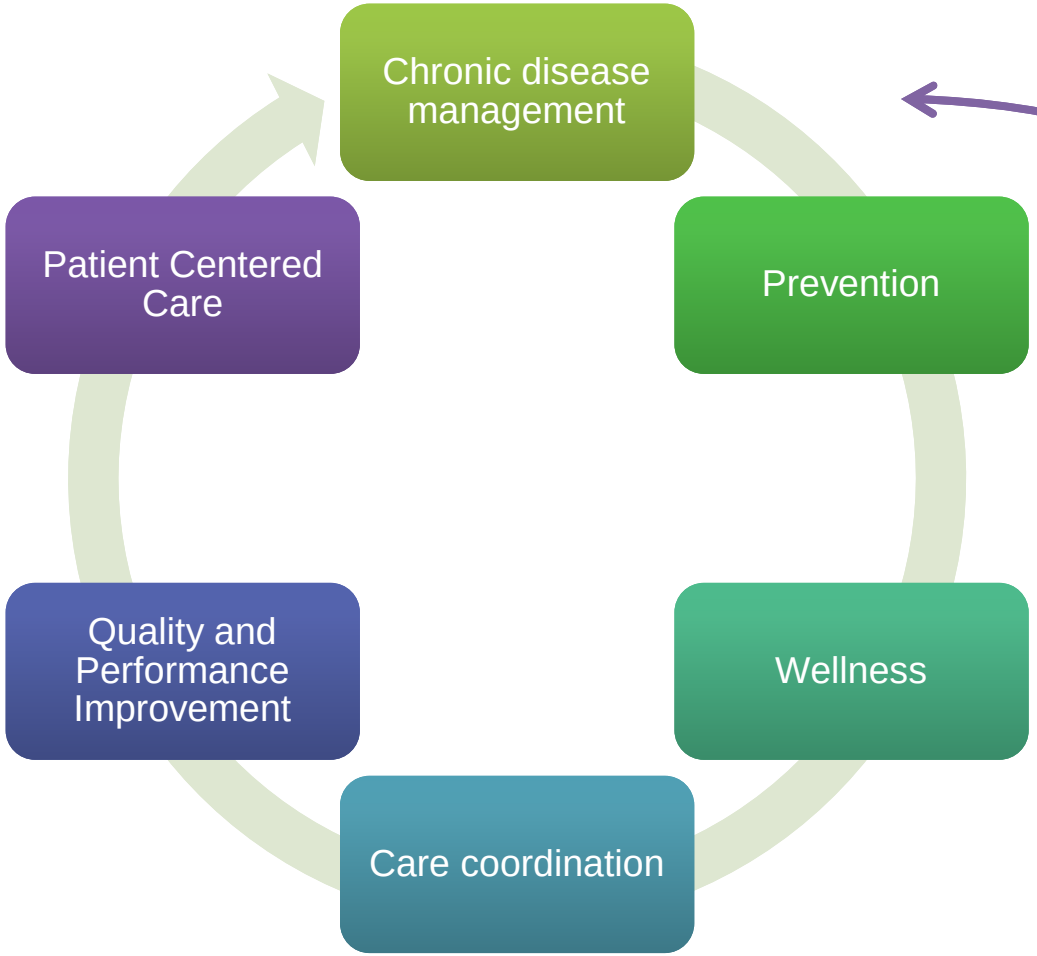
RDNs have the unique skill set to contribute to PCMH goals:



RDNs have the unique skill set to assist with these goals!

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Comparing Models

Traditional Primary Care	Patient-Centered Medical Home
Physician makes decisions 	Care Teams
	Patient Registries
Limited chronic disease monitoring	 Care Coordination
Clinic open during average work hours 	Extended Patient Access
Limited patient involvement	 Patient/Family Centered Care

Our Patient Centered Medical Home Team

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How does this relate to RDNs?

- RDNs currently have important window of opportunity into the primary care world
- Primary care is an ideal place for RDNs
  - *Prevention and wellness*
  - *Chronic disease management*
  - *Opportunities for leadership skills*
- Urgency for need to recognize this huge opportunity for the profession

A Growing Field: Primary Care Dietetics

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What are one or two things you think a primary care RDN would do in his/her job?

Who wants to share?

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What is Primary Care Dietetics?

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Clinical + Community

Clinical

- Medical Nutrition Therapy
- Chronic disease management
- Multidisciplinary efforts

Community

- Prevention
- Program design and implementation
- Outreach
- Community collaboration
- Social Determinants of Health
- Population health Management

Why should RDNs be in primary care?

Less than 45% of primary care visits by adults with hyperlipidemia, hypertension, obesity, or diabetes mellitus include diet counseling, and only 30% of visits include physical activity counseling.

American College of Preventive Medicine. “Coaching & Counseling Patients Clinical Reference For Nurses” Accessed 5 November 2015: http://www.acpm.org/?NurseCoachingClinRef#RolePrimaryCare

Approximately 60% of patients coming into our clinics on any given day have a nutrition-related diagnosis.

Basically, most patients with a diet-related chronic disease aren’t receiving diet counseling , and fewer receive physical education counseling.

Why?

- PCPs don't have time (average PCP visit is 16-18 minutes)
- Acute concerns crowd out chronic care management
- Physicians' poor self-efficacy and lack of training in behavior change
- Only about ¼ feel very effective in their counseling of exercise, diet, and weight reduction

American College of Preventive Medicine. "Coaching & Counseling Patients Clinical Reference For Nurses" Accessed 5 November 2015: http://www.acpm.org/?NurseCoachingClinRef#RolePrimaryCare

Our Model

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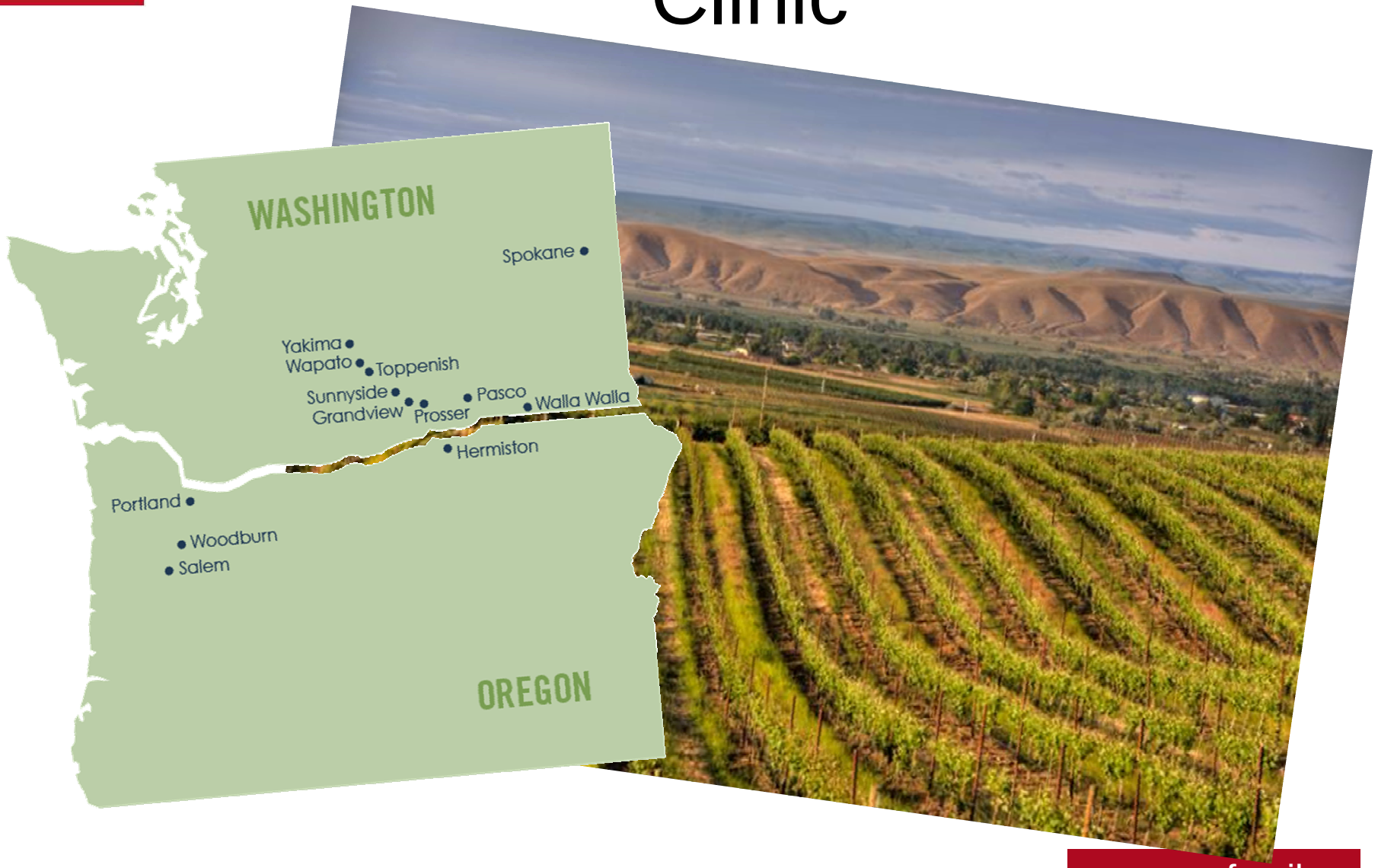
Yakima Valley Farm Workers Clinic



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A look at our population

- 34% are migrant/seasonal farm workers
- 20% are uninsured
- 58% are on Medicaid
- 74% are at 100% or below the FPL
- 12% are homeless
- 48% of patients' primary language is not English

Data from the 2014 YVFWC Report to Our Communities, the 2013 YVFWC Report and Washington Behavioral Risk Factors Surveillance System 2011-2013

Our Team

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What we’re doing

Reaching our patients as part of their regular clinic visit, expanding the typical primary care 15-minute visit into a longer encounter by utilizing the care team (RDs, BHCs, etc.) and regularly completing brief interventions.

Our model includes:

- Integration of care team
- Integrated providers
- Helping meet organization measures
- Interdepartmental collaborations
- Community collaborations

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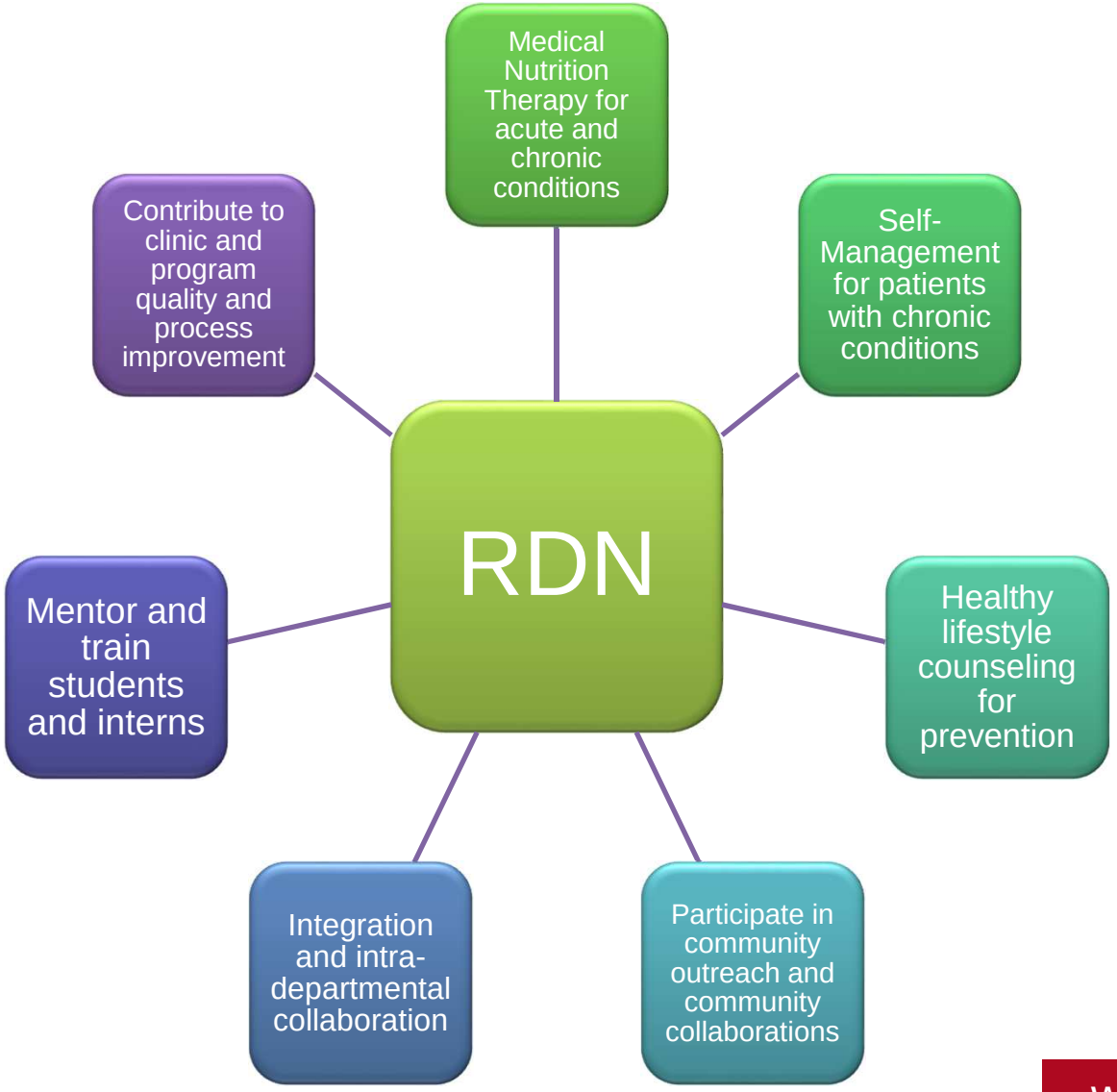
Traditional Role of the Outpatient RDN

Role of the Primary Care RDN



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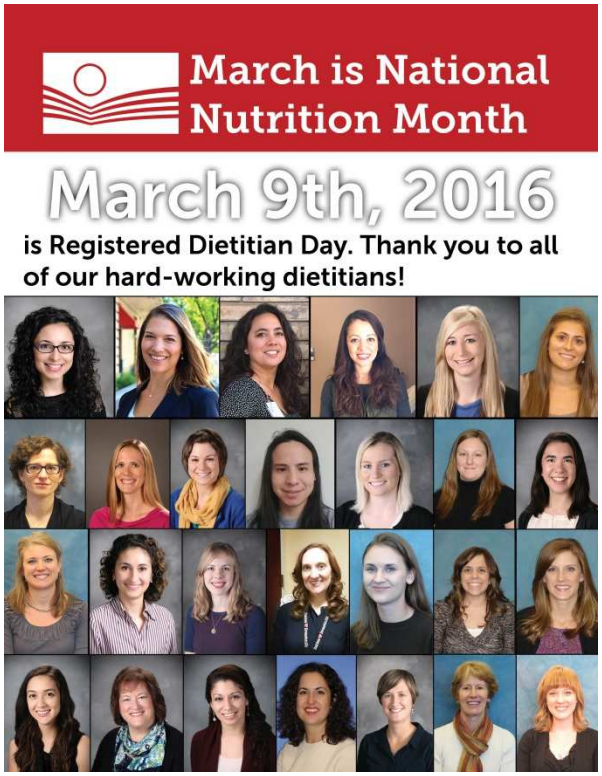
	Typical Outpatient Nutrition Model	YVFWC Nutrition Model
RD Availability	Limited, possibly 1 day/week, not at all sites	Full-time at every clinic
Accessibility	Long wait for available appointments; only most urgent patients referred; depends on insurance coverage; only covered diagnoses	Same day access, before or after visit with provider; all patients seen regardless of insurance status or diagnosis
Appointment Type	All scheduled	Mostly warm hand-offs
Counseling Style	Complete nutrition assessment (food recall, etc.), extensive nutrition education, treatment plan consists of several goals	Brief, Motivational Interviewing, short assessment and education based on patient's priorities, 1-2 patient-set goals
Appointment Length	60 minutes	15 minutes
Patients Seen Per Day	Average 8 patients/day, factor in no-show rate	~15 patients/day

Video

Warm Handoff Model



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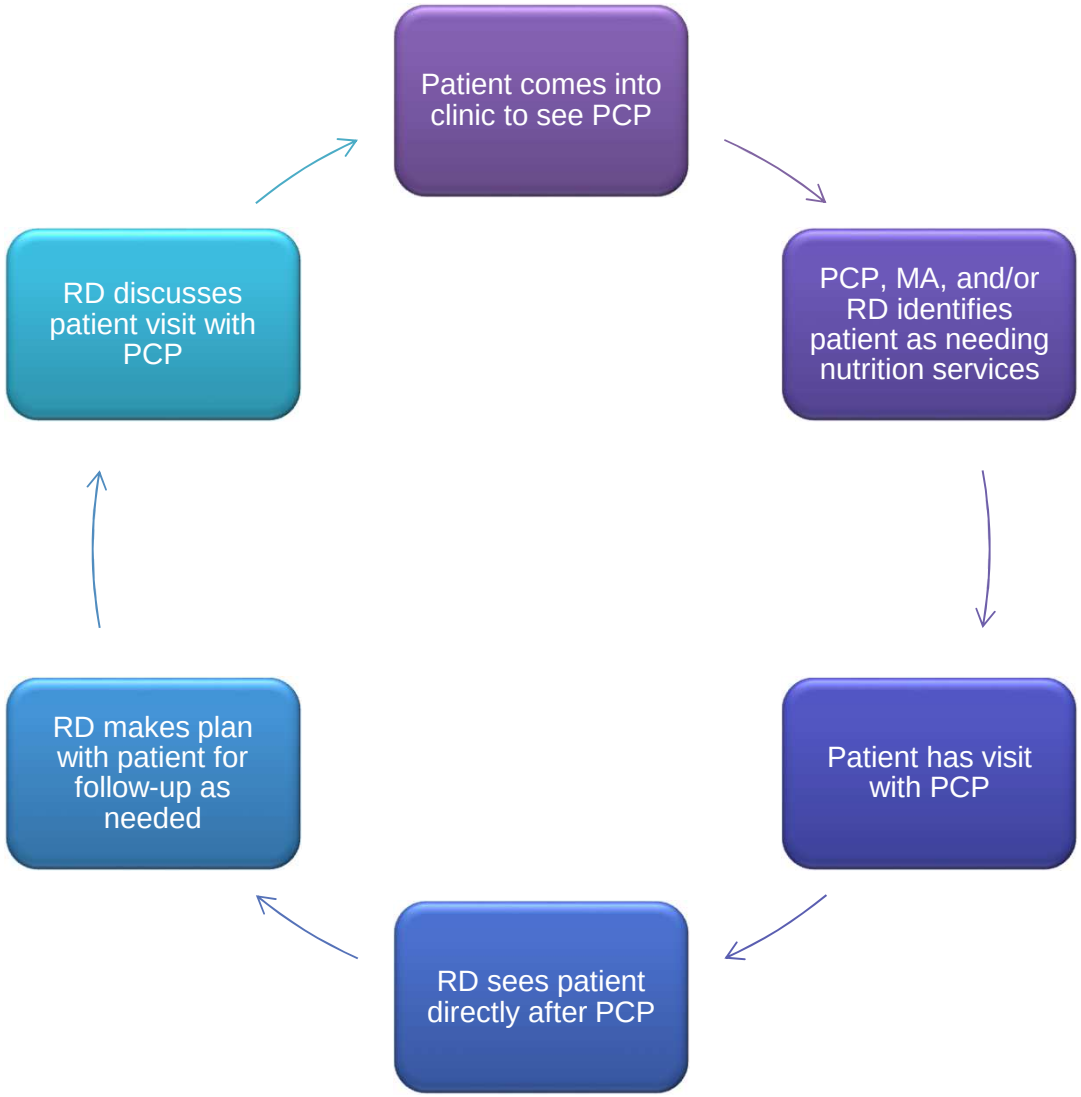
Warm Handoff Model



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1. Patient comes into clinic

2. PCP sees patient

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3. Patient identified for RDN visit
   - By PCP, MA, RN, RD, self-referred
   - Using reports, registries, screens, chart scrubbing
   - Identified before or while patient in clinic

Time	Provider	[redacted]	Type 2 Diabetes	Diabetes Self-Mgmt	Other Diabetes	Cardio-vascular	Weight Management	Digestive	Prevention
10:30 am	CARLTON, ANNE	[redacted]	X					X	
10:40 am	SHAW, KATHY T.	[redacted]				X			
10:40 am	DRAPIZA, LESLIE A.	[redacted]							WELL CHILD CHECK
10:40 am	OCHOA SOSA, SILVIA	[redacted]	X	12/24/2014		X			
10:45 am	LFHC OB INTAKE	[redacted]	X						
11:00 am	SHAW, KATHY T.	[redacted]							NEW PATIENT
11:00 am	LFHC LAB	[redacted]	X	03/23/2015		X			
11:00 am	WIESENFELD, AMBER F.	[redacted]						X	
11:00 am	BARLOW, MELANIE	[redacted]						X	
11:00 am	OCHOA SOSA, SILVIA	[redacted]							WELL CHILD CHECK
11:20 am	LFHC NURSE	[redacted]			X				
11:20 am	OCHOA SOSA, SILVIA	[redacted]						X	
12:00 pm	BARLOW, MELANIE	[redacted]						X	
12:40 pm	DRAPIZA, LESLIE A.	[redacted]				X			
1:00 pm	LFHC OB INTAKE	[redacted]							NEW OB VISIT/INTAKE
1:00 pm	SHAW, KATHY T.	[redacted]				X			
1:00 pm	TRUXILLO, LAUREN	[redacted]				X			
1:20 pm	TRUXILLO, LAUREN	[redacted]				X			
1:40 pm	OCHOA SOSA, SILVIA	[redacted]							WELL CHILD CHECK
2:00 pm	TRUXILLO, LAUREN	[redacted]							NEW PATIENT
2:00 pm	LFHC OB INTAKE	[redacted]							NEW OB VISIT/INTAKE
2:00 pm	WHITE, LAURA J.	[redacted]						X	
2:00 pm	BARLOW, MELANIE	[redacted]	X	04/29/2015	X	X			
2:20 pm	DRAPIZA, LESLIE A.	[redacted]							WELL CHILD CHECK
2:20 pm	WIESENFELD, AMBER F.	[redacted]				X			
2:40 pm	DRAPIZA, LESLIE A.	[redacted]							WELL CHILD CHECK
2:40 pm	TRUXILLO, LAUREN	[redacted]							WELL CHILD CHECK
3:00 pm	WIESENFELD, AMBER F.	[redacted]					X		WELL CHILD CHECK
3:00 pm	LFHC OB INTAKE	[redacted]							NEW OB VISIT/INTAKE
3:00 pm	LFHC NURSE	[redacted]	X	03/17/2015		X			
3:00 pm	OCHOA SOSA, SILVIA	[redacted]							WELL CHILD CHECK
3:00 pm	BARLOW, MELANIE	[redacted]				X			
3:20 pm	TRUXILLO, LAUREN	[redacted]				X			

Time	Provider	Patient Name	MRN	Type 2 Diabetes	Diabetes Self-Mgmt	Other Diabetes	Cardio-vascular	Weight Management	Digestive	Prevention
10:30 am	CARLTON, ANNE			X					X	
10:40 am	SHAW, KATHY T.						X			
10:40 am	DRAPIZA, LESLIE A.									WELL CHILD CHECK
10:40 am	OCHOA SOSA, SILVIA			X	12/24/2014		X			
10:45 am	LFHC OB INTAKE			X						
11:00 am	SHAW, KATHY T.									NEW PATIENT
11:00 am	LFHC LAB			X	03/23/2015		X			
11:00 am	WIESENFELD, AMBER F.								X	
11:00 am	BARLOW, MELANIE								X	
11:00 am	OCHOA SOSA, SILVIA									WELL CHILD CHECK
11:20 am	LFHC NURSE					X				
11:20 am	OCHOA SOSA, SILVIA								X	
12:00 pm	BARLOW, MELANIE								X	
12:40 pm	DRAPIZA, LESLIE A.						X			
1:00 pm	LFHC OB INTAKE									NEW OB VISIT/INTAKE
1:00 pm	SHAW, KATHY T.						X			
1:00 pm	TRUXILLO, LAUREN						X			
1:20 pm	TRUXILLO, LAUREN						X			
1:40 pm	OCHOA SOSA, SILVIA									WELL CHILD CHECK
2:00 pm	TRUXILLO, LAUREN									NEW PATIENT
2:00 pm	LFHC OB INTAKE									NEW OB VISIT/INTAKE
2:00 pm	WHITE, LAURA J.								X	
2:00 pm	BARLOW, MELANIE			X	04/29/2015	X	X			
2:20 pm	DRAPIZA, LESLIE A.									WELL CHILD CHECK
2:20 pm	WIESENFELD, AMBER F.						X			
2:40 pm	DRAPIZA, LESLIE A.									WELL CHILD CHECK
2:40 pm	TRUXILLO, LAUREN									WELL CHILD CHECK
3:00 pm	WIESENFELD, AMBER F.							X		WELL CHILD CHECK
3:00 pm	LFHC OB INTAKE									NEW OB VISIT/INTAKE
3:00 pm	LFHC NURSE			X	03/17/2015		X			
3:00 pm	OCHOA SOSA, SILVIA									WELL CHILD CHECK
3:00 pm	BARLOW, MELANIE						X			
3:20 pm	TRUXILLO, LAUREN						X			

- Chart scrubbing

Provider	PVP To Do	Last BMI	Last BP	Last HBA1C
tment e J. Miller, PA-C	Schedule with dietitian	40.37 kg/m²	150/70	9.4
Natalie J. Miller, PA-C	Schedule with dietitian	19.18 kg/m²	100/62	
Natalie J. Miller, PA-C		24.38 kg/m²	112/78	
Natalie J. Miller, PA-C		None	None	

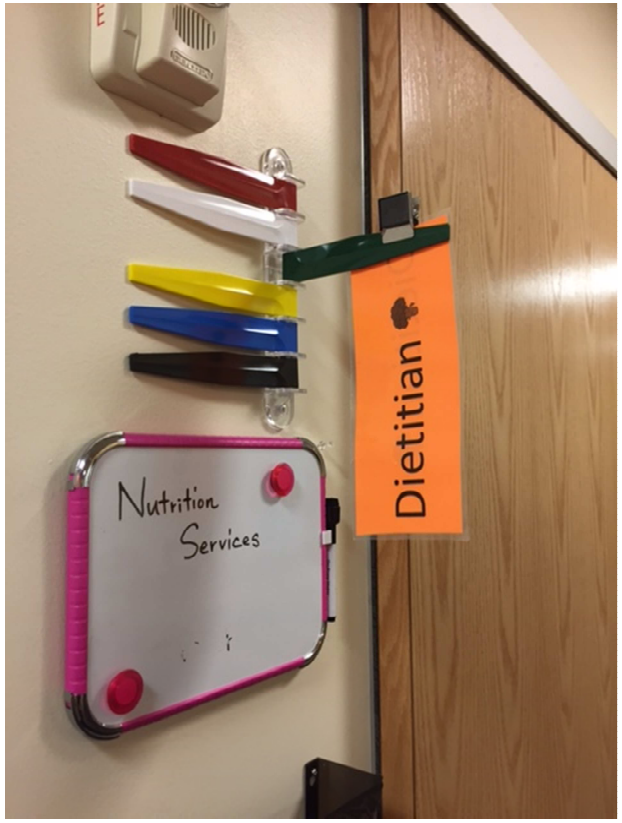
Schedule with dietitian

4. RD sees patient

5. RD discusses patient with PCP and/or routes chart note to PCP

Brief Interventions

- RDNs utilize Motivational Interviewing counseling techniques
- 15 minute appointments
- Goal-setting
- Barriers and social determinants of health assessment



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Population Management

What is a registry? A list of your patients with a distinct medical condition or age-related need. The basic tool that allows the healthcare team to work together to provide the comprehensive care you want for your patients.

Age	[redacted]	PCP	Risk Score	Disease Risk	Last SW Date	Last HBA1C	HBA1C Date	Is on Insulin?	Last BP	Next Appt	Last Appt With Me	Next Appt With Me	Last Visit Date	Last BP Dt	Last microalbu
40 y.o.	[redacted]	Tacheny, Heather	4	D3	5/18/2015	9.5	08/24/2015	No	134/92	09/24/2015			8/24/2015	8/24/2015	
65 y.o.	[redacted]	Opera, James	3	D2	8/10/2015	6.1	08/10/2015	No	140/70				9/2/2015	9/2/2015	02/13/2014
57 y.o.	[redacted]	Madsen, Alison D.	2	D2	4/27/2015	7.2	04/27/2015	No	130/90					4/27/2015	01/22/2015
46 y.o.	[redacted]	Opera, James	1	D1	3/18/2015	5.9	06/22/2015	No	112/64					6/22/2015	05/12/2014
67 y.o.	[redacted]	Madsen, Alison D.	1	D1	8/31/2015	6.7	08/07/2015	No	130/60				8/31/2015	8/31/2015	08/07/2015
55 y.o.	[redacted]	Madsen, Alison D.	1	D1	4/9/2014	6.4	08/28/2014	No	112/62	09/28/2015				10/13/2014	06/26/2013
56 y.o.	[redacted]	Rodriguez, Evelyn	0	D1	12/8/2014	7.5	04/17/2015	No	120/78	09/21/2015				4/27/2015	05/27/2014
42 y.o.	[redacted]	Tacheny, Heather	4	D3	2/19/2014	9.2	05/13/2015	No	118/82					5/13/2015	01/19/2015
61 y.o.	[redacted]	Opera, James	0	D1	9/12/2013	5.8	04/01/2015	No	128/72	10/05/2015			8/24/2015	8/24/2015	04/01/2015
49 y.o.	[redacted]	Tacheny, Michael	2	D2	1/26/2015	6.6	01/22/2015	No	132/76	09/30/2015				3/23/2015	03/02/2015
65 y.o.	[redacted]	Dempster Summers, Matthew D.	1	D1	1/7/2015	8.2	05/05/2015	No	138/82					7/24/2015	01/02/2015
57 y.o.	[redacted]	Rodriguez, Evelyn	3	D2	10/2/2013	12.1	03/18/2015	No	100/78					4/10/2015	03/19/2015
45 y.o.	[redacted]	Tacheny, Michael	1	Insufficient data				No	124/82					7/20/2015	

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Diabetes Self-Management

- Diabetes self-management measures required for PCMH accreditation
- RDs were part of PCMH clinic implementation teams
  - Made sense to take on SM as nutrition experts and trained in Motivational Interviewing
  - Accessible model meant easy referrals
  - Population approach (diabetes registry)
- Monitored data to show completion of different SM measures by clinic
- RDNs complete 80-90%

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RD Impact on SM Completion

	Oct. 2013	Dec. 2013	Mar. 2014
RD FTE at Yakima Medical	0.5	1.0	1.0
Rate of Completed SM Assessments at Yakima Medical	15%	50%	73%

% of Self-Management visits completed by RDNs

YAKIMA MEDICAL-DENTAL CLINIC	NUNEZ, MAYRA	97	100%
	Total	97	100%
MIRAMAR HEALTH CENTER	SUTHERLAND, LAURA	34	100%
	Total	34	100%
MIRASOL FAMILY HEALTH CENTER	MELENDEZ-BLANCH, ANGELIQUE	2	4%
	NGUYEN, AMY F.	1	2%
	SUTHERLAND, LAURA	48	94%
	Total	51	100%
FAMILY MEDICAL CENTER	DAWS, PAMELA	37	100%
	Total	37	100%
GRANDVIEW MEDICAL & DENTAL CLINIC	PARODI, MONICA	60	100%
	Total	60	100%
SALUD MEDICAL CENTER	CUTTS, JULIETTE L.	1	2%
	MILLER BLACKWELL, NORA	31	53%
	THOMAS, SARAH	25	43%
	TURBES, ANNA S.	1	2%
	Total	58	100%
TOPPENISH MEDICAL-DENTAL CLINIC	ACEVEDO, CECIA (DIANELY)	73	94%
	FOX-BEHRLE, VICTORIA F.	3	4%

New Efforts

- Food insecurity screening
- Dental collaborations
- Oregon Food Bank diabetes collaboration
- Grocery store tours
- RDN staffing model
- Strategic plan
- Veggie prescription program
- CSA prescription program

- Integrated provider work
- BMI/ped counseling measures
- Aligning with org metrics
- Patient satisfaction

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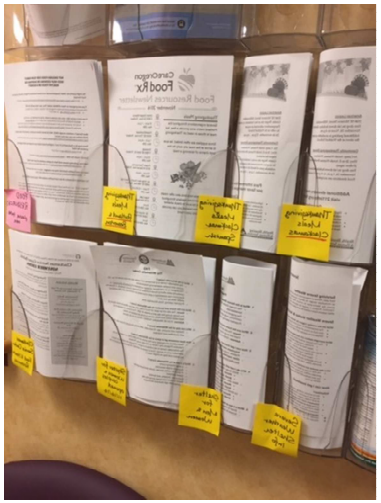
Value Brought by RDNs

- Accessible and visible to both providers and patients
- Expertise
- Aligned with organizational goals
- Involved
- Team-focused



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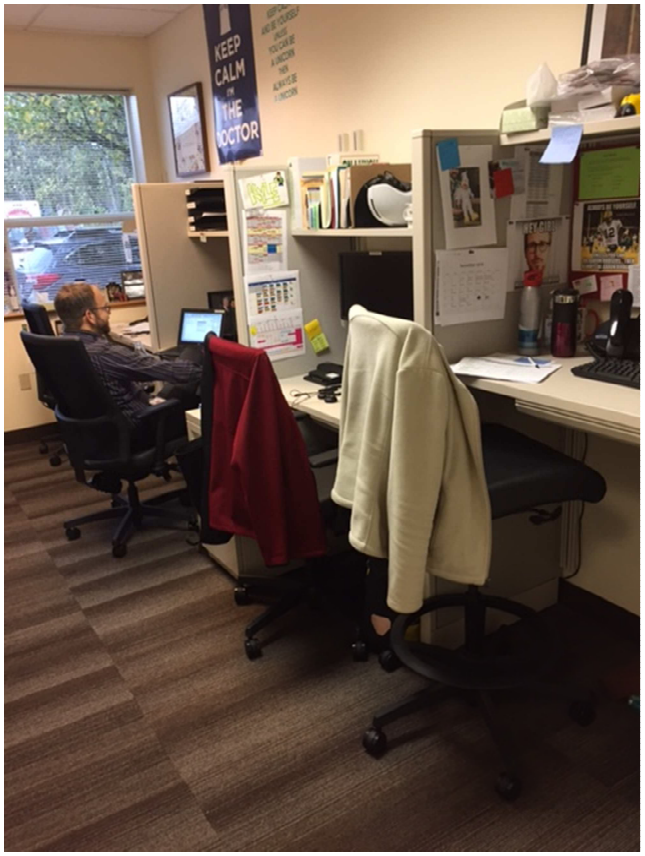
Tips for Successful Integration



- Co-location and availability

- Collaborate with integrated provider peeps
- Participate in clinic meetings
- Shadow each other
- Network with clinic admin and providers
- Get to know all staff
- Make it easy for them
- Scrub charts, put in the work
- Clear lines of communication
- Know how to market yourself!

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Characteristics of a successful primary care RDN

- Flexibility
- “Go with the flow” attitude
- Go-getter
- Confidence working with other health professionals higher on the traditional food chain
- Detail-oriented
- Listening skills
- Motivational Interviewing training
- Experience working with underserved populations

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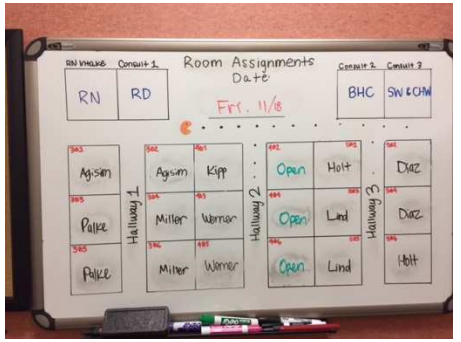
I’m interested. What next?

- Learn about healthcare transformation, different models, payment structures
- Read RDNs in the New Primary Care Toolkit at www.eatrightpro.org
- Know your organization’s goals; how can you play a part in improving outcomes and increasing reimbursement?
- AND RDNs in Healthcare Transformation group/listserv
- Take initiative to speak with leadership
- Attend primary care and health care conferences
- Students—ask for primary care rotations
- Reach out to others and build contacts doing similar work
- Share ideas with others
- Share resources with others



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Know Organization's Goals

- Be part of the conversation to figure out how you can help reach goals
  - Attend clinic/organization meetings and problem-solve with the team – you might have to invite yourself!
  - Get involved in the early stages of organizational transitions and new efforts – if you come in late you might be left behind
  - Seek out opportunities – grants, metrics
- Create PDSAs and new workflows around reaching goals
- Measure outcomes!

Outside Networking

- Attend primary care and health care conferences (e.g. Oregon Primary Care Association, Oregon Health Authority, Oregon Public Health Association)
  - Introduce yourself, network, think about presenting!
- State structures/CCO always looking for innovative models and solutions to improve care and meet metrics

WIC/Primary Care

- YVFWC's program started with WIC RDNs 1 day/week in primary care clinic
- Lots of overlap in type of counseling/services

- Considerations: MNT for all ages population vs. 0-5 yo, PP and OB population, flexible/unknown patient load

Action Step Today

Take initiative to speak with leadership and key players

- Share examples of effective Nutrition Services models
- Know what's important to key players (e.g. helping meet measures, saving them time)

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RETHINK
YOUR
DRINK


Yakima V
m Worke


SMOOTHIES


Yakima Valley
Farm Workers Clinic

Thank you!

I’m grateful to have spoken with you all today – thank you for your time!

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