Integrating the Registered Dietitian (RD) into Primary Care:
Comprehensive Primary Care Initiative (CPCI)
Introduction

Welcome to the Academy of Nutrition and Dietetics (Academy) Center for Medicare & Medicaid Innovation (CMMI) Comprehensive Primary Care Initiative (CPCI) toolkit. The goal of the CPCI is to help primary care practices deliver higher quality, better coordinated, and more patient-centered care. The CPCI project was made possible by the Affordable Care Act (ACA) and recognizes that a primary care practice is a key point of contact for patients' health care needs. The purpose of this toolkit is to provide information to registered dietitians (RD) and primary health care providers who are participating in the CPCI about the benefits of including RDs as part of their care teams.

The Academy has developed this toolkit to provide important resources for RDs and health care providers. This toolkit is divided into five sections and will provide information on the following topics:

Section I: Introduction to the Comprehensive Primary Care Initiative: an overview of the CPCI, the Patient-Centered Medical Home (PCMH), Accountable Care Organizations (ACOs), Meaningful Use and quality measures, and how these align with opportunities for RDs.

Section II: Aligning Yourself with Comprehensive Primary Care Initiative Practices: how RDs can align with participating CPCI practices in their states or regions, including effective marketing and contractual strategies.

Section III: Comprehensive Primary Care Initiative Team-Based Care: an overview of team-based care in a PCMH and the opportunities for RDs to become fully integrated care team members as part of the CPCI project.

Section IV: Quality Measures and Measuring Effectiveness: an overview of the quality measures for CPCI and the role of the RD in collecting and reporting quality measures.

Section V: Resources and Tools: resources and tools for the CPCI project.

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We are grateful to the registered dietitians who shared their time to create, write, and review this toolkit:

Academy of Nutrition and Dietetics Coding and Coverage Committee:
Jessie Pavlinac, MS, RD, CSR, LD (Chair)
Jaime Lynn Lewis, RD, LDN (Vice-chair)
Keith Ayoob, EDD, RD, FADA
Lucille Beseler, MS, RD, CDE, LDN
Lisa Eaton Wright, MS, RD, LDN
Judith Kolish, RD, CDE, LDN
Becky Sulik, RD, CDE, LD
Elizabeth Thompson, MPH, RD
Jane White, PhD, RD, FADA, LDN
Nancy Collins, PhD, RD, LD/N, FAPWCA
Lindsey Hoggle, MS, RD, PMP
Kari Kren, MPH, RD, LD
Sharon McCauley, MS, MBA, RD, LDN, FADA
Colleen Sloan, RD, LD/N
Anne Wolf, MS, RD

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SECTION I: Introduction to the Comprehensive Primary Care Initiative

This section provides an overview of the Comprehensive Primary Care Initiative (CPCI); describes the integration of the Patient-Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs); and outlines the opportunities for registered dietitians (RDs) and primary care practices in this new model of care. The results of the CPCI may have important implications for primary care delivery in the future, and this is an important time for RDs and primary care clinicians to understand the initiative.

CPCI Overview

The CPCI will be testing a different delivery model and primary care compensation structure with the goal of driving improvements for health care quality and financial outcomes. The aim of CPCI is better health, better care, and lowered cost through practice improvement and payment reform. The CPCI project is based on the results from several PCMH demonstration projects:

- Community Care of North Carolina program: focused on care coordination in primary care; results showed a decrease in preventable hospitalizations for asthma (40%) and visits to the emergency room (16%).
- Group Health Cooperative in Puget Sound program: transformed their primary care practices into PCMHs and reduced emergent and urgent care visits by 29% and hospital admissions by 6%.
- The Geisinger Health Plan’s PCMH program: reduced admission rates by 18% and hospital readmissions by 36% per year.

Other programs across the country have shown that health coverage policies that emphasize primary care, coordinated care, and other preventive strategies support a healthier population and also save the health care system money. The CPCI tests a delivery model and primary care compensation structure with the goal of driving improvements for health care quality and financial outcomes. Providers participating in CPCI are expected to incorporate “5 functions” of primary care:

1. **Manage care for patients with high health care needs:** This includes patients with serious or multiple medical conditions who need more support to ensure that they are getting the medical care needed. Participating practices will engage these patients by developing care plans that uniquely fit each patient’s individual circumstances and values.
2. **Ensure access to care:** Participating primary care practices will increase accessibility to patients 24/7 through the utilization of patient data tools to give real-time, personal health care information.
3. **Deliver preventive care:** Participating primary care practices will be able to proactively assess their patients to determine their needs and provide appropriate and timely preventive care.
4. **Engage patients and caregivers:** Participating primary care practices will have the ability to engage patients and their families in active participation in their care.
5. **Coordinate care across the medical neighborhood:** Participating practices will work together with a patient’s other health care providers and the patient to make decisions as a team.

The CPCI project implements a different payment structure for participating primary care practices. CPCI is working with Medicare and commercial and state health insurance plans to offer bonus payments to primary care doctors who better coordinate care for their patients. The compensation model is a blended one:

- **Fee for service:** participating practices charge usual fees for services rendered to patients.
- **Risk-adjusted care coordination per-member, per-month (PMPM) payments:** to support value-added nonbillable practitioner time, advanced care team functionality, or investments in health information technology (HIT) utilization. Payments will average $20 PMPM for years 1 and 2, and average $15 PMPM for years 3 and 4.
- **Share in saving eligibility:** practice-level quality and utilization metrics in many studies have shown that it costs less to provide comprehensive and coordinated health care. After 2 years, all participating practices will have the opportunity to share in a portion of the total Medicare savings in their market.

The seven states/regions chosen to participate in the CPCI include:

1. Arkansas: Statewide
2. Colorado: Statewide
3. New Jersey: Statewide
4. New York: Capital District-Hudson Valley Region
5. Ohio and Kentucky: Cincinnati-Dayton Region
6. Oklahoma: Greater Tulsa Region
7. Oregon: Statewide

There are a total of 500 practices with approximately 2,144 providers participating in CPCI that will impact approximately 313,000 estimated Medicare beneficiaries. Practices began rolling out the project in November 2012 and the required milestones each practice will need to achieve in year 1 include:

**Milestones for Improvement**

CPCI practices must meet nine milestones by the end of year 1:

- Create a budget forecast showing where CPCI money is reinvested.
- Demonstrate the provision of case management services for high-risk patients.
- Establish provider access to patient data 24/7 so providers can participate in care decisions with their patients any time, and allow patients 24/7 access to the care team.
- Demonstrate improved patient experiences.
- Demonstrate use of data to guide patient care at the care team level via use of quality management projects.
- Demonstrate active engagement across the medical neighborhood.
- Improve shared decision making with patients.
- Participate in regular learning sessions and market-based learning collaboratives.
- Meet requirements for electronic health record (EHR) Meaningful Use Stage 1.
At 12 and 18 months, payers share data with the practices and practices report measures and improvement plans. This information exchange can occur in Centers for Medicare & Medicaid Services (CMS) learning sessions. In the CPCI’s second, third, and fourth years, payers and providers continue to participate in learning sessions. At 24 months and every 6 months thereafter, practices will compare their Medicare patients’ costs and health care utilization to market targets and an evaluation of process and quality measures.

**Overview of the Patient-Centered Medical Home**

The Patient-Centered Medical Home (PCMH) is a multifaceted approach to providing health care that is based on the relationship between the patient and the provider. The concept of the PCMH began in 1967 with the American Academy of Pediatrics (AAP). In this model, the PCMH referred to having a central location for archiving a child’s medical record. In 2002, the AAP expanded the PCMH concept to include operation characteristics, including accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. In 2007, the American Academy of Family Physicians (AAFP), the AAP, the American College of Physicians (ACP), and the American Osteopathic Association (AOA) developed joint principles to describe the PCMH.2

These seven principles include:

- **Personal physician**—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- **Physician-directed medical practice**—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation**—the personal physician is responsible for providing for all of the patient’s health care needs.
- **Care is coordinated and/or integrated across all elements of the complex health care system.**
- **Quality and safety for patient care.**
- **Enhanced access to care is available through practice systems.**
- **Payment reform that appropriately recognizes the added value provided to patients who have a PCMH.**

**PCMH Recognition**

In January 2008, the National Committee for Quality Assurance (NCQA) released standards for Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH). These standards were updated in 2011. The new PCMH 2011 standards built on the success of earlier standards and have an emphasis on responsiveness to patient needs. The 2011 standards also closely align many of the specific elements of the federal program that rewards clinicians for using health information technology to improve quality (i.e., CMS and Meaningful Use). There are three different possible levels of recognition: Level 1, Level 2, and Level 3, with Level 3 the highest level of recognition. To be chosen to participate in the CPCI project, practices needed to demonstrate that they are working toward or have achieved some level of NCQA PPC-PCMH recognition.

**RDs and the PCMH**

The PCMH model recognizes a team approach to providing comprehensive patient care, including nutrition services. Responding to this new model of care, the Academy, in March 2009, appointed a Medical Home Workgroup. The PCMH workgroup was charged with gathering and assessing information related to RDs’ current involvement in this model of care and to develop a strategic plan. The Academy PCMH Workgroup sent out a survey to a random sample of 7,800 RDs and found:
• 1,056 RDs (13.5%) responded online
  o 805 RDs (77.3%) were unfamiliar with the PCMH concept
  o 236 RDs (16.5%) were familiar with the PCMH but did not work in a PCMH setting
  o 67 RDs (6.3%) participate in a PCMH model for care in 19 different states

The results of this limited survey indicate that RD knowledge and participation in the PCMH is minimal. The Academy PCMH Workgroup concluded that “RDs must take a more proactive approach if their role is to be fully recognized and funded by the PCMH.” This group developed a strategic plan to address RD participation in PCMH activities with the following two goals:

**Goal 1:** Current and future RDs are empowered to advocate for inclusion in the PCMH and other health care models as the preferred provider for food and nutrition services.

**Goal 2:** The PCMH providers value and choose RDs as preferred providers for food and nutrition services.

The full report can be accessed at “Health Care Reform (Fall 2010).”

**The Importance of RD Participation in the PCMH**

The PCMH emphasizes disease prevention and management of comorbidities. Multiple studies have shown that medical nutrition therapy (MNT) provided by an RD improves health outcomes related to chronic diseases, such as type 2 diabetes, disorders of lipid metabolism, obesity, and hypertension.3 In addition:

• The Medical Home Policy Statement calls for comprehensive health care that includes several nutrition-related services: “provision of primary care, including but not restricted to acute and chronic care and preventive services.”3
• Primary care physicians see the benefit of RDs as part of their health care team. Studies have shown that physicians believe that nutrition is important for the care of their patients, yet they feel inadequately trained to provide optimal nutrition counseling.3-4
• RDs have unique skills related to assessment and multidisciplinary team approach that are essential elements of a PCMH.
• RDs traditionally work with other team members to provide evidence-based, patient-centered care and have shown efficacy for facilitating self-management support.
• RDs have demonstrated strong management and operation skills and are well-positioned to work as case/care managers in the PCMH.

Specific marketing strategies for RDs are addressed in Section II of this toolkit.
Overview of Accountable Care Organizations
Adapted with permission from “Paradigm Shift in Health Care Reimbursement: A Look at ACOs and Bundled Services Payments.” JAND 2012; 112 (7):974-976.

ACOs are teams of doctors, hospitals, and other health care providers and suppliers working collaboratively to coordinate a patient’s care for Medicare participants. The creation of Accountable Care Organizations (ACOs) was among the many reforms born with passage of the Patient Protection and Affordable Care Act (HR 3590) in March of 2010. And with those ACOs, officials see clearly a system trending toward bundled payment models for reimbursement, away from the traditional fee-for-service approach. ‘Bundled payment’ refers to a single payment for all care related to a treatment or condition – a payment that is then apportioned to multiple providers across many settings.

In the hypothetical case of a bypass surgery for a patient suffering uncontrolled diabetes, the fee-for-service payment would entail $47,500 to the hospital and $15,000 to the surgeon; $12,000 for the hospital and $2,000 to the physician for uncontrolled diabetes management. This case assumes an additional 3 days in the hospital and another $25,000 for readmission 1 week after discharge to treat an infection from the vein. The grand total for that under the fee-for-service model would be $101,500. In contrast, under the model of bundling, the overall budget for the case would be set at $89,300. This would allow $61,000 for the hospital, $13,000 for the physician and an allowance of $15,300 for potentially avoidable costs. In comparison, the cost to the insurer is $12,200 less under the bundling model, and if readmission is prevented, the hospital and physician would be paid $12,800 more. Providers are thus financially rewarded for good outcomes rather than number of visits. However, the provider bears the risk of negative outcomes, as complications arising afterwards will not be reimbursed, nor will follow-up visits.

The triple-aim goals to be met by the ACO are improving the health of the targeted population; improving the patient experience; and improving the affordability of health care. The Medicare Shared Savings Program launched January 1, 2012.

Why is this important for the RD?
While RDs are not listed by profession in these models, institutions and providers have a financial incentive to prevent issues such as re-admission. Including RDs and nutritional services could be seen as an investment to improve the health and well-being of the patient. Those professionals, such as RDs, who can demonstrate outcome improvement will become invaluable players on health care teams at every level.

The Academy’s Marsha Schofield advises RDs to embrace the changes and move with them as they present an opportunity to shine. “RDs have strong documentation skills and a proven track record of improving outcomes,” she points out. “Adding these assets can help them rise above competitors from other fields. Speaking the language of quality outcomes, data management, demonstrated results and evidence-based protocols will make RDs welcomed members of those teams.”

Further Reading
Overview of Meaningful Use and Quality Measures

The overarching goal of the Meaningful Use (MU) requirements is to facilitate the transition to real quality improvement and population health. In 2009, the Obama administration and Congress provided the health care community with a transformational opportunity to break through the EHR barriers. The Health Information Technology for Economic and Clinical Health Act (HITECH) authorized incentive payments through Medicare and Medicaid to clinicians and hospitals when they use EHRs privately and securely to achieve specified improvements in care delivery. Through HITECH, the federal government will make available payments totaling up to $27 billion over 10 years, or as much as $44,000 (through Medicare) and $63,750 (through Medicaid) per clinician. HITECH’s goal is not just adoption of an EHR, but actual “meaningful use”—that their use by clinicians achieves significant improvements in care. The HITECH legislation ties payments specifically to the achievements of advances in health care processes and outcomes.5

The process of showing MU will be divided into four stages (Stage 4 taking effect in 2014), with each more difficult than the last to achieve:

- **Stage 1** criteria focuses on electronically capturing health information in a coded format; using that data to track key clinical conditions; communicating that information for purposes of care coordination; implementing clinical decision support; and reporting clinical quality measures.
- **Stage 2** criteria will focus on expanding the requirements for eligible professionals (EPs) and hospitals to "encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible."5
- **Stage 3** criteria will focus on promoting improvements in quality, safety, and efficiency, with an emphasis on decision support for national high-priority conditions, patient access to self-management tools, access to comprehensive patient data, and improvement of population health.
- **Stage 4** criteria are still being determined and will emphasize the use of data to develop shared care plans and observations of daily living to encourage active participation of patients in their care.

However, for many physicians, this will be difficult to achieve, even if they have top-of-the-line EHRs. They will still need supplemental information technology that automates the basic tasks of identifying, contacting, and tracking patients who need preventive and chronic care services, coupled with reports that care teams can use for quality improvement and reporting. Reporting quality measures is an important aspect of the CPCI project, and many of these measures align with Meaningful Use. RDs may be able to play an important role in assisting physicians and primary care practices in monitoring patient registries and providing population management reports. Section IV of this toolkit addresses this component in detail.

Opportunities for RDs in the CPCI Project

Providers participating in the CPCI will be expected to incorporate “5 functions” of primary care, and each of these present opportunities for RDs:

- **Care management:** This is an important component of CPCI and care managers will have a central role in each CPCI practice. Although CMS does not have a specific definition of “care management,” a care manager will be expected to collaboratively assess, plan, facilitate, and evaluate patient’s health care and psychosocial needs to promote quality and cost-effective outcomes. RDs are uniquely trained and qualified to perform care management, particularly
for patients with complex health needs. RDs have shown efficacy for working with patients with multiple chronic diseases.

- **Enhanced access**: RDs may be able to assist practices with enhanced access by offering care management services via telephone, email, or other asynchronous methods.
- **Planned care for chronic conditions and preventive care**: RDs have strong skills sets for providing care for chronic disease management and preventive care.
- **Patient engagement and proactive patient planning**: RDs have demonstrated the ability to engage patients in their care, develop shared care plans, and proactively plan patients’ care.
- **Care coordination across the medical neighborhood**: RDs are skilled in team-based care and with working with health care providers across all disciplines.

In summary, this is an exciting time for RDs and primary care clinicians to engage in a new model of health care. However, it involves RDs and clinicians developing some new skills, honing present skills, and developing new frameworks for delivering nutrition care. This toolkit will address each of these issues.

**References**

2. Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation. Comprehensive Primary Care Initiative Fact Sheet.
SECTION II: Aligning Yourself with Comprehensive Primary Care Initiative Practices

As described in Section I, the Comprehensive Primary Care Initiative (CPCI) is an exciting new model of health care delivery that emphasizes comprehensive care for patients with complex health care needs within a primary care practice. The payment structure to primary care practices includes per-member per-month (PMPM) fees that provide the monetary resources necessary to provide comprehensive care management. Registered dietitians (RDs) are uniquely qualified to provide these services. Evidence has shown that RDs improve health outcomes for people with type 2 diabetes and cardiovascular risk factors and work well within health care teams. RDs therefore have the ability to become an integral part of the success of the CPCI. This section will cover how RDs can align with participating CPCI practices in their states or regions and offer effective marketing strategies, payment structures for the CPCI, and contractual strategies.

Aligning with CPCI Practices and Effective Marketing Strategies

The CPCI is being offered in seven states and regions:

1. Arkansas: Statewide
2. Colorado: Statewide
3. New Jersey: Statewide
4. New York: Capital District-Hudson Valley Region
5. Ohio and Kentucky: Cincinnati-Dayton Region
6. Oklahoma: Greater Tulsa Region
7. Oregon: Statewide

This Web site lists the participating practices in each state or region. There is a “filter” function on the site that provides the ability to search for practices from a specific state or region.

How do you go about aligning yourself with CPCI practices? Following is a step-by-step guide.

**Step 1:** Go to the above Web site and identify the practices within your state or region that are participating in the CPCI. Review the list for practices that you know, already work with, or have contacted in the past, as it is helpful to already have some relationship or connection. Keep in mind that your best contact may be a midlevel primary care provider within the practice. Flag the practices you want to approach first, considering the following ideas:

In This Section
- RD Comprehensive Primary Care Initiative Marketing Checklist
- Menu of Services RDs Can Provide to CPCI Practices
- “RDs and PCPs: A Healthy Partnership for the Comprehensive Primary Care Initiative” Handout
- RD Comprehensive Primary Care Initiative Talking Points
- Sample Cover Letter
- Contact List Worksheet
• Primary care doctors who already send you referrals
• Primary care doctors and/or primary care providers you have worked with in a hospital, clinic, or nursing home
• Your own primary care doctor
• A primary care doctor you know through networking at a church or synagogue
• A primary care doctor who is highly recommended by your patients

**Step 2:** Review the list of CPCI practices in your geographic region that you don’t know but would like to contact about working with on the project.

**Step 3:** Contact your affiliate dietetic association’s Reimbursement Representative, as he or she may have contacts with practices looking for RDs or care managers. To find your Reimbursement Representative, visit our [Leadership Directory](#) and click on the link for Policy Initiatives and Advocacy Leader Groups.

**Step 4:** Develop a plan of action! Your plan should include:

- **Communication strategies.** Consider these questions before reaching out:
  - Why would the doctor want to hire or contract with an RD to assist with the CPCI project?
  - What benefit will an RD be to the doctor and practice for the CPCI?
  - How can I make a difference for the practice?

- **Perfect your communication messaging.** Be prepared to deliver information on:
  - How RDs can improve the overall health of patients in the practice and help the practice meet quality measures for the CPCI.
  - How RDs can save the doctor and practice time by offering more comprehensive care.
  - The value of RDs as the nutrition experts.

Note that this information is available as handouts in the Medical Nutrition Therapy (MNT) Kit, “Meeting the Needs for Obesity Treatment: A Toolkit for the RD/PCP Partnership,” and in the CPCI toolkit—but be prepared to discuss all of these points with the doctor and practice.

- **Communication methods.** Determine how you will communicate with the doctor and practice. Will you use email, phone, or in-person contact?

- **Marketing materials:**
  - Cover letter introducing yourself to the practice (see sample letter)
  - Materials that describe how your skills can benefit practices participating in the CPCI (see handout)
  - Contractual agreements

**RD Comprehensive Primary Care Initiative Marketing Checklist**

- Contact list of targeted CPCI practices
- Cover letter for each practice
- Marketing materials: “RDs and PCPs: A Healthy Partnership for the CPCI” handout; sample contract; your resume or marketing brochure/materials from your business/practice
- Practice your marketing pitch
- Follow-up plan
Private practice marketing materials you currently use

- List of practices, contacts at each practice, and timeline for making contacts and follow-up.

**Step 5**: Determine your follow-up procedures:

- How often will you follow up with the doctor or practice you have contacted? You may want to consider following up within the week, the following week, and again two weeks later.
- How will you follow up with the doctor or practice you have contacted? Will you use email, phone, letter, or other method? You may need to consider multiple methods of follow-up (i.e., an email and a phone call).

**Payment Structure for the CPCI**

One of the unique features of the CPCI is a new payment model participating practices will test over the 4 years of the project. As any primary care provider or RD can attest, a major barrier to transforming practices and providing the necessary services to patients has been the current fee-for-service payment model and the lack of reimbursement for lifestyle counseling. This new payment model provides the funding necessary for practices to provide care management and invest in health information technology (HIT) to develop patient registries (a document containing uniform information about individual persons, collected in a systematic and comprehensive way, to obtain information about a disease state, such as type 2 diabetes) and report on quality measures.

Why are payers interested in this new type of payment model for primary care practices? Payers believe that several demonstration projects (described in Section I) have shown that providing practices with PMPM fees results in:

- Improved health outcomes
- Improved patient care
- Decreased health system costs

The results of the CPCI will inform national payment policy for primary care for Medicare—so the outcome of this initiative is very important!

**CPCI Payment Model and the RD Marketing Plan**

Understanding the specifics of the CPCI payment model is a key to developing a marketing plan for working with practices.

**Blended Compensation Model**

The CPCI blends the following compensation methods into a new type of payment model:

- **Fee-for-service**: Practices can still charge normal fees for patient office visits. RDs should refer to the “Meeting the Needs for Obesity Treatment: A Toolkit for the RD/PCP Partnership” toolkit for information regarding reimbursement for weight management services in primary care practices. This fee may be an additional benefit for the CPCI practice, the patient, and the RD.
- **Per-member per-month (PMPM) payment**: PMPM refers to the amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan, in this case, the CPCI. This risk-adjusted care coordination (PMPM) payment is
intended to support value-added, nonbillable practitioner time, advanced care team functionality, or investments in HIT utilization. The average PMPM fee (risk adjusted) in the first 2 years will be $20 and then will be reduced to an average of $15 PMPM in years 3 and 4. Although the $20 PMPM fee does not sound like a lot, for most practices it adds up to a significant income source. For example, for a practice with 1,000 patients meeting the risk-adjusted highest $20 PMPM fee, the payment equates to an additional $20,000 per month. This is an important point for RDs to consider, because CPCI practices will have the monetary resources necessary to hire care managers and health care providers that can assist with managing their complex patients.

- **Share in saving eligibility:** After 2 years, all CPCI practices will have the opportunity to share in a portion of the total Medicare fee-for-service savings in their market. Studies have suggested that it costs less to provide health care to patients who receive care from primary care practices that offer comprehensive services than to patients whose primary care practices don’t provide such services. This innovative payment model may allow practices to share the Medicare savings that result from their enhanced care management services to their patients.

**RD Marketing Plan**

The CPCI payment model is a shift away from *just* fee-for-service. This new payment model has the potential to provide RDs with new and exciting opportunities to work in primary care practices and provide comprehensive services. Yet, this initiative requires RDs to conceptualize different ways of marketing to participating primary care practices. It also requires RDs to see themselves performing expanded roles beyond traditional medical nutrition therapy (MNT) services. New strategies for RD payment include:

- **Bundled services (care management):** Each CPCI practice will be actively looking to hire care managers to provide comprehensive services to their patients. RDs may be able to negotiate with the practice(s) for both fee-for-service and fees for care management from the PMPM fee. For example, under Medicare, the RD can directly bill for diabetes and renal disease diagnoses, provide portions of the Medicare annual wellness visit, bill “incident to the physician” for weight management, and then also negotiate with the practice for a monthly care management fee that includes:
  - Proactively assessing practice patient population to determine health care needs and provide lifestyle-related preventive care.
  - Providing MNT for patients with multiple medical conditions (type 2 diabetes, hypertension, hyperlipidemia, cardiovascular disease).
  - Engaging patients and families in a plan of care that uniquely fits each patient’s individual circumstances and values. This includes between-visit follow-up via phone or asynchronous (email or patient portal) communication.
  - Reporting on quality measures. RDs can take on the important role of

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tracking the CPCI-designated quality measure reporting for the practice. Details on the CPCI quality measure can be found in Section IV of this toolkit.

- Participating in practice team-based care and quality improvement. CPCI practices will be involved in demonstrating team-based care and continuous quality improvement. For the RD, this means including time in “bundling” services for active participation on the practice team(s) and with the quality improvement efforts. Details of team-based care and quality improvement can be found in Section III of this toolkit.

- **Limited bundled services:** RDs can consider providing specific services that are limited to a few areas. For example, the RD can negotiate just offering comprehensive lifestyle care management services and quality measures reporting for this group of patients. The RD can also participate in practice team-based care and quality improvement.

- **Fee-for-service:** RDs can choose to provide only fee-for-service for diabetes and renal diagnoses. However, it is worth noting that CPCI practices are encouraged to provide comprehensive care management services for their patients and may not be as interested in fee-for-service arrangements.
RDs and PCPs: A Healthy Partnership for the Comprehensive Primary Care Initiative

Why Adding an RD to Your Practice Team Is Good Medicine

RDs are Effective
Improved health outcomes using medical nutrition therapy (MNT) by registered dietitians (RDs) have been published in the areas of diabetes, hypertension, disorders of lipid metabolism, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults. Several of these quality measures will need to be reported as part of the Comprehensive Primary Care Initiative (CPCI).

In addition, RDs have demonstrated improved outcomes related to weight management:
• Studies show MNT provided by an RD to overweight and obese adults for less than 6 months yields significant weight losses of approximately 1 to 2 pounds per week.
• MNT provided from 6 to 12 months yielded significant mean weight losses of up to 10% of body weight with maintenance of this weight loss beyond 1 year.
• Overweight/obese individuals who received MNT provided by RDs, in addition to an obesity-related health management program that included physician visits, nursing support, and educational materials and tools, were more likely to achieve clinically significant weight loss than individuals who did not receive MNT.

RDs Provide a Positive Return on Investment
• MNT is linked to improved clinical outcomes and reduced costs related to physician time, medication use, and hospital admissions for people with obesity, diabetes, disorders of lipid metabolism, and other chronic diseases.
• An RD-delivered lifestyle approach to diabetes and obesity improved diverse indicators of health, including weight, HbA1c, health-related quality of life, use of prescription medications, productivity, and total health care costs. For every dollar invested in the RD-led lifestyle modification program there was a return of $14.58.
• The Lewin Group documented an 8.6% reduction in hospital utilization and a 16.9% reduction in physician visits associated with MNT for patients with cardiovascular disease. The group additionally documented a 9.5% reduction in hospital utilization and a 23.5% reduction in physician visits when MNT was provided to persons with diabetes mellitus.

RDs are Cost-efficient Providers
• RDs provide MNT and have experience and training in behavior counseling and weight management.
• RDs’ fees are lower than those of physicians, nurse practitioners, and physician assistants.
• RDs have a strong clinical and counseling background and therefore can effectively provide Intensive Behavioral Therapy (IBT) for Obesity and help with the Annual Wellness Visit incident to the primary care provider.

• MNT by the RD for diabetes and chronic kidney disease is a covered, billable benefit by Medicare Part B and many private health insurance companies.
• Many RDs are certified diabetes educators and can provide and bill for Diabetes Self-Management Training.

RD Services are Integral to the Patient-Centered Medical Home and the CPCI
RDs work hand-in-hand with referring providers and multidisciplinary health care team members to deliver coordinated and cost-effective care. In addition to providing MNT, RDs address areas such as glucose monitoring and chronic disease self-management.

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Sources


5. Wolf AM, Crowther JQ, Nadler JL, Bovbjerg VE. The return on investment of a lifestyle intervention: The ICAN Program. Accepted for presentation at the American Diabetes Association 69th Scientific Sessions (169-OR), June 7, 2009, New Orleans, LA.

Mastering the Art of Negotiation
By Nancy Collins, PhD, RD, LD/N, FAPWCA, and Colleen Sloan, RD.

We can bargain at garage sales and settle arguments, but when it comes to negotiating for a better employment package, we freeze. Negotiating for the best deal not only involves salary or hourly wages, but also work hours, weekend coverage, duties, or benefits package. For the consultant registered dietitian, additional issues arise such as the number of hours allotted for a particular facility, the process of handling recommendations, and dealing with facility-wide problems. The process of negotiation takes a lot of creativity, practice, effort, and research. However, if you equip yourself with the right skills and information you will be able to successfully negotiate your way into the ideal career or contract.

Why Negotiate?
Whether you are entering the workforce or a seasoned professional looking to change careers, negotiating skills are essential to getting what you want out of the job. Negotiating provides an opportunity for you to demonstrate your problem-solving skills, business etiquette, and ability to sell your worth. Although both the company and the candidate are looking to get the best deal for themselves, ultimately, negotiation is about compromising. You need to convince the company that your request for increased compensation, hours, or benefits is justified. The company needs to believe that your work experience and knowledge will add to their growth and bottom-line.

Knowing Your Make-Up
Mastering the art of negotiation must begin with understanding the importance of self-awareness. Being certain of who you are and what you are capable of is vital to successfully selling yourself. Although it takes time and experience to develop this confidence, there are several things you can do to harness an understanding of yourself. Take time to reflect on past responsibilities and determine what skills or attributes you obtained. Consider a situation in which you had to make a decision or resolve a conflict and relate that to your interpersonal or problem-solving skills. Think about how your career has progressed thus far and where you would like it to be in the future. Often times to discover traits within yourself you must seek advice from third-party individuals. Discuss your work ethic, demeanor, abilities, or areas to improve with a superior or mentor. An honest, unbiased opinion may bring to light character traits or situations you never considered. Determining your worth not only depends on your education and background, but also the geographic location, size, and financial state of the company.

In addition to knowing who you are, it is helpful to keep a record of your achievements. One of the best ways to showcase your accomplishments is to create a professional portfolio. If maintained over a period of time, this can be a great way to prepare for your meeting and review key moments in your career that you would like to discuss. Save awards and recognitions, publications, thank you notes from clients, and letters of recommendations from superiors. Be sure to keep this up-to-date so it will be ready when needed. When kept organized and presented professionally this portfolio can be a very impressive, visible sample of who you are and what you have done in the past.

Understanding the Company and Job Profile
Once you have a good grip on your character and ability, you should become familiar with the company with which you are seeking to further your involvement. Regardless of what you are negotiating, it is essential that you are keenly aware of the company philosophy and mission. Your recommendations and suggestions for improvement or change should support the company goals. If a larger salary or wage is what you are after, be sure to do your research to determine the average pay for comparable positions. You do not want to overstep your boundaries or appear uninformed. Search online sites or ask individuals who are currently in a similar
position for a general idea of a plausible salary. Be sure the job and pay-grade is an appropriate level for you. Your goal should be to maximize your salary and benefits package from the start. Have a specific package deal you would like and know what you will and will not accept. For example, if you cannot reach an agreement on the salary perhaps you can negotiate an additional week of vacation time. Sometimes, it takes creativity to reach an agreement where all parties feel they have won. At some point, you must be willing to walk away if you simply cannot be happy with the deal.

Not only is it important to have an understanding of the company profile, but you should have a solid understanding of what the job entails. If you are a consultant, you must be clear on the duties and how your recommendations will be instituted and the steps that will be taken if they are not. Be familiar with past inspection reports, pending litigation and any other information that will both necessitate and justify additional hours in your contract.

Renegotiating
Consultant registered dietitians are often in the position of renegotiating contracts because many are written as one-year agreements. After one year, you may find that the contract was not appropriate for some reason and now you want to change certain aspects of the agreement. Be prepared with data and solid reasons for requesting changes. Often the issue is insufficient time to provide adequate care for the residents. In this case, you must know basic information such as number of monthly admissions, number of high risk and complex residents, abilities of other nutrition staff members, and any recent deficiencies or complaints. It is important to remember that as a consultant you are not an employee and typically are not covered under the umbrella insurance policies of the facility. This means should a legal problem arise, you will be treated as a separate entity. For your own peace of mind, it is imperative that you feel your contract is adequate to meet the needs of each and every resident. Let your conscience be your guide and explain this while negotiating. It is reasonable to explain that your professional credentials and/or license come with a professional and ethical duty to provide a certain level of care. If in your heart you believe you cannot do this, you must renegotiate or walk away. Walking away is difficult especially in some rural areas where other jobs may be hard to find. However, it is only through fierce negotiating and standing up for what we believe that we will ever change the tide.

Closing the Deal
Keep in mind that business is about business, not friendship. You should have the mindset that you are a valuable employee or consultant and the company is fortunate to have you. Don’t shy away from asking for what you deserve because you don’t want to upset your relationship with your superior. Knowing your capabilities should empower you to be confident to ask for what you deserve.

Once you are fully versed on how much you are worth and how you benefit the company, you need to be able to sell yourself. This not only encompasses your education, training, and prior experience, but also your personality, demeanor, and verbal and non-verbal communication skills. No matter what you are negotiating, your goal should be to make the employer believe without a shadow of a doubt that they need you and your services. To be an effective negotiator it is important to know what key messages you want to discuss, have supporting examples or scenarios, and present the information with meaning and relevance. Developing this confidence takes time, so be patient and remain positive. The key to becoming a successful, confident negotiator is practice, practice, practice. Role play in front of the mirror, practice with your friends, and recite responses in the car. Find a method that works for you and stick to it.

References

RD Comprehensive Primary Care Initiative Talking Points

Starting the conversation regarding your skills and how they can benefit a primary care practice can be difficult for many RDs, since for most of us “sales” do not come naturally. Following are some talking points and conversation starters for effective marketing:

1. **Start by explaining the benefits of your services for improving the quality of care provided to the practice’s patient population.** Practices will want to know how your services can help them achieve the goals of the CPCI, particularly for care management and improved quality measures.

2. **Review the CPCI goals and the role of the RD:**
   a. Care management: RDs are uniquely trained and qualified to perform care management, particularly for patients with complex health needs. RDs have shown efficacy for working with patients with multiple chronic diseases.
   b. Enhanced access: RDs may be able to assist practices with enhanced access by offering care management services via telephone, email, or other asynchronous methods.
   c. Planned care for chronic conditions and preventive care: RDs have strong skill sets for providing care for chronic disease management and preventive care.
   d. Patient engagement and proactive patient planning: RDs have demonstrated the ability to engage patients in their care, develop shared care plans, and proactively plan patients’ care.
   e. Care coordination across the medical neighborhood: RDs are skilled in team-based care and working with health care providers across all disciplines.

3. **Discuss your specific qualifications and experience:**
   a. The CPCI involves care management of your patients with “high” health needs, including those with several chronic conditions. I have several years of experience providing medical nutrition therapy for patients with diabetes and cardiovascular disease risk factors. Studies have shown that RD-delivered lifestyle counseling has led to improved patient outcomes. I would like to discuss with you how my skills can benefit your practice.
   b. A focus of the CPCI is to improve the health, quality of care, and cost of delivery of services. I would like to tell you about my experience counseling patients for improving their diabetes management, improving their lipid profile, and helping them lose weight. I have data to share with you that shows improvements for my clients for these outcomes.
   c. RDs have been shown to improve clinical outcomes and reduce costs related to physician time, medication use, and hospital admissions for people with obesity, diabetes, disorders of lipid metabolism, and other chronic diseases. I would like to tell you about my experience and outcomes providing nutrition services and counseling.

4. **Discuss how your services can benefit the practice:**
   a. RDs are skilled at managing patients with “high health needs” and providing comprehensive services for these patients, including care management. Many RDs have been trained in health behavior change techniques that encompass diet, physical activity, and stress management.
      i. CPCI practices needed to show progress toward becoming a Patient-Centered Medical Home (PCMH). Services provided by RDs are an important component of becoming a PCMH practice.
b. RDs are also a good return on investment! For every dollar invested in the RD-led lifestyle modification program there was a return of $14.58.
   i. MNT provided by RDs has been shown to reduce physician office visits, which saves practices money and allows primary care providers to focus their limited time on patients with higher health needs.

c. RD services can also save physicians in the practice time. Health behavior change counseling related to chronic disease management can be time consuming for physicians and staff. RDs have demonstrated a positive return on investment for providing these services. Including RDs as part of a comprehensive health care team enhances the ability of all providers to practice at the top of their license.
   i. Studies have shown that primary care physicians see the benefits of including RDs as part of the health care team, and they feel inadequately trained to provide optimal nutrition counseling.

d. RDs are uniquely qualified to provide health behavior change counseling and have extensive training in nutrition therapy. The Institute of Medicine (IOM) of the National Academy of Sciences describes RDs as "the single, identifiable professional with the standardized education, clinical training, continuing education, and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy."

e. Many RDs have also received further certification for diabetes education and certificates for weight management. (Note: Be prepared to describe your credentials, certifications, and certificates.) Other health care professionals, including nursing staff, have generally not received this type of training.

f. The CPCI emphasizes care coordination across health care providers, and RDs are accustomed to working hand-in-hand with referring providers and multidisciplinary health care team members to deliver care that is coordinated and cost-effective. MNT, when provided as part of a care team, has been shown to be effective in improving health outcomes.
   i. RDs have unique skills related to working in multidisciplinary teams.

g. RDs have demonstrated strong management and operational skills and are well positioned to work as case/care managers in CPCI practices. (Note: Be prepared to discuss your specific experience and skill set.)
Sample Cover Letter

Practice Name
Practice Address
Date

Dear (Physician and/or Office Manager):

As a practice participating in the Comprehensive Primary Care Initiative, I would like to introduce myself and provide information regarding how my services can benefit your practice. The Comprehensive Primary Care Initiative is an exciting new model for providing health care to your patients, and I am enthusiastic about the potential to work with you on meeting the goals of this initiative for better health, better care, and lower costs. Registered dietitians have been shown to improve clinical outcomes and reduce costs related to physician time, medication use, and hospital admissions for people with obesity, diabetes, disorders of lipid metabolism, and other chronic diseases.

I am a registered dietitian (RD) and have been in practice in your area for (#) years. Medical nutrition therapy provided by an RD has been shown to improve health outcomes for people with diabetes, hypertension, disorders of lipid metabolism, and obesity. RDs have also demonstrated a broad range of skills, including cost-effective care, coordination across health care providers, quality measure reporting, the ability to work as part of a comprehensive health care team, and integration as part of the Patient-Centered Medical Home. (Provide details of your experience here).

I would welcome the opportunity to discuss my qualifications and how these can benefit your patients and practice. I can be reached at (phone number) or (email address and/or website). Thank you for your consideration. I look forward to discussing the ways I can work with your practice on this very important initiative.

Sincerely,

Name, Credentials
Title
Organization/Practice Name
# Contact List Worksheet

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<tr>
<th>Practice Name</th>
<th>Location/Address</th>
<th>Contact Name</th>
<th>Phone Number</th>
<th>Email Address</th>
<th>Date of Initial Contact</th>
<th>Follow-Up Contact</th>
<th>Notes/Comments</th>
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SECTION III: Comprehensive Primary Care Initiative Team-Based Care

The Comprehensive Primary Care Initiative (CPCI) emphasizes the importance of team-based care in primary care practices. Building effective team-based patient care has been shown to improve patient outcomes, improve office efficiency, and decrease health care costs.¹ This section provides an overview of team-based care in a Patient-Centered Medical Home (PCMH) and discusses opportunities for registered dietitians (RDs) to become fully integrated care team members as part of the CPCI project.

RD’s Role and Opportunities
RDs are accustomed to working on care teams, particularly in a hospital setting. However, the role of RDs in the team approach to care for a PCMH and the CPCI has some similarities and some differences with how RDs work as part of patient care teams and quality improvement (QI) teams. Specifically, RDs will be part of the care team (for the most part) in the practice rather than as an outside referral. In other words, medical nutrition therapy (MNT) and nutrition counseling will take place within the practice, and the RD will be an integrated part of the patient’s care team.

RDs also have the opportunity to expand their roles in health care beyond being direct care providers for nutrition services to serving as members or leaders of QI teams and as case or care managers for CPCI practices and collecting and reporting on quality measures.

These roles fit RDs well because:

- RDs have unique skills related to assessment and the multidisciplinary team approach, which are essential elements of a PCMH.
- RDs traditionally work with other team members to provide evidence-based, patient-centered care and have shown efficacy for facilitating self-management support.
- RDs have demonstrated strong management and operational skills and are well-positioned to work as case/care managers in the PCMH.

Team-Based Care Overview
Why is team-based care so important to primary care and the CPCI in particular? It is estimated that up to 40% of work done in a primary care office is “rework,” and a team approach can decrease these duplications. A team approach to patient care has been shown to increase work efficiency by 80%, and high-functioning teams can accomplish more in less time—improving patient outcomes and staff and provider satisfaction.

The Canadian health care system recognized the benefits of team-based patient care in the report Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada.² Main messages from the report include:

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A health care system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among health care professionals.

Successful teams recognize the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility.

The makeup and functioning of teams vary depending on the needs of the patient. Patients and their families are important team members with important roles in decision making.

These key messages highlight the importance of the RD as part of a well-functioning health care team, particularly for collaboration between the health care team and the patient. This concept will be discussed further in this section.

**Definition of a Primary Care Team**

What exactly is a primary care team? A working definition is a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members. Teams can be defined further as employees functioning at the same place to accomplish common goals. Elements of successful team-based care include:

- Common purpose
- Measurable goals
- Agreed on policies and procedures
- Implementation of division of labor through defined tasks and assignments of roles
  - Match the individual’s licensure and capability
  - Cross-train staff
- Training for functions performed by team members
- Effective leadership
- Process for improving communication structures and processes
- Data to inform team members of the results of their efforts

Most of the CPCI practices will have developed care teams that include clinicians and nursing staff, and these teams focus on providing daily patient care. Care teams are often co-located and work together on a daily basis. For example, many practices have divided up their patient rooms into “team colors” with the same clinicians and nursing staff (including medical assistants) on different colored teams. The “blue team” would consist of a team of clinicians and nursing staff that work together regularly. This type of consistent team-based care has been shown to increase communication, efficiency, continuity, and patient and staff satisfaction. The RD is an important part of patient care teams and will most likely rotate between teams rather than participate on one specific team.
Elements of Teamwork and Being a Team Member

The Essential T-E-A-M concept provides a framework for how effective teams operate. Essential T-E-A-M elements include:

- Trust
- Empathy
- The right attitude
- Mutual respect

Trust: Trust allows team members to be honest about their strengths and weaknesses.

Empathy: Empathy is the ability to imagine yourself in another person’s situation. It means being aware of and appreciating another person’s experiences and feelings. Health care workers are empathy experts. Extending this level of consideration to coworkers helps strengthen the team.

Attitude: Attitude is a manner, disposition, feeling, or position about a person or thing. Teams function best if all team members leave their personal problems at home, expect the best from one another, and recognize and resolve small conflicts.

Mutual Respect: Mutual respect means recognizing and attempting to uphold the rights and dignity of another person.

How do you know if you are being a good team member? Rate yourself on the “Team Member Assessment” at the end of this section.

Quality Improvement and Team-Based Care

Practices chosen to participate in the CPCI needed to show progress toward becoming a PCMH, including demonstration of a culture of continuous improvement. Quality improvement includes developing and implementing processes to improve the process of patient care, patient safety, and patient outcomes. QI teams differ from care teams in that they include everyone in the practice and they focus on improving office processes. Most of the CPCI practices have functioning QI teams.

What Is a QI Team?
- Smaller teams from the care teams that meet regularly (about twice a month).
- QI teams work to improve patient care, and each team includes a clerical staff member and other members from all areas of the office.
- A team tasked with implementing change efforts.

Why Use QI Teams for Change?
- Help the practice understand the overall practice system, what’s actually happening
- Increase the diversity of perspectives
- Increase the number of staff empowered to identify and seek solutions to problems—“shared leadership”
- Help create conditions for success, buy-in, and momentum—20% want change, 50% on the fence, 30% against change
- Use data to make sure changes are improvements
QI teams utilize the following processes and tools for quality improvement:

![Quality Improvement Steps Diagram]

**Case Study Example**
The QI team at MidValley Primary Care wants to improve their diabetes care. They follow these steps:

**Global AIM statement:** We aim to improve the diabetes care for our patients at MidValley Primary Care. We will begin this process by establishing a diabetes patient registry (collection of secondary data related to patients with a specific diagnosis, condition, or procedure) so that we know who our diabetes patients are and so we can monitor their progress. By working on this we expect to see improvements in HgA1c, blood pressure, lipids, and overall self-management support goals.

**Process mapping/work flow analysis:** The practice then maps their current process with their diabetes patients. Process maps allow teams to work together to develop a shared understanding of the actual steps in a process (current state); provide a workflow analysis to improve efficiency, reduce redundancy, and/or identify gaps or areas of instability; and provide a structured format to create an improved process (ideal state).

**An Example of a Diabetes Process Map**

1. Patient calls to make appointment (less than 1 month in advance)
2. Appointment made with primary care physician if possible or other provider (not team based)*
3. At appointment, clerk registers patient
4. Clerk asks if patient is diabetic*
5. Clerk flags the chart in the electronic health record (EHR) with a red label that indicates the patient has a diabetes mellitus (DM) diagnosis*
6. Clerk messages the medical assistant (MA) that the patient has arrived and notes the red flag
7. MA retrieves EHR with DM in red (does not always happen)*
8. MA calls patient back
9. MA does vital signs
10. MA takes client to room

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11. MA finishes checking client in exam room
12. MA asks for self-management goal (SMG—does not always get done)*
13. MA retrieves encounter automatic diabetic report card
14. Report card to patient (either by MA or provider)
15. MA reviews encounter to check for DM preventive tests
16. Provider reviews diabetic report card, discusses SMG with patient, refers to RD for MNT

*Indicates area that needs improvement and is targeted for Plan-Do-Study-Act (PDSA) cycle

Model for improvement: Next, the QI team chooses a specific process to improve by using a PDSA cycle worksheet.

<table>
<thead>
<tr>
<th>PDSA Cycle #___:</th>
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<tbody>
<tr>
<td><strong>Plan:</strong></td>
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<tr>
<td>The change: (What, who, when, where, and who responsible?)</td>
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<tr>
<td>Prediction: (What do we expect to happen?)</td>
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<tr>
<td>Data: (What information, who, what, where, when collected?)</td>
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<tr>
<td><strong>Do:</strong></td>
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<tr>
<td>What was tested? What happened?</td>
</tr>
<tr>
<td>Observations? Problems?</td>
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<tr>
<td><strong>Study:</strong></td>
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<tr>
<td>Summarize what was learned and compare to prediction.</td>
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<td><strong>Act:</strong></td>
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<tr>
<td>What adjustments should be made for the next cycle, what will next cycle be?</td>
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The PDSA cycle is shorthand for testing a change—by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning:

- Perform small tests of change until you have reached your aim
- Communicate the results
- Implement the proposed change

For example, MidValley Primary Care chooses to improve the process of having the MA ask the patient about the SMG, documenting this in the EHR, notifying the provider, and then engaging the RD in working with the patient.

**Plan:** The MA will ask each patient with diabetes about their SMG and document in the EHR. The provider will have a follow-up discussion with the patient, document in the chart, and refer to the RD. The RD will work with the patient on their SMG and document in the EHR. We expect to see improvements in our diabetes patients for their HgA1c, blood pressure, and lipids. The practice will review the EHR to see if each diabetes patient is receiving this process with their SMG and review the diabetes patient registry to look at clinical outcomes.

**Do:** We tested our process for working with our diabetes patients on their SMG. We found that we had to make sure that the front desk was flagging the patients with diabetes so that the MAs could ask about their SMG. If this happened, then the rest of the process worked well.

**Study:** We found that we needed to work with our front office staff to make sure that they were identifying our patients with diabetes and flagging this on the face sheet in red.

**Act:** We conducted an educational session with our front desk staff about the face sheets and found that this improved the identification of our patients with diabetes.

The RD is also a valuable member of QI teams, as demonstrated in the example above. RDs are used to collecting and recording data and can utilize this skill as part of the QI process. RDs also have “flexible” skill sets that can benefit team-based care in CPCI practices.
Now try your own quality improvement project!
Choose a health behavior change you would like to make and go through the quality improvement steps. Following is an example:

*Global AIM Statement:* Increase my daily physical activity to improve my health and fitness and manage my stress.

*The process begins with* getting 15 minutes of physical activity every morning and ends with achieving 30 minutes of physical activity on 6 days of the week.

*By working on this process* I expect to have more energy, sleep better, be in a better mood, lose 5 pounds, and feel better!

*It is important for me to work on this process* because I am getting older and I want to improve my health and be a good role model for my children.

Next, complete a process map for your current process:
1. Go to bed too late night before (11:30 p.m.).
2. Alarm goes off at 6:15 a.m., hit snooze button twice.
3. Get out of bed at 6:45 a.m., am rushed, take quick shower, grab piece of toast and cup of coffee as I run out the door.
4. Arrive at primary care practice 5 minutes late (7:50 a.m.)—day starts with being behind schedule.

Identify key areas for process improvement:
1. Go to bed earlier—by 10:30 p.m.
2. Wake up at 6:15 a.m. and get out of bed.
Team-based care is an important part of the CPCI because it has been shown to improve office efficiency, patient outcomes, and staff and provider satisfaction. Team-based care involves both patient care teams and QI teams. RDs possess skills that are an integral part of patient care teams and the quality improvement process.
Team Member Assessment

Please use the scale below to indicate how each statement applies to how you interact on a team. It is important to evaluate the statement honestly and without overthinking your answers.

3 = usually
2 = sometimes
1 = rarely

_____ I am passionate and unguarded in the discussion of practice and patient issues.
_____ I am able to effectively deal with conflict that arises on a team.
_____ I know what my team members are working on and they know what I am working on and how these contribute to the collective good of the team.
_____ I am able to willingly make sacrifices to contribute to the needs of the team.
_____ I am able to openly admit my weaknesses and mistakes.
_____ I am concerned about the prospect of letting down my team.
_____ I am able to contribute to team discussions with clear and specific resolutions and calls to action.
_____ I am able to challenge myself and other team members about approaches to patient care and team processes.

Add up your scores and assess your highest and lowest scores. For your lowest scores, how can you improve these areas? Consider developing a plan of action for improvement in these areas.


References

SECTION IV: Quality Measures and Measuring Effectiveness for the CPCI

Measuring and reporting on clinical quality measures has become an important part of health care reform and is a major component of the Comprehensive Primary Care Initiative (CPCI). This section provides an overview of quality measures and population management; discusses specific quality measures for the CPCI; and describes the role of the registered dietitian (RD) in collecting and reporting quality measures.

Definition of Clinical Quality Measures
What exactly are quality measures? The Institute of Medicine (IOM) defines clinical quality measures as “measures of processes, experiences, and/or outcomes of patient care, observations or treatment that relate to one or more of the IOM domains of health care quality (e.g., effective, safe, efficient, patient-centered, equitable and timely).” Medicare defines quality as “the degree to which health services increase the likelihood of desired health outcomes.”

Why is there an emphasis on gathering and reporting on quality measures? Data is a powerful tool for driving change!

- You can’t manage what you can’t measure.
- You can’t improve what you can’t measure.
- Measurement and analysis add to the understanding of the system you are trying to improve and your insight about what changes might work to improve the process.
- It is important to note that all that can be measured is not important and all that is important cannot be measured.

Population Management and Quality Measures
Population management can be defined as the ability to assess the health needs of a specific population; use this information to implement and evaluate interventions to improve the health of that population; and apply those interventions to the individual patient in the context of the patient’s culture, health status, and health needs. The CPCI will utilize population management in this same manner by examining the health outcomes of the population as a whole, at the state/regional level, at the practice level, and at the individual patient level. Electronic health records (EHRs) will be used by CPCI practices to gather this data and report on specific quality measure outcomes.

Patient data collected through an EHR can then be analyzed for disease-specific purposes in the form of patient disease registries. The National Committee on Vital and Health Statistics describes registries used for a broad range of purposes in public health and medicine as “organized system[s] for the collection, storage, retrieval, analysis, and dissemination of information on individual persons who have either a particular disease, a condition (e.g., a risk factor) that predisposes [them] to the occurrence of a health-related event, or prior exposure to substances (or circumstances) known or suspected to cause adverse health effects.” CPCI practices will be modifying and configuring their EHRs so they can produce data to support reporting on quality measures. Producing reports on these measures will assist CPCI practices in providing preventive care, conducting outreach to patients with multiple chronic diseases, and determining progress toward meeting quality measures for specific diseases (e.g., diabetes).
Improving Quality and Obtaining Payment Through Quality Measure Data

Measuring and evaluating clinical quality measures provides important information for the RD, clinician, and practice staff. Most health care providers, when asked, think that they provide excellent care for their patients. However many are surprised, when given data on hemoglobin A1C, blood pressure, BMI, or lipids for their patient panel, that most of their patients don’t meet quality measure goals. Bridging the gap between what healthcare providers think they do and actual patient outcomes is an important part of many of the new health care initiatives, including CPCI.

For example, the figure below shows trends for a particular physician for his/her patients for systolic blood pressure, both for the number of patients with a documented blood pressure and for the percent of patients at goal for patients with diabetes (≤130/80 mm Hg):
Registry data can also be a great way to engage patients in their care when they can see their own data. For example, the following report can assist the patient in seeing the trends for their A1c and LDL cholesterol:

In fact, reporting on and meeting quality measure goals are so important that several aspects of reimbursement are tied to these outcomes. Note that the CPCI is only implementing the Meaningful Use reporting, but many other payers and initiatives are implementing systems of reporting patient outcomes that are tied to payment structure. Some examples include:

- **Meaningful Use**—Centers for Medicare & Medicaid Services (CMS) has issued specific quality measures (meaningful use), and eligible providers’ payment will be tied to reporting on these quality measures.
• Pay-for-Performance (P4P)—Many insurers are instituting payment systems that reward physicians, hospitals, medical groups, and other health care providers for meeting certain performance measures for quality and efficiency.

• Physician Quality Reporting System (PQRS)—Established in 2006 by Medicare, this voluntary program allows physicians and other health care professionals to report information to Medicare about the quality of care they provide to people with Medicare Part B who have certain medical conditions. This reporting system includes incentive payment for eligible health professionals who satisfactorily report data on the identified quality measures. RDs are eligible to participate in the PQRS program, and there are currently 13 measures on which RDs can report outcomes. CMS and the Office of the National Coordinator for Health IT (ONC) plan to align quality reporting measures by 2014 to reduce the reporting burden on eligible professionals (EPs) and eligible hospitals who participate in any program. For more information on how to report national performance measures, click here.

Quality Measures and the CPCI
Utilizing data to achieve better health at a lower cost is at the heart of the CPCI. To achieve this goal, CPCI practices will be collecting data to be used for three distinct purposes:

• **Improvement**: This is the most important function of these measures, as the data generated from quality measures gives practices opportunities for improvement and provides information to CMS about a practice’s progress toward meeting goals.

• **Payment**: Information from quality measures will partly determine a practice’s share of any Medicare shared savings it generates in its market. (This information may also be used by other payers for performance-based payments.)

• **Evaluation**: CMS is evaluating the effect of the CPCI on health outcomes, quality, and cost. The data collected as part of this project is a major part of CMS’s evaluation strategy.

CPCI will track three distinct types of quality measures:

• **EHR-Based Measures**: Termed “eMeasures,” this data will be generated by the practice’s EHR and reported to CMS and, if applicable, to other participating CPCI payers.

• **Survey-Based Measures**: CMS will be conducting the Consumer Awareness of Healthcare Providers and Systems (CAHPS) survey annually and for a sample of patients within the practice. Information about this survey can be found here.

• **Claims-Based Measures**: CMS and participating payers within each state or region will be using claims data to calculate a short set of agreed-on claims-based measures as a means of tracking utilization of care across the medical neighborhood by patients in participating CPCI practices. These will vary by state and region (refer to the CPCI Web site for details).
“eMeasures” are the basis for quality measures and are aligned with the CMS EHR incentive program for Meaningful Use Stage 1 and/or Stage 2 (see Section I for details on Meaningful Use). During 2012, CMS expected CPCI practices to redesign workflows and customize EHR technology so that the eMeasures could be reported, and the first reporting period will be January 2014. Following is the list of eMeasures that all CPCI practices will be collecting and reporting:

<table>
<thead>
<tr>
<th>Domain</th>
<th>NQF#*</th>
<th>Measure Title/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Population/Public Health</td>
<td>0041</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old</td>
</tr>
<tr>
<td>3. Clinical Process/Effectiveness</td>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>4. Clinical Process/Effectiveness</td>
<td>Formerly 0031</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>5. Clinical Process/Effectiveness</td>
<td>0059</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
</tr>
<tr>
<td>10. Clinical Process/Effectiveness</td>
<td>0083</td>
<td>Heart Failure (HF): Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>11. Patient Safety**</td>
<td>0101</td>
<td>Falls: Screening for Future Falls Risk</td>
</tr>
<tr>
<td>12. Clinical Process/Effectiveness**</td>
<td>0418</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
</tbody>
</table>

*National Quality Forum
**Required quality measure to be reported on in January 2015.

Important Note: The quality measures listed in the table are required eMeasures for all CPCI practices; however, each state and region may require additional quality measures. For example, in 2014, the Colorado CPCI practices will also need to report on weight assessment and counseling for children.
and adolescents and on use of appropriate medications for asthma. Please refer to the CPCI Web site for state and region-specific information.

**Population Management, Quality Measures, and the Role of the RD**

RDs are accustomed to gathering data on patient outcomes and reporting to other health care providers and have an excellent skill set to provide this valuable service to CPCI practices. Many RDs are using an outcomes management system, which is a system that evaluates the effectiveness and efficiency of the Nutrition Care Process (NCP). Following are ways in which RDs can participate in their CPCI practices for population management and reporting on quality measures:

- RDs are uniquely qualified to provide medical nutrition therapy (MNT) and lifestyle counseling for several CPCI required quality measures. For example, three of the quality measures consist of diabetes outcomes (HgA1c, blood pressure control, and LDL cholesterol management). RDs have demonstrated efficacy for providing MNT that produces significant improvements for all of these clinical outcomes (see Section III for specific references). Controlling high blood pressure is another quality measure where there is strong evidence of MNT provided by an RD resulting in clinical improvement.
  - In addition to providing lifestyle counseling for diabetes and cardiovascular outcomes, dietitians are also well-versed in preventive care and can consider providing smoking cessation counseling.
- The care manager (preferably an RD) will be working with patients with multiple chronic diseases. Having the ability to enter data into the EHR and manage patient registries within the practice will be of great benefit to the practice.
  - If the RD does not have experience working with an EHR (there are a variety of EHR products on the market and they all operate differently), the RD should be proactive and ask the practice to take a course on use of the EHR. Please see Section V of the toolkit for resources for EHRs and Informatics.
- Becoming an RD requires analytical skills. These skills can be used in managing registries and creating reports for the practice. RDs are “naturals” for this type of work.
- The emphasis for the CPCI quality measures will be reporting to CMS about the progress of the practice toward meeting goals. However, an important part of the RD’s involvement in the CPCI is reporting on the effectiveness of the RD! Following is an example of how the RD has the required skills to access and evaluate data, develop appropriate interventions, and promote meeting quality measures goals:

**Case Example**

Kathy Smith, MS, RD, was hired by the CPCI Ozark Internal Medicine and Pediatric Clinic in Clinton, Arkansas. She will be the new care manager and will be managing the clinic’s panel of patients with multiple chronic diseases. As part of her contract with the practice, Kathy will be utilizing their EHR to create patient registries for diabetes and hypertension and identifying patients who need preventive immunizations and screenings. In order to produce these reports, Kathy requested training by the practice’s EHR vendor and the CPCI Arkansas EHR support services. By receiving training from both of these organizations, Kathy will be able to configure the practice’s EHR so that she can provide the quality measures and data needed for managing the practice’s patient population and reporting quality measure outcomes to CMS.

Kathy will also be providing MNT for diabetes care and hypertension for patients within the practice. She will be utilizing the patient registry data she generates from the EHR to proactively reach out to these patients for an office visit for lifestyle counseling. She will also be offering diabetes group visits each month at the practice and following up weekly via phone or email with each patient. She will be entering the quality measures data into the EHR for each visit or encounter. At the end of each month, she will generate a report for the practice’s quality improvement teams to determine progress and improvement.
In conclusion, RDs have unique skills for assisting CPCI practices for MNT and lifestyle counseling to improve patient outcomes that are required for CPCI; for data gathering and reporting; and for managing panels of complex patients. RDs are well-positioned to be an asset for CPCI practices.
In Practice: Using an Outcomes Management System to Enhance Marketing
By Anne Wolf, MS, RD
Charlottesville, VA

Sitting at the table with the employer, the health insurance company, and the partnering Fitness and Wellness Center, I heard myself say, “And we need to collect outcomes.” After months of planning, we had created a model weight loss program for high health-risk employees. In this role, I was wearing the hat as the RD who would be overseeing the program and delivering the nutrition components. I could have felt great about “doing my job” as the clinician. So why would I advocate collecting and evaluating outcomes when that translated into more work, no additional revenue, and “not part of my nutrition job”? I realized that I was sitting at that table in the first place because I was able to show effectiveness and a positive return on investment for MNT based on the Improving Control with Activity and Nutrition (ICAN) project, a randomized controlled trial of MNT’s effectiveness and cost-effectiveness in diabetes and obesity. Also, I understood that this was a new program and without effectiveness data to justify its effectiveness, I believed that the program could easily be scratched if budget woes hit the table (they did and we survived). Lastly, I was curious. We were using newer delivery technologies such as Web-based group classes and tele-delivery of follow-up MNT visits, and I wanted to know how effective and acceptable these modes of delivery were in practice. So, I set up my outcomes management system.

I want to be clear here. I have a lot of experience in research and outcomes. I worked for the Nurse’s Health Study (NHS) and grew up with the Willet Food Frequency Questionnaire. I validated the NHS physical activity questionnaire. I chaired the TOOLS Task Force for the Obesity Society, a task force whose goal was to find a set of clinically useful outcome measures for clinicians when they worked with obese patients. I was the principal investigator of the ICAN project. So, I had a lot of confidence that I could measure this program’s effectiveness. But I had never done it in practice.

What helped is that our program’s frequency and schedule of visits, like the IBT for Obesity, is intense and long enough to support and measure weight loss and behavior change; we could easily do a before and after analysis of employees’ changes. So, what outcomes did I choose to collect and evaluate? I wanted to measure “success” in more ways than weight alone, which meant that I needed to expand my list of outcomes. Including anthropometric outcomes was straightforward because that was part of my initial assessment. I measured body weight, height (calculate BMI), waist circumference, and neck circumference (we have a lot of sleep apnea). Body fat was collected only because a BodPod was available at the Fitness facility and they included that measurement into the package for free. Including clinical labs was also straightforward. The employer had a contract with a local lab and was able to set it up so that I had electronic access to the program employees’ labs. We decided on fasting lipid panel and HbA1C for people with diabetes and a history of pre-diabetes.

The behavioral outcomes were more complicated. I could not find a validated tool that measures behavior change that is short, clinically useful, and free. The Block Fat and Fruit/Vegetable Screeners are excellent to measure relative fat and fruit/vegetable intake, but they cost money to administer. So I developed my own Food and Physical Activity Behavior Questionnaire, which scores the following areas:

- Physical inactivity level
- Physical activity level
- Dietary Score—Overall
  - Dietary Fat Score
  - Meal Regularity Score
  - Caloric Drink Score
  - Fruit, Vegetable, and Fiber Score
  - Eating Out Frequency Score
  - Behavioral Eating Score
The questionnaire is short (four pages), quick to complete (5-10 minutes), clinically useful, and easy to score. The other outcomes that I evaluate are employee retention, participation, and satisfaction with the survey.

**Reporting Outcomes to Your Partners**

Equally if not more important than measuring outcomes in your practice is sharing them with your partners. A before and after summary of an employee’s progress is given and reviewed with each employee at the final visit. It is so rewarding to review not only weight changes (which, for many patients, is never enough) but also patients’ labs and behavioral changes. My final review with patients is always uplifting as they recognize how far they have come. Also, after each program, I send a report that summarizes the aggregated anthropometric, clinical, and behavioral impact of the program. I also include retention, participation, and program satisfaction. The report is long (about eight pages) and filled with graphs and tables (vs. words), but it tells my stakeholders (the employer and health insurance company who pay for the program) about the following outcomes (not all outcomes included due to space). On average, the employee has the following changes:

- 17-pound weight loss (7% of initial body weight)
- 2.9-inch reduction in waist circumference
- 3% body fat loss
- 30% improvement in physical activity
- 38% improvement in fruit, vegetable, and fiber intake
- 0.54% reduction in Hemoglobin A1c (for people with diabetes)
- 32% reduction in fasting triglycerides
- 85.5% program retention at 6 months (100% at 3 months)
- 78% attend all group classes
- 90% attend all one-on-one nutrition sessions
- Out of a possible rating of 5, participants rate our program a 4.4 (and the RD is a 4.8)

**The Rest of the Story**

The program and I have not only weathered the recession but continue to grow. The current employer is an advocate of the program and my services. When they were going through the bidding process for a health insurance provider, they listed my services, among others, as being a prerequisite for getting the final contract. Two other local employers are now starting the program, and I am training their RDs to deliver the program. The health insurance company, Coventry Health Care, has branded the program and is bringing it to other employers. After the first pilot program, I requested and now receive payment for the leasing, collection, analysis, and reporting of my outcomes system. I am now contracted to do the outcome analysis at other sites using my outcome system, called WM SNAP® (Systematic Evaluation and Reporting for Weight Management Programs). What started out as good practice and curiosity is now creating jobs for RDs and paying me a reasonable income. More than that, I feel satisfied and good about my practice because I know it is having a meaningful impact—I can measure it!

**Resources**

- Agency for Healthcare Research and Quality (AHRQ) Fact Sheet on Outcomes Research.
- CMS Website on Physician Quality Reporting System.
References


SECTION V: Comprehensive Primary Care Initiative and Nutrition Resources and Tools

Click on the links to access the resource.

**Comprehensive Primary Care Initiative Resources**

1. **Centers for Medicare & Medicaid Services. Comprehensive Primary Care Initiative Web site.**
   The main Web site for information on the CPCI, list of participating states and regions, and participating practices in each area.

2. **Consumer Awareness of Healthcare Providers and Systems (CAHPS) survey.**

**Patient-Centered Medical Home Resources**

1. **Patient-Centered Primary Care Collaborative Web site.**
   The mission of the Patient-Centered Primary Care Collaborative (PCPCC) is to advance an effective and efficient health care system built on a strong foundation of primary care and the Patient-Centered Medical Home (PCMH). This Web site is full of resources for the PCMH.

2. **American Academy of Family Physicians (AAFP) Web site.**
   This Web site provides an overview of the PCMH and practice-based resources for transforming a practice to become a PCMH.

3. **TransforMED.**
   This Web site is sponsored by the AAFP and provides comprehensive resources for NCQA PPC-PCMH recognition and for topics related to the PCMH.

4. **Institute for Healthcare Improvement (IHI).**
   This Web site focuses on practice improvement related to the PCMH and advocates for the “Triple Aim”: improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care.


**CPCI Quality Measures Resources and Tools**

1. **National Quality Forum Web site.**

2. Diabetes medical nutrition therapy (MNT) resources:
Resources to Improve Your Nutrition and Weight Management Practice and Counseling Skills

Although weight management and body mass index are not direct quality measures for the CPCI, management of type 2 diabetes, hyperlipidemia, and hypertension all involve weight management and nutrition counseling skills.

1. **Weight Management DPG membership.** The Weight Management Dietetic Practice Group’s mission is to help you meet your career goals through our resources, continuing education activities, networking, and advocacy. Cost is $25 for Academy members and $15 for students per year.

2. **Adult Weight Management Guideline.** The guideline is an evidence-based approach to nutritionally caring for the overweight and obese patient. You must sign in to the Evidence Analysis Library in order to get full access to the guideline.

3. **Adult Weight Management Toolkit.** This toolkit is designed to assist the RD in applying the ADA Adult Weight Management Evidence-Based Nutrition Practice Guidelines. The toolkit includes resources such as the MNT protocol, sample documentation forms, client education materials, and outcomes monitoring forms. Available for $20.00.

4. **Adult Weight Management Self-Study E-Module.** The new online Adult Weight Management Self-Study Module addresses the fundamentals of adult weight management. The module has been awarded 16 CPEUs. Available for $69.00.

5. **Commission on Dietetic Registration’s Certificate Courses on Weight Management.** Level I and II Adult Certificate courses and Level I Pediatric Weight Management courses are available throughout the year.

6. **Use of the Academy’s Evidence Analysis Library (EAL).** Access evidence-based nutrition information (condition-specific information), MNT effectiveness review, and MNT cost-effectiveness review. You must be logged in to the EAL site to access the EAL.

7. **Nutrition Care Process.** The Nutrition Care Process and Model is the framework for the critical thinking process used by dietetics professionals as they provide nutrition services to their clients/patients. You must be logged in to the EAL site to access.

Reimbursement Resources and Tools

1. Academy Member Web site. Go to www.eatright.org/coverage and www.eatright.org/mnt for many resources on billing, practice management, and Medicare Part B MNT services.

2. Medicare Part B MNT Resources. When providing MNT to Medicare Part B beneficiaries, the Academy provides many resources and handouts to help you enroll, manage, and get reimbursement rates.

3. MNT Advocacy. Academy resources to aid the practitioner in advocating for expanded coverage for MNT services in the public and private markets.

4. MNT Provider Newsletter. A monthly publication from the Academy that is an essential practice management resource for RDs and includes articles on business skills, technology, coding and coverage, nutrition practice guidelines, Medicare and Medicaid, and more.

Business Practice Tools

1. Nutrition Entrepreneurs DPG membership. Offers many business resources, tools, and networking for getting your business started and succeeding in business. Cost is $35 for Academy members per year.

2. Diabetes Care and Education DPG membership. Offers information for members interested or involved in patient or professional education and research for the management of diabetes mellitus. Cost is $30 for Academy members per year.

3. MNT Business Practice Tools. Academy handouts to aid the practitioner in providing MNT services.


5. Medical Nutrition Therapy MNTWorks® Kit. This kit provides handouts that can be used during meetings and presentations to local third-party payers, employer groups, and hospital finance and billing departments to expand MNT coverage.

6. FastTrac: Educational Programs for Aspiring Entrepreneurs. Funded by the Kauffman Foundation and offered nationally through 300 alliance organizations.

7. Business Stages for Entrepreneurs. By the esteemed James H Hill Reference Library, this free online information resource for small businesses and entrepreneurs is loaded with business publications and information, including free podcasts on business strategies, an entrepreneur seminar series, and more.


10. **Academy Website – Affiliate Reimbursement Representatives.**

11. **Academy Website – DPG Reimbursement Representatives.**

12. **Academy Member Website – Nutrition Informatics.**


14. **Electronic Health Record Toolkit.** Access online tools developed to set up Electronic Health Records from the experts! Toolkit includes a "roadmap" to guide you, allows tailored assistance as you enter the path at any point in the process. Available for purchase.