

Emerging Paradigms in Dietetics Practice and Health Care: Patient-Centered Medical Homes and Accountable Care Organizations



BUILDING ON DISCUSSIONS that are decades in the making, the 21st century has ushered in sweeping changes to American health care on many levels. To this end, those in the health care field and academia alike agree that emerging opportunities are present and that registered dietitian nutritionists (RDNs) are particularly well suited to reap substantial benefits if they seek them out. A new paradigm through which health care is being delivered, particularly involving the practice models described as, or associated with, the Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO), represents a shift away from the traditional fee-for-service practice and more toward a patient-centered, whole-person approach. The prevalence of these models is expected to only grow, as provisions of the 2010 Patient Protection and Affordable Care Act (ACA) continue to roll forward.¹ By emphasizing wellness and rewarding improved outcomes, these models are helping to negate the historic challenge RDNs have faced in terms of securing adequate reimbursement. This shift opens the door for their participation in a myriad of multidisciplinary programs coming to fruition in areas as diverse as small primary care practices to the federal government. RDNs, with regard to nutrition, now have the opportunity to demonstrate their value as specialists in prevention and wellness, as research continues to reveal links between diet and chronic illness.^{1,2}

In addition, with the passage of the ACA, some might argue that health care

is a civil right, and access to medical nutrition therapy (MNT) likewise is a right to be defended, as opposed to a benefit that must be advocated. Piek Tan, RDN, CDE, CDN, past New York State Dietetic Association reimbursement representative, in a publication to members, described MNT as a medical service that should now be made available to all citizens regardless of their socioeconomic status and ability to pay.

Subtle as the difference might be to some in the laity, the substance of this argument is proving sufficient as RDNs leverage greater access to the bigger health care landscape.

East to west, north to south, reports grow of incredibly rewarding opportunities in areas previously unexplored, and RDNs should consider the burgeoning career field. Bonnie Jortberg, PhD, MS, RDN, CDE, said some in health care have been a bit apprehensive about changes associated with the shifting paradigms, but those attitudes are quickly changing for those who can demonstrate the ability to improve outcomes. “[RDNs] are recognized as the nutrition experts, as we should be,” Jortberg said, reiterating something that so many health care professionals observe daily, that nutrition and health are inextricably linked.² But, in addition to acknowledging this relationship, the new paradigm allow for RDNs’ service to be more financially favorable to their respective organizations.

As the PCMH and ACO models continue to grow in prevalence, more changes and newer models will undoubtedly emerge. Different states and agencies might use different terms, and those changes are expected to continue.¹ To capitalize on these trends, RDNs can advocate at all levels for inclusion of the profession, position themselves within their organizations so as to demonstrate value, and collaborate for new partnerships.²

Jortberg, an assistant professor in the University of Colorado’s School of

Medicine, Department of Family Medicine, was among experts who served on the Academy’s 2013-2014 PCMH/ACO workgroup, and noted that awareness of the new paradigm has been growing among RDNs in recent years, but more information is still needed. According to a survey of 1,056 RDNs conducted in 2009 by the Academy’s PCMH Workgroup, only 236 RDNs (16.5%) reported familiarity with the PCMH model, but did not work in such a setting; 805 RDNs (77.3%) were unfamiliar with the PCMH concept; and only 67 RDNs (6.3%) reported working in a PCMH model of care at that time. In 2014, the group issued a similar survey with 6,733 RDNs responding, revealing 20% were working in a PCMH and 58% were still unfamiliar with the term.

This familiarity level will have to rise, as PCMH-related initiatives in particular are central to many of the efforts driving health care reform in the era of the ACA.¹ National surveys conducted between 2009 and 2013 reveal initiatives featuring payment reform incentives had increased from 26 to 114, and the number of patients covered by these programs rose from approximately 5 million to 21 million.¹ Researchers concluded that, “The patient-centered medical home model is likely to continue both to become more common and to play an important role in delivery system reform.”¹

BREAKING DOWN THE PCMH AND ACO

For those completely unfamiliar with the terms, it might help to consider they are distinctly different entities, although both are born of a common mission and are often found in conjunct. The most recent incarnations of a century-long campaign toward health care reform, the PCMH and ACO are both rooted in the concept of patient-centeredness, the

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whole-patient model, and payment for value.³ The concept of patient-centeredness was defined as such by authors of the Institute of Medicine's 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, as "providing care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."⁴ In terms of reimbursement, these models emphasize wellness and prevention, and encourage providers treat whole-patient issues, as opposed to the traditional fee-for-service model that attached bills to each individual point.

The terms in their present use have, in fact, expressed the desired aim of public sector health care advocates for decades. As part of its address to what authors determined to be a "quality gap," the report recommended six quality aims, specifically that health care should be safe, effective, patient-centered, timely, efficient, and equitable.⁴ Underlying reasons for the long-widening quality gap in health care include, but are not limited to, poor delivery due to decentralization of resources within a number of "cottage industries,"⁴ leading authors to focus heavily on the concept of interdisciplinary teamwork and communication, between and within specialties.

ACO

The concept of the ACO has been an evolving one, practiced under different

names over the years, both in coordination with Medicare and independently. Medicare recognized and created their own brand of the mechanism in accordance with the ACA, and functionally they came into effect within that system January 1, 2012. The US Centers for Medicare and Medicaid Services (CMS) defines Accountable Care Organizations in relatively broad terms, stating "Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients,"⁵ adding that the "goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."

To those working in the field, the term ACO might be strongly associated with the concept of "bundled payments," which refer to a single payment for all care related to treatment or a condition, also known as episode-based care. The CMS had been studying pilot programs for various bundling models since the 1990s. Consider the hypothetical case constructed by earlier CMS models of study, titled the "Prometheus Model," 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 Prometheus Model of bundling, the overall budget for the case would be set at \$89,300. This would allow for \$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 Prometheus and, if readmission is prevented, the hospital and physician would be paid \$12,800 more. Providers are financially rewarded for good outcomes rather than number of visits. However, the provider bears

the risk of negative outcomes, as complications arising afterward will not be reimbursed, nor will follow-up visits.⁶

As providers of MNT, RDNs are extremely valuable players in this new paradigm, particularly in the cases involving chronic disease. In turn, the PCMH serves as a partner model to the ACO, in most cases serving as its foundation.

PCMH

Conceptually, the patient-centered medical home was born in the 1960s but has only recently gained significant attention as professional associations and payers both public and private see it as a means of improving quality, reducing cost, and strengthening overall primary care. Originally the model was designed to address the field of pediatrics by coordinating care for children with special needs. Under the model as presented at that time, the pediatrician and affiliated practice would be considered a central coordinator of the child's medical care and records. The idea of expanding this into more areas, including general family practice, is a more modern incarnation.⁴

In 2004, the American Academy of Family Physicians assumed the position that every American should have a medical home as a potential remedy to the lack of patient-centeredness found in many primary care practices.⁴ By 2007, the American College of Physicians, which represents internists, the American Academy of Pediatrics, and American Osteopathic Academy had all come to advocate similar positions. In 2007, the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, and American Osteopathic Academy published a joint statement establishing the principles believed requisite in the patient-centered medical home model. These principles emphasize personal relationships, team delivery of care for the whole person, coordination across specialties and settings of care, quality and safety improvement, and open access.⁵

PCMH has come to be a designation for "practices that provide first contact, continuous, comprehensive, whole person care for patients across the

ACO and PCMH Defined

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together to voluntarily give coordinated high-quality care to their patients.⁷ Medicare offers a number of ACO programs including the Medicare Shared Savings Program, the Advance Payment ACO Model, and the Pioneer ACO Model. For more information, visit the Centers for Medicare & Medicaid Services at: www.cms.gov.
- The Patient-Centered Medical Home (PCMH) is a way of organizing primary care in a way that emphasizes care coordination and communication.⁸ For more information, visit the National Care Quality Association at: www.ncqa.org.

practice.”⁵ As issued as a designation by the National Committee for Quality Assurance (NCQA), it is broadly defined by that organization as “a way of organizing primary care that emphasizes care coordination and communication to transform primary care into what patients want it to be.”⁵

Providers describe the benefits associated with the PCMH as being numerous. In achieving status as a PCMH, they solidify their compliance with multiple programs and agencies, from CMS to the Physician Quality Reporting System and electronic health record incentive programs. A PCMH also supports participation in clinical integration initiatives and, as a matter of course, ACOs. In addition, the model can help groups prepare for future reform initiatives because it aligns with the Institute for Healthcare Improvement Triple Aim of improving patient care, improving health, and reducing health care costs. This model, as developed by the NCQA, also provides a clear plan of action, platform of standards, performance factors, and scoring. Well-defined medical home certification platforms have also been developed by the Utilization Review Accreditation Commission, Accreditation Association of Ambulatory Health Care, and The Joint Commission.

RDNs: A MOST WELCOME INGREDIENT

Jortberg encourages RDNs to be proactive in learning about opportunities that these changes may present, from administrative roles to reimbursement improvements, as they will be capitalized upon regardless, whether by RDNs or those marketing themselves as nutrition experts. The more one learns about the shifting paradigm in reimbursements, the more clearly they can see how cost-efficient and financially rewarding the utilization of MNT alone can be.

“Number one, be educated about what these models are and how you can take advantage of them,” she advised.² Depending upon the sector in which one works, RDNs might not fully understand how services such as MNT are, or have been, reimbursed, she pointed out. The degree to which RDNs participate in the billing of their services varies widely. But Jortberg said

that might need to change, as many feel the impediments to receiving reimbursements for services such as MNT will dissipate under the ACO and PCMH models. This is particularly the case given the amount of money spent on chronic disease, which is one place where RDNs really come into play here. Lifestyle and diet are key elements in treating chronic disease.

The question in years past was the about affordability of providing for an RDN’s services and how to get them reimbursed through fee-for-service payments. Given the role improved outcomes and cost-effectiveness now play in payment for health care services, the question of affordability is reversing itself. Jortberg said some physicians may have, in years past, been control-oriented in terms of administering their own nutrition counseling, but that is changing as they realize their time can be spent more effectively elsewhere. This is particularly the case for RDNs who demonstrate their value as multifaceted professionals. “I think as RDNs we need to think outside the box a bit,” she said. As professionals, RDNs are not limited to just administering MNT, and can very easily help with activities such as reporting quality measures, wellness visits, and health fairs. None of these conflict with the scope of practice, and all raise the profession’s profile while generating revenue.

Ultimately, if RDNs do not seize the opportunity, competing fields will, Jortberg warned. She and others within the Academy’s leadership hope to showcase the successes being achieved in PCMH and ACO models so as to continue increasing awareness.

OPPORTUNITIES OUTSIDE THE BOX

Kate Myerson, RDN, CD, CDE, has taken the role of an RDN to a logical, albeit nontraditional, height in her position of chronic care coordinator at Community Health Services of Lamoille Valley in Vermont. As with many positions opening up in PCMHs across the country, this job was not advertised under the heading of dietetics and came by way of networking via the Vermont Association of Diabetes Educators. “Communication is a two-way street,” she remarked, encouraging aspiring trailblazers to be prepared to

talk their way into some of these positions, advocating the multifaceted applications of a dietetics skillset. “I don’t necessarily have to just talk about nutrition,” she said, noting she also addresses smoking cessation and exercise in this role. RDNs know that many of the underlying behaviors associated with chronic disease blend together, whether they are poor nutrition, smoking, alcohol abuse, mental illness, or obesity. It is difficult to parcel out a diet for a patient with a drug addiction, or one suffering from mental illness, each of which complicate the other and prove barriers to following a regimented meal plan. The goal is to treat the whole person, and taking their medication list into consideration is also valuable, as this interacts with diet. It is also valuable to understand the financial impact of these issues combined. “It rarely is just one chronic disease or just one issue going on,” she said.

Community Health Services of Lamoille Valley is a PCMH, a family practice with two locations, offering dental, behavioral health, and wellness programming. As the chronic care coordinator, Myerson also serves on the Community Health Team, a multidisciplinary group funded by Blueprint for Health, which works directly with payors on behalf of patients. “It’s very multi-layered,” she said.

Myerson indicates that physicians involved in the PCMH model recognize the role nutrition plays in chronic illness. Given that reimbursements are tied to outcomes, her credentials make sense to all involved. Physicians within these models value the RDN, she said. “They’re grateful for the service,” she explained, pointing out that nutrition counseling can consume a lot of time physicians could utilize elsewhere.

Myerson said that, on the whole, the dietetic community may be largely unaware of the PCMH and ACO models. Past conversations she has had produced concern about RDNs losing their specialization amid a team-based approach. So far, that is not been the case in her experience. Whatever generalization exists within these roles serves as opportunity, and physicians in private practice are especially interested in utilizing the abilities of an RDN to serve the needs of a patient.

RDNs with a background in diabetes education like Myerson’s are especially

well-suited for roles in a whole-person model addressing chronic illness. Diabetes and prediabetes are topics of interest in any discussion concerning the cost of health care. “Of all the chronic diseases, diabetes is probably on the top of the list,” she said, recalling that during her own interview for this position, the physicians described her RDN credentialing as a key factor, and her status as a Certified Diabetes Educator as “icing on the cake.”

And, as with most PCMH and ACO models, which view their clients and patients as members of a sort, nutritional consultation with an RDN seems a value-added benefit. “I love to tell patients it’s a cost-free service,” she said, explaining that by packaging the RDN into the team of specialists, health care is meeting them where they are. Instead of physicians trying to bill out her services separately, or her charging the patient individually, the fees are rolled into one. For patients used to juggling multiple specialists, bills, prescriptions, and appointments, this one-stop approach is quite welcome, she said.

MAKING THE WAY INTO PRIVATE PRACTICE PRIMARY CARE

Because the new paradigm is structured in such a way so as to penalize readmissions and reward improved outcomes, the RDN is receiving new attention from primary care practices. Tan referenced her own experience as the outgoing reimbursement chair of the New York State Dietetic Association, observing that although the struggle for equitable reimbursement of MNT relative to pharmaceuticals remains a reality, the tide now favors the RDN. “Prevention is always cheaper than treatment and that’s what RDNs do. We’re the prevention specialists,” she said. In the long term, Tan predicts stand-alone private physician practices will either convert to the PCMH and/or ACO model, or disappear. The financial incentives are simply too high, and the cost of operation and regulatory compliance are likewise rising too fast to remain unchanged.

For Tan, the concept of opportunity is particularly noteworthy, as she was instrumental in creating her own role as director of dietetic services and American Diabetes Association Education

Recognition Program coordinator for CNY Family Care, LLP, located in East Syracuse, NY. “This is a second career for me actually,” the Syracuse University alumna, Class of 2000, said. Her interest in nutrition had been life-long though, sparked by work in the marketing side of her family’s supermarket business. And while her first job in nutrition was in the clinical side of long-term care, she discovered an interest in diabetes and felt that the nursing home environment was too late to really make an impact. Wellness, she believed then as now, is the key, and subsequently she earned her Certified Diabetes Educator status in 2005, shortly before joining CNY Family Care, LLP, a private practice of primary care physicians and providers. That practice, she said, has grown significantly in recently years, up from 5 partners to 7, with 11 physicians by 2015, 13 mid-level providers, and more than 70,000 patients. It is also a PCMH in the process of coordinating work with an ACO.

Tan described the founding partners of CNY Family Care as being very progressive visionaries. When hired in January of 2006 to develop an American Diabetes Association Education Recognized Diabetes Program and provide in-house nutrition services, her role was a rare one for a primary care setting. Even before the ACA was passed, her physicians were among those seeking to advance the primary care practice. That foresight, coupled with Tan’s efforts, has borne fruit. The practice’s in-house Diabetes Education Program has been certified since 2007 and has augmented the in-house dietetic service accessible to all CNY Family Care patients. The practice is NCQA PCMH-certified at Level 3, 2011 towards 2014 standards for meaningful use, and she is working towards a Diabetes Recognized Physician (DRP) certification for 2015. This year, they will also pilot a program for Shared Nutrition Appointment services, she said. The patient-centered, team-based environment associated with the PCMH is as much to credit as the innovative attitude of the physicians who fostered it, she said. “It’s not by accident that I selected them,” she said, adding she actually selected that practice as her own family’s provider before soliciting work with them as an RDN. Crediting her background in marketing, she encourages RDNs to strategize their

pursuit of opportunity, knowing it might not always be labeled as such.

Tan observed that, initially at least, her employer did not hire her with the idea of revenue-generation in mind. Rather, they saw the service as possessing potential value for the patient. But in 2015, with reimbursements increasingly tied to outcomes and readmissions, her participation is proving valuable on all levels. RDNs are trained in documentation procedures, and now that data-driven approach can translate into real dollars. Considering the money spent annually on diabetes and heart-related medications alone, a private practice can score very well on its performance measures by combatting these illnesses with an evidence-based nutrition approach. Furthermore, physicians are finding that the presence of an RDN saves them valuable time with patients. The RDN not only draws patients, but also helps maximize the team’s time spent on other billable services. “That’s an intrinsic benefit that you can’t put numbers on,” she said, describing it as a true win-win dynamic.

The patient-centered approach to preventing disease through nutrition is what RDNs are called to do anyway, she said. Her work in a primary care clinic affords her the opportunity to better compete with those who continue to pitch unsubstantiated claims via fad diets and unregulated supplements, or “noise” as Tan called it. And whereas she said Americans have traditionally been more willing to spend money on nutritional supplements and medication than consultation with an RDN, the decision-making process changes dramatically when an RDN is present in the patient’s primary care office and their services come as part of the package.

Tan credits some of her success to being resourceful, as well as finding supportive physicians. To capitalize on the opportunities presented by the newer reimbursement paradigms, she advises her colleagues to find ways to develop symbiosis within their organizations, becoming so integral that they cannot be overlooked. In terms of capitalizing on the PCMH, she recommends interested RDNs visit the NCQA website and consider becoming certified as a PCMH facilitator. This certification will be valuable in coming years, as the PCMH model continues to grow

in numbers. “RDNs are the perfect people to become facilitators of a PCMH,” she said, pointing out this opens up career opportunities across the country in organizations ranging in size from small private practices to larger institutions, and can in fact lead to more responsibilities at the managerial or executive level.

OPPORTUNITIES VIA THE PUBLIC SECTOR

Sammy Gardeen, RDN, LD, CDE, credits the PCMH model—referred to as Health Care Homes in Minnesota—as opening up new avenues for funding her work with the Indian Health Board. Gardeen’s position within that designation—which is also a Federally Qualified Health Center—is funded by a grant from the Indian Health Services, and she, like others, advises her peers to embrace the possibilities rather than succumb to fear of change. “[Registered dietitian nutritionists] should not be afraid to participate,” she said, recalling provider buy-in was initially a concern since overcome. “They have a lot to offer the Health Care Homes.”

Gardeen said working within such a model, whether in the private or public sector, complements the goals of an RDN. Her work with the Indian Health Board began in the Fall of 2011 as a dietetics case manager, and she said the Health Care Home (HCH) is a work in progress, but one which demonstrates real value. “It’s been great for the patient,” she said, describing the heightened communication involved between providers, from preplanning through treatment. The goal, she said, is for the providers to be in sync so as to avoid overwhelming the patient. Physicians in particular are encouraged to communicate. “We’re constantly trying to make that smoother.”

Gardeen’s clinic serves Native Americans primarily, a minority population that, in her area, tends to be un- or underinsured. Health problems facing her patients are similar to those of comparable socioeconomic demographics and nutrition is at the core.

The multidisciplinary approach of the HCH affords RDNs opportunities not necessarily advertised as such, she said, noting that although she serves as a Certified Diabetes Educator, one of her colleagues is the heart health educator, balancing smoking cessation

programs alongside nutrition. RDNs, she said, make terrific heart health educators, given the relationship between diet and cardiovascular issues. Opportunities such as this are not necessarily advertised under the heading of RDN; however, they are present for the taking. Both serve as case coordinators under the HCH model. No real conflict exists between these opportunities and the dietetics scope of practice. Instead, the lines between dietetics practice, nursing, and social work often blur, as her patients face barriers similar to those impacting Medicaid populations—lack of transportation, inadequate resources with which to obtain nutritious food and medicine, and occasional homelessness. “I tell my interns to consider all of the attributes they bring to the position,” she said, encouraging RDNs to practice to the top of their licensure, push some boundaries, and consider roles such as heart health educators and smoking cessation specialists.

Designations such as PCMH or HCH help organizations qualify for state, local, and federal programs, especially as evidence continues to mount in their favor. The Indian Health Board in Minneapolis has made particular strides in reducing patient visits to hospital emergency departments and the costs associated with those incidents. “That’s one of the biggest things we have worked on and improved,” she said, predicting these models will grow in popularity as people become more familiar with them.

PCMHs Actively Seeking RDNs

Kara Ellis, MD, RD, CD-N, lead dietitian for Community Health Center, Inc, said in January that her Connecticut-based PCMH was preparing to hire two additional RDNs, expanding the team she manages to five. Demand for RDNs is on an upswing, and Ellis credited changes associated with the PCMH and ACO models, as nutrition becomes a more valued, affordable element of care.

The nonprofit Community Health Center, Inc is presently the largest PCMH in the state of Connecticut, with Ellis managing the RDNs employed at its multiple locations. While some health care professionals might initially focus their thoughts about this model

on the changing relationship with payors, Ellis pointed out that PCMHs also result in a restructured work environment, one with advantages for the RDN seeking to practice at the top of their licensure.

In embracing the patient-centered approach, where all specialists focus inward on the person as opposed to the individual person juggling multiple providers, Ellis’ organization utilizes what she described as a “pod system” designed to encourage team huddles. The pod system utilizes a large, open office space where team members sit and work together. The RDN is then quite literally at the same table as the nurse, behavioral specialist, medical technician, and physician, making for a true interdisciplinary team. In this manner, the team considers the multifaceted elements of individual patients. The team huddles resemble those utilized in football, where players with different specialties meet as equals, all conspiring together for the achievement of a shared goal. For RDNs who have struggled to achieve parity with their colleagues in other fields, this move represents a major victory. “The pod system is really great for coordinated care,” she said, contrasting it to the traditional hierarchical system. That top-down approach often resulted in specialists working within metaphorical silos, and impeded the RDN attempting to practice to the top of their license, Ellis said. In the pod system, each teammate brings more than just their academic training to the discussion. Life experience and related skills, such as critical thinking, are shared. The pod system nurtures relationships between the team members, who learn volumes about the dynamics involved in chronic disease. In the case of diabetes, for example, behavior modification and diet swirl in together with obesity, heart, and cardiovascular problems.

This team-based concept helped Ellis launch the standing nutrition order initiative within her organization 2 years ago, where patients can self-refer to an RDN if they have a medical condition that warrants nutrition counseling. For those physicians or administrators who fear this might be an encroachment on their own work territory, Ellis encourages them to evaluate the time saved with such a move. For physicians in particular,

the time previously spent discussing nutrition can be better spent elsewhere. The plan is also in keeping with the spirit of health care reform in its holistic approach, incorporating nutrition and pharmaceutical discussions into the same visit. This system simultaneously removes a step from the workflow and empowers the patient, she said.

Ellis said the mission of the PCMH is driven by the ideal of meeting patients where they are, and in embracing that, Community Health Center, Inc has been able to establish a number of innovative programming, including its partnership with the YWCA of New Britain and local school corporation to form the House of Teens. Funded in part by a Physical Education Recovery Grant and the Robert Wood Foundation, the program was initiated in 2007, originally to address the number of young girls from lower-income homes failing physical education class due to lack of participation. Ellis said many of the girls felt uncomfortable in the traditional physical education environment, and the goal was to create an alternative, incorporating facilities at the local YWCA. Since then it has grown considerably and Ellis contributes nutrition education, cooking classes, and women's health to the students.

Funding opportunities for programs associated with the groups meeting the PCMH designation are becoming more available, she said, pointing out that these kind of activities are in line with the core mission—multiple disciplines joining to deliver care to the patient.

“They really give us the time because they respect the role of nutrition,” Ellis said of physicians in particular. While work remains in terms of advancing the value associated with RDNs, the new patient-centered paradigm and its appreciation for wellness is a good environment for those efforts. Ellis encourages RDNs to seek out opportunities in these environments, particularly as they pertain to allowing one to explore new avenues of outreach. “We are capable of so much more,” she said of RDNs, advising RDNs to ask themselves how they can use their nutrition skill sets to help the whole patient.

ACADEMY OF NUTRITION AND DIETETICS SUPPORT

The Academy of Nutrition and Dietetics (the Academy) has tremendous resources available for members seeking more information about the possibilities opening up by way of ACOs and PCMH models. The Academy stands as a resource for information and advocacy on those topics, both at the national and state level, as well as through associated dietetics practice groups. Discussions differentiating scope of practice from daily routines can be both helpful in the professional sense and informative on the topic at hand. Members are encouraged to engage with the Academy's Nutrition Services Coverage team, their state affiliates, and dietetics practice groups as they endeavor to learn about new opportunities, develop strategies for the capitalization of them, and

advocate on behalf of the profession as a whole.

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