

A Change of Mind

No economic, political, or military power
Can compare with the power of
a change of mind.

By deliberately changing
their images of reality
people are changing the world.

- Willis Harman

The RD and The Medical Home



Francine Grabowski MS RD CDE
NJ Consulting Dietitians
Princeton, NJ
October 29, 2009

Salute to the Sun



Traveling with the Turtle <http://paceebene.org/book/traveling-turtle>

National Healthcare Quality

AL	25,344	IL	31,197	MT	25,056	RI	29,028
AK	31,957	IN	23,874	NE	25,838	SC	27,095
AZ	27,843	IA	23,746	NV	27,950	SD	24,072
AR	25,724	KS	25,740	NH	25,706	TN	26,464
CA	38,573	KY	25,012	NJ	39,810 #1	TX	28,466
CO	25,888	LA	26,830	NM	24,616	UT	23,936
CT	32,636	ME	25,196	NY	38,369	VT	27,050
DE	28,450	MD	36,337	NC	25,829	VA	25,435
DC	39,637	MA	31,985	ND	23,855	WA	27,698
FL	29,604	MI	28,427	OH	25,005	WV	23,789
GA	26,267	MN	27,411	OK	25,227	WI	25,343
HI	33,518	MS	25,705	OR	25,509	WY	25,173
ID	23,697	MO	25,681	PA	28,487	US	29,199

Inpatient and Part B spending per decedent during last 2 years of life

Source: Dartmouth Atlas of Healthcare. 2006.

National Healthcare Quality

AL	27.7	IL	31.1	MT	19.0	RI	24.0
AK	18.4	IN	24.5	NE	25.6	SC	27.7
AZ	26.6	IA	22.5	NV	33.1	SD	22.4
AR	29.0	KS	24.5	NH	21.3	TN	29.7
CA	34.9	KY	27.5	NJ	41.5 #1	TX	30.9
CO	23.1	LA	31.0	NM	20.7	UT	17.0
CT	25.4	ME	20.3	NY	35.3	VT	19.1
DE	32.3	MD	29.4	NC	24.3	VA	26.1
DC	34.2	MA	26.8	ND	19.9	WA	20.0
FL	34.9	MI	28.3	OH	26.3	WV	25.7
GA	26.5	MN	20.6	OK	25.7	WI	22.0
HI	34.5	MS	28.3	OR	17.9	WY	19.6
ID	18.1	MO	26.3	PA	31.9	US	29.0

Physician visits per Decedent During the Last Six Months of Life

Source: Dartmouth Atlas of Healthcare. 2006.

National Healthcare Quality

AL	12.1	IL	12.2	MT	8.6	RI	11.4
AK	10.9	IN	10.0	NE	9.7	SC	13.1
AZ	9.4	IA	10.0	NV	10.3	SD	10.1
AR	12.5	KS	10.5	NH	9.7	TN	12.1
CA	11.7	KY	11.7	NJ	15.2 #4	TX	11.1
CO	8.6	LA	11.6	NM	9.5	UT	7.3
CT	11.4	ME	10.6	NY	16.3	VT	10.1
DE	12.4	MD	12.1	NC	11.8	VA	11.9
DC	15.8	MA	11.5	ND	9.0	WA	8.5
FL	11.3	MI	10.8	OH	10.1	WV	12.1
GA	11.3	MN	9.5	OK	11.4	WI	9.7
HI	16.4	MS	14.2	OR	7.8	WY	9.1
ID	8.2	MO	11.0	PA	11.6	US	11.7

Days Spent in the Hospital per Decedent During the Last Six Months of Life

Source: Dartmouth Atlas of Healthcare. 2006.

National Healthcare Quality

AL	23.5	IL	28.2	MT	12.0	RI	31.2
AK	16.7	IN	23.1	NE	20.2	SC	27.9
AZ	28.5	IA	18.9	NV	32.1	SD	17.6
AR	20.5	KS	18.6	NH	24.2	TN	26.4
CA	27.4	KY	22.5	NJ	38.7	TX	25.2
CO	23.1	LA	26.3	NM	18.7	UT	15.0
CT	29.2	ME	19.5	NY	35.6	VT	19.2
DE	35.8	MD	34.2	NC	24.3	VA	28.7
DC	35.1	MA	34.2	ND	16.6	WA	20.1
FL	34.6	MI	30.7	OH	27.9	WV	21.6
GA	24.3	MN	23.0	OK	17.6	WI	21.4
HI	20.8	MS	20.7	OR	14.5	WY	10.8
ID	13.3	MO	23.0	PA	34.1	US	27.5

Percent of Decedents Seeing Ten or More Physicians During the Last Six Months of Life

Source: Dartmouth Atlas of Healthcare. 2006.

National Healthcare Quality

AL	1.09	IL	1.07	MT	1.24	RI	1.20
AK	1.44	IN	1.01	NE	1.41	SC	1.01
AZ	0.91	IA	1.20	NV	0.77	SD	1.67
AR	1.35	KS	1.37	NH	1.32	TN	1.17
CA	0.83	KY	1.19	NJ	0.70	TX	0.95
CO	1.06	LA	1.03	NM	1.37	UT	0.98
CT	1.13	ME	1.47	NY	1.17	VT	1.37
DE	0.93	MD	0.95	NC	1.21	VA	1.06
DC	0.69	MA	1.23	ND	1.32	WA	1.07
FL	0.77	MI	1.30	OH	1.04	WV	1.41
GA	0.89	MN	1.47	OK	1.19	WI	1.15
HI	1.22	MS	1.24	OR	1.27	WY	1.49
ID	1.29	MO	1.45	PA	0.97	US	1.04

Variation, by State, in the Ratio of Primary Care to Medical Specialist Labor Inputs

Source: Dartmouth Atlas of Healthcare. 2006.

National Healthcare Quality

AL	20.0	IL	18.4	MT	13.0	RI	15.4
AK	17.9	IN	17.1	NE	14.8	SC	21.2
AZ	15.5	IA	13.2	NV	19.2	SD	11.7
AR	18.0	KS	16.0	NH	13.4	TN	20.5
CA	21.8	KY	18.6	NJ	25.1	TX	19.7
CO	12.2	LA	18.2	NM	17.5	UT	13.8
CT	17.1	ME	14.7	NY	19.8	VT	13.5
DE	22.4	MD	20.2	NC	19.0	VA	20.1
DC	24.8	MA	16.6	ND	11.8	WA	15.9
FL	20.7	MI	16.9	OH	17.0	WV	18.6
GA	19.5	MN	13.3	OK	16.6	WI	13.6
HI	21.3	MS	18.1	OR	13.6	WY	14.0
ID	13.4	MO	18.4	PA	18.5	US	18.5

% deaths related to an ICU admission

Source: Dartmouth Atlas of Healthcare. 2006.

<http://www.dartmouthatlas.org/>

Camden
Population 80,000

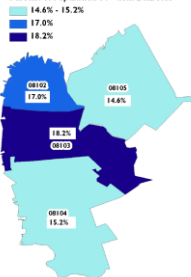
• 13% of all patients in Camden were responsible for 80% of total healthcare costs.

• 20% of all patients are responsible for 90% of healthcare costs in local hospitals

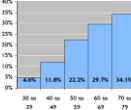
• The most expensive patient (2002-07) resulted in \$3.5 million in payment to hospitals through Medicaid and Medicare

QuickTime™ and a
TIFF (uncompressed) decompressor
are needed to see this picture.

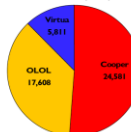
Percent of Population 30+ with Diabetes



Prevalence of Diabetes by Age



Diabetes Visits by Hospital



Number of Visits	Total Visits	Total Patients	Charges	Receipts
I to 10	19,930	4,992	\$606,910,340	\$84,943,020
11 to 20	12,475	875	\$328,629,988	\$43,928,131
Over 20	15,595	428	\$278,015,450	\$34,729,624
TOTAL	48,000	6,295	\$1,213,555,777	\$163,600,775

Diabetes
In Camden
2002 - 2007

<http://www.camdenhealth.org>



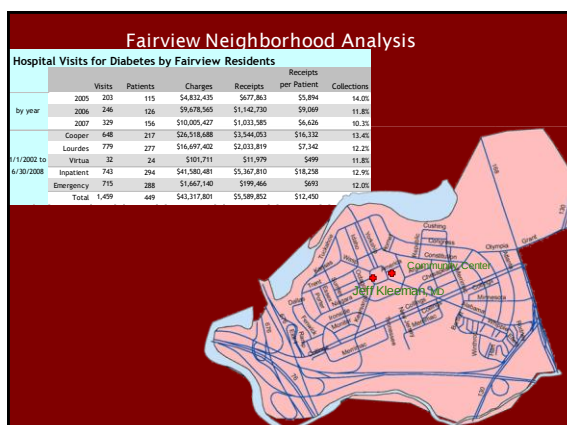
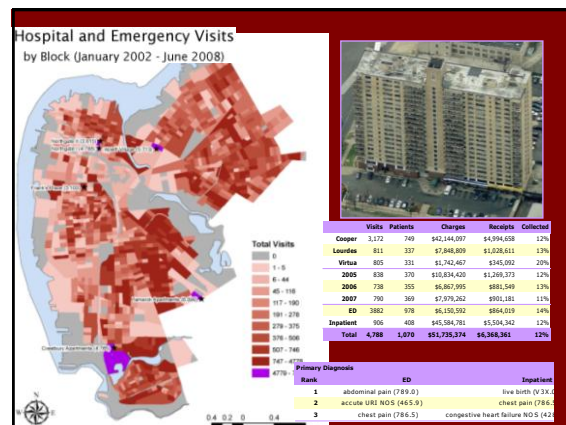
Camden Citywide Diabetes Collaborative

- Merck Foundation
- \$400,000 per year x 5 years
- Matched by Cooper, Lourdes, Virtua with each contributing \$50,000 per year x 5 years

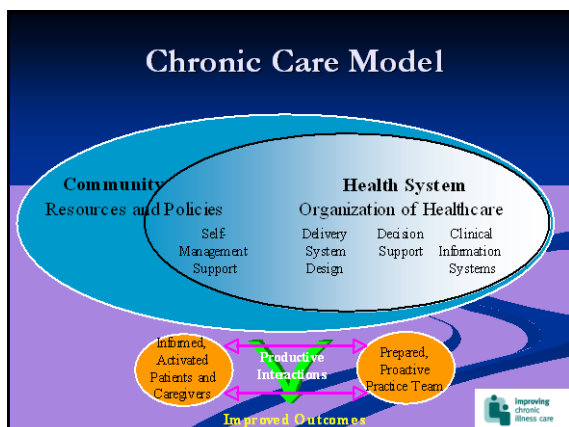

Camden Coalition of
Healthcare Providers

Camden Citywide Diabetes Collaborative

1. Transform primary care at 10 local offices to Medical Home
2. Targeted care of the high cost/high needs DM patients



My change of
mind about my
role in health
care.



Standards and Guidelines for Physician Practice Connections®—Patient-Centered Medical Home (PPC-PCMH™)

The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

National Committee for Quality Assurance

<http://www.ncqa.org/>

Providers must pass to receive recognition as:

Patient Centered Medical Home

- Self Management Support
 - Identifying Important Conditions
 - Guidelines for Important Conditions
- Access and Communication Processes
- Referral Tracking
- Test Tracking and Follow-up Patient Tracking

Measures of Performance
Reporting to Physicians (oversight)
Access and Communication Tracking
Organizing Clinical Data

Access and communication process 9 points

The practice provides patient access during and after regular business hours, and communicates with patients effectively.

1.	Scheduling each patient with a personal clinician for continuity of care
2.	Coordinating visits with multiple clinicians and/or diagnostic tests during one trip

Self-Management Support ---4 points

- Assesses patient/family preferences, readiness to change and self-management abilities
- Provides educational resources in the language or medium that the patient/family understands
- Provides self-monitoring tools or personal health record, or works with patients' self-monitoring tools or health record, for patients/families to record results in the home setting where applicable
- Provides or connects patients/families to self-management support programs
- Provides or connects patients/families to classes taught by qualified instructors
- Provides or connects patients/families to other self-management resources where needed
- Provides written care plan to the patient/family

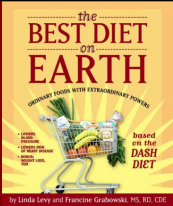
PARADE

Sunday, October 11, 2009

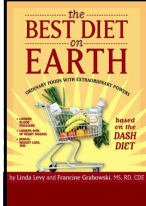
The 'medical home' could transform the way we receive care

A Team of Doctors Will See You

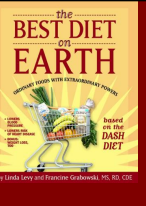




Develop a Self-Management Support Program

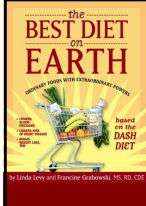






Access and Communication Processes

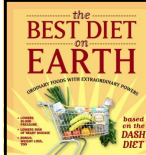
(or delivery system design)



- Analyze structure of office-- "mapping"
- Step by step written approach to delivering a service
- Review delivery system with healthcare provider & staff
- Provider makes referral, MA everything else
- Designate a "champion" in office for reminder, no-shows, and follow-up calls
- Scripts for every call



Confirmation script for third class



Hi _____, this is _____ calling from Dr. Kleeman's office. Thank you for coming to Diabetes Classes at Fairview.

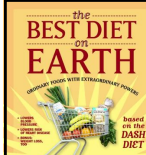
Just reminding you the third class is this Friday _____.

Come at 9 am for an individual session preceding the class instruction. This class will be figuring out how your medication and food affect your blood glucose. Don't forget your three day science experiment.

You are an important member of the class!



Collaborative Tracking Behavior Change



Charting Patient Behavior Change
based on AADE7

I will eat fruit with each meal	0 1 2 3	0 1 2 3	0 1 2 3
I will walk 30 minutes three times each week	0 1 2 3	0 1 2 3	0 1 2 3

Tracking Referrals, completion of self-management program, and behavior change

Camden Citywide Diabetes Collaborative

Camden Coalition of Healthcare Providers

AADE Behavior Change

Patient _____ D of B _____

DSME	Intro to Insulin	Advanced Insulin	Weight Loss Class	Healthy Nutrition	Carb Counting Class	Meat Instruction
Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial
CDE signs						Documented assessment performed
						Y N
						Y N
						Y N

AADE Behavior Change Goal

Healthy Eating:	Date	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Date	Date	Date	Date	Date	Date
Healthy Eating:	Date	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Date	Date	Date	Date	Date	Date
Healthy Eating:	Date	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
Date	Date	Date	Date	Date	Date

Healthy Eating: I will not drink regular sodas, sugary drinks, juices or flavored milk

Tracking, Measuring, Organizing Data



EMR ----as an RD: repeat, repeat, repeat

We have what it takes....

Crossing the Quality Chasm: 10 Simple Rules for the 21st Century Health Care System, IOM 2001
<http://www.iom.edu/About-IOM.aspx>

- *Care based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits*
- *Care based on patient needs and values - Customization*
- *Care based on evidence-based decision making. Patients should receive care based on the best available scientific knowledge*

Care based on continuous healing relationships With Community Food Resources: Eve's Garden



Care based on Continuous healing relationship with our government policies

In the United States 35.5 million people including 12.6 million children live in households that experience hunger or the risk of hunger.

This represents more than one in ten households in the United States (10.9 percent).

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

Household Food Security in the United States, 2006, USDA Economic Research Service, November 2006.

Care based on Continuous healing relationship with our government policies

90% of subsidies go to 5 crops



Most \$ goes to big producers

<http://www.networklobby.org>

Care based on Continuous healing relationships with our local farms



CSA'S
COMMUNITY SUPPORTED AGRICULTURE

Community Supported Agriculture consists of a community of individuals who pledge support to a farm operation so that the farmland becomes, either legally or spiritually, the community's farm, with the growers and consumers providing mutual support and sharing the risks and benefits of food production.

By direct sales to community members, who have provided the farmer with working capital in advance, growers receive better prices for their crops, gain some financial security, and are relieved of much of the burden of marketing.

<http://www.state.nj.us/jerseyfresh/>

Care based on patient needs and values - Customization

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Poland: The Sobczynski family of Konstancin-Jeziorna
Food expenditure for one week: 582.48 Zlotys or \$151.27

Care based on patient needs and values - Customization

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Italy: The Manzo family of Sicily
Food expenditure for one week: 214.36 Euros or \$260.11

Care based on patient needs and values - Customization

QuickTime™ and a
TIFF (LZW) decompressor
are needed to see this picture.

Ecuador: The Ayme family of Tingo
Food expenditure for one week: \$11.00

Care based on on patient needs and values-customization



Evidence-based decision making.
Patients should receive care based on
the best available scientific knowledge.



<http://www.smartchoicesprogram.com/>

Evidence-based decision making.
Patients should receive care based on
the best available scientific knowledge

LYON HEART

Study stopped after 46 months because the experimental group
50-70% lower risk heart disease than control group

Food Pattern: more bread, more root vegetables and green vegetables,
more fish, less beef, lamb and pork replaced with poultry,
no day without fruit, olive oil or rapeseed oil

Special food: butter and cream replaced with margarine high in -linolenic acid

QuickTime™ and a
TIFF (Uncompress) decompressor
are needed to see this picture.

QuickTime™ and a
TIFF (Uncompress) decompressor
are needed to see this picture.

QuickTime™ and a
TIFF (Uncompress) decompressor
are needed to see this picture.

QuickTime™ and a
TIFF (Uncompress) decompressor
are needed to see this picture.

Mediterranean diet, traditional risk factors, and
the rate of cardiovascular complications after
myocardial infarction: final report of the Lyon
Diet Heart Study
de Lorgeril M, Salen P, Martin J-L, et al. *Circulation*.
1999;99:779-785

Evidence-based decision making. Patients should receive care based on the best available scientific knowledge

DASH

DASH diet: 9 - 11 servings of fruits and vegetables and 2-3 servings of milk, includes whole grains, poultry, fish and nuts and is reduced in red meat and sweets and sugar containing drinks.

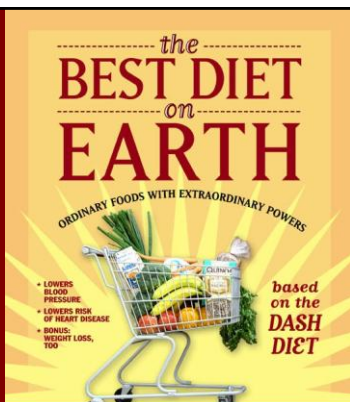
- Lowers blood pressure
- Lowers cholesterol LDL
- Lowers Insulin Resistance

A clinical trial of the effects of dietary patterns on blood pressure.
DASH Collaborative Research Group
Appel LJ, Moore TJ, Obarzanek E, et al.
N Engl J Med. 1997 Apr 17;336(16):1117-24.

QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

Improving Outcome and Attendance

You can make a difference!



by Linda Levy and Francine Grabowski, MS, RD, CDE