Registered Dietitian Nutritionists Bring Value to Emerging Health Care Delivery Models

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ABSTRACT

Health care in the United States is the most expensive in the world; however, most citizens do not receive quality care that is comprehensive and coordinated. To address this gap, the Institute for Healthcare Improvement developed the Triple Aim (ie, improving population health, improving the patient experience, and reducing costs), which has been adopted by patient-centered medical homes and accountable care organizations. The patient-centered medical home and other population health models focus on improving the care for all people, particularly those with multiple morbidities. The Joint Principles of the Patient-Centered Medical Home, developed by the major primary care physician organizations in 2007, recognizes the key role of the multidisciplinary team in meeting the challenge of caring for these individuals. Registered dietitian nutritionists (RDNs) bring value to this multidisciplinary team by providing care coordination, evidence-based care, and quality-improvement leadership. RDNs have demonstrated efficacy for improvements in outcomes for patients with a wide variety of medical conditions. Primary care physicians, as well as several patient-centered medical home and population health demonstration projects, have reported the benefits of RDNs as part of the integrated primary care team. One of the most significant barriers to integrating RDNs into primary care has been an insufficient reimbursement model. Newer innovative payment models provide the opportunity to overcome this barrier. In order to achieve this integration, the Academy of Nutrition and Dietetics and RDNs must fully understand and embrace the opportunities and challenges that the new health care delivery and payment models present, and be prepared and empowered to lead the necessary changes. All stakeholders within the health care system need to more fully recognize and embrace the value and multidimensional role of the RDN on the multidisciplinary team. The Academy's Patient-Centered Medical Home/Accountable Care Organizations Workgroup Report provides a framework for the Academy, its members, and key partners to use to achieve this goal.
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THE ULTIMATE GOAL OF ALL health care is meeting the needs of the individual patient. In a world of limited resources, viewed through the lens of a changing population, rapid advances in knowledge, and increasingly complex needs, the concept of value—quality outcomes relative to costs (see Figure)—becomes paramount. This white paper defines the role of the registered dietitian nutritionist (RDN) in achieving value in the context of several of the new payment models.

Health care in the United States is the most expensive in the world, accounting for 17% of the gross national product, and estimates put that percentage to 20% by 2020.[1] Although the United States spends a significant amount of money on health care, most of our citizens do not receive quality care that is comprehensive and coordinated. To address this gap, the Institute for Healthcare Improvement developed the Triple Aim—defined as simultaneously improving population health, improving the patient experience of care, and reducing per-capita cost—as a goal for new health systems that contribute to the overall health of populations while reducing costs.[1] Both the patient-centered medical home (PCMH) and the concept of the accountable care organization (ACO) have adopted the Triple Aim as a fundamental notion in improving health care.

Considering the complexities of providing quality care and meeting patients' health care needs, it is difficult to imagine any clinician providing care in isolation. The incorporation of multiple perspectives of various disciplines offers the benefit of diverse knowledge and experience. Therefore, a high-performing multidisciplinary team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective health care delivery system.[2]

THE PCMH AND ACO

The concept of patient-centeredness was identified as one of the six aims of quality in the Institute of Medicine's 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st*

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All registered dietitians are nutritionists, but not all nutritionists are registered dietitians. The Academy's Board of Directors and Commission on Dietetic Registration have determined that those who hold the credential Registered Dietitian (RD) may optionally use "Registered Dietitian Nutritionist" (RDN) instead. The two credentials have identical meanings. In this document, the term RDN is used to refer to both registered dietitians and registered dietitian nutritionists.

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$$Value = \frac{\text{Quality Outcomes}^{a}}{\text{Costs}^{b}}$$

[a]Person's needs and goals met.
[b]Not just dollar costs, but also reputational costs and market share.

Figure. Definition of "value" in health care.

Century.[3] The Institute of Medicine stated that patient-centeredness is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."

In 2002, a group of national family medicine organizations launched The Future of Family Medicine Project. This project culminated with the publication of "The Future of Family Medicine: A Collaborative Project of the Family Medicine Community."[4] The final recommendations of this report would prove to be prescient, recognizing the needs of the American population in a changing world. It stated: "The leadership of US family medicine organizations is committed to a transformative process. In partnership with others, this process has the potential to integrate health care to improve the health of all Americans. This process should include taking steps to ensure that every American has a personal medical home."

Following in the footsteps of this report, the American College of Physicians published a policy paper, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care" [5] that proposed fundamental changes in the way primary care is delivered.

The PCMH is a philosophy of primary care that is focused on the individual. It delivers comprehensive, team-based, coordinated, and accessible care, and it continually strives toward the six aims of quality. It is a philosophy of health care delivery that encourages providers and care teams to work together to meet the needs of the individual and their families, where people are treated with respect, dignity, and compassion, and enable strong and trusting relationships with all members of the care team. Above all, the medical home is not a final destination; instead, it is a model for achieving primary care excellence. The medical neighborhood is an important part of the PCMH, as it includes other health care services for the patient, including the RDN, community and social service organizations, and state and local public health agencies.

The goals of improving population health and managing costs have been consistent across countries and populations. There is a strong correlation between primary care and population health. Several studies have compared primary care internationally and within the United States. These have provided evidence of the benefits of strong primary care, in terms of better opportunities to control costs, improved quality of care, better population health, and less socioeconomic inequality in health.[6-8] Studies have shown that regions with a higher primary care physician density, but not a higher specialist density, have a healthier population than regions with a higher specialist and lower primary care physician density.[9-11]

Both the structure of care and the coordination and comprehensiveness of primary care have a positive relationship with health outcomes for individuals with chronic disease, such as ischemic heart disease, cerebrovascular disease, diabetes, asthma, bronchitis, and emphysema.

ACOs are essentially defined as a coalescence of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth for a defined population of patients.[12] These health care organizations may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians, such as independent practice associations. RDNs are active and valuable resources within and for these systems. Many of these ACOs encompass primary care practices that are recognized as PCMHs. With the enactment of the Patient Protection and Affordable Care Act of 2010 (the Patient Protection and Affordable Care Act of 2010 includes a number of provisions that establish ACOs in Medicare and other federal programs and that encourage public-private collaboration for accountable care. These include a "shared savings" accountable care program in Section 3022 and additional flexibility for implementing accountable care in Section 10307),[13] the concept of ACOs as an alternative to the current volume-based system now has the official imprimatur of health reform. Consumers and health care professionals alike have anticipated change in both the effectiveness and clinical efficiency of a damaged system. However, despite some encouraging reports, to date the ACOs have not demonstrated the significant savings originally envisioned.[14] Regardless of the outcomes of ACOs in particular, the overall concept of population health management remains critical to the success of achieving the Triple Aim. Concomitant to this goal, teams that include RDNs must be part of any care-delivery strategy focused on managing the health of populations.

Implementation of ACOs is likely to be more effective if it can be aligned with a range of other reforms that also increase the emphasis on and support for improving quality and reducing costs. This is particularly true for primary care–oriented reforms, such as the PCMH.[12]

ROLE OF THE PRIMARY CARE PHYSICIAN

The Joint Principles of the Patient-Centered Medical Home,[15] as adopted by the Patient-Centered Primary Care Collaborative, includes the following principles:

- The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care, chronic care, preventive services, and end-of-life care.
- Care is coordinated and/or integrated across all elements of the complex health care system (eg, nutrition services, subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (eg,