# MNT Works: Connecting to Opportunities

## Reaching stakeholders to increase access to and payment for Medical Nutrition Therapy

eat right. Academy of Nutrition and Dietetics

# Contents

# Introduction

## Medical Nutrition Therapy (MNT) works. As Registered Dietitian Nutritionists (RDNs) and other nutrition professionals, we know that providing safe, timely, and effective nutrition care is essential to not only treating and managing many chronic disease and conditions, but it is also a crucial component of preventative care.

RDNs play a vital role in advocating for increased access to and payment for MNT services. This advocacy can take place in multiple settings where patients seek care and with those that determine (and affect) payment for MNT and other nutrition services.

As you move through this toolkit, you will find information specific to a variety of audiences that play a role in shaping both the delivery and coverage for MNT services. For the purposes of this toolkit, stakeholders are defined as anyone who can influence or determine a positive outcome on payment for nutrition services. Also, while some of the examples in the toolkit are limited to one target audience, the overall point/message of the content applies to all target audiences. Advocacy for Medicare and Medicaid are beyond the scope of this toolkit.

The nutrition "noise" in the marketplace is overwhelming; consumers and stakeholders alike are receiving constant messages not only about what is "good nutrition," but also who is the most qualified to deliver that information. The key to rising above the noise is to effectively "sell" MNT delivered by the RDN as the go-to reputable source for both nutrition information and management of nutrition care. This toolkit approaches MNT from the lens of a business professional, and focuses on positioning MNT as a service/product so that it can be leveraged as effectively as possible when meeting with stakeholders. It is recommended that you spend time reading and reflecting on the information in the Sales 101 section as the information included here will lay the groundwork for the rest of the toolkit.

**This toolkit aims to provide RDNs and fellow partners with a step-by-step playbook for advocating for improved access and coverage of MNT to stakeholders, such as:**

- Commercial Payers
- Employers and Benefits Consultants
- Hospital Administrators
- Primary Care Providers

Additionally, this toolkit will address the role that consumers play in supporting advocacy efforts. Consumers create demand. Not only are consumers our patients, but they are also the customers of stakeholders such as commercial payers, hospitals and primary care providers. And as customers, they have a lot of leverage when it comes to asking for safe and effective nutrition care provided by an RDN.

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# Section I:
# Sales 101

## Why are we talking about sales?

### You may be asking yourself, why am I reading about sales in a toolkit about advocating for increasing coverage and/or payment for nutrition services?

- Are you looking for new or additional opportunities to expand your services or to grow your own practice?
- Are you committed to advancing the future of the profession?
- Do you want to be paid more?
- Are you seeking to expand your patient network?
- Do you want to create more jobs for RDNs?

If you have answered yes to any of the above questions, then you are already working in sales. The ability to effectively sell yourself, your services, and your profession is key to achieving your goals/getting what you want. You are helping your potential customers or business partners understand what you do and how it can align with what they want or need.

Whether you are seeking to bring on new clients, have your services included or added to an employer health plan, or looking to create a new job opportunity within your local health market, an understanding of fundamental sales skills and knowledge of how to apply those skills is essential.

The aim of this section of the toolkit is to provide a foundation and "road map" for RDNs to secure more opportunities to provide nutrition services to target audiences — whether with a local medical group, community program, private practice, or corporation. This section will highlight key skills that are considered the gold standard for successful effective sales representatives, review the fundamentals of the sales process, and share recommendations for closing the deal.

**A few things to keep In mind while reading through this section:**

- There is no one size fits all approach to sales. Each interaction and customer will be unique with its own set of opportunities and challenges.
- "Making the sale," aka "getting the business," is a marathon and not a sprint. Building, growing, and maintaining relationships requires attention and care.
- Some sales relationships may move along very quickly while others take more time.
- Making the sale may involve moving out of your comfort zone (in industry lingo, it's called "leaning into discomfort"), or being flexible or creative with your opportunities.

Lastly, think of sales skills as opportunities for professional growth. And, just like any newly learned skill, it requires practice. In the end, the return on investment (ROI) for increasing your proficiency in sales will make you a more capable and versatile professional. Rest assured, these are all skills that with a little practice and patience can be honed and used effectively!

## Being Effective

Regardless of industry, individuals who are successful in sales possess a core set of skills that set them apart and help them to obtain their objective(s). Often, these are referred to as soft skills and include such characteristics as preparation, emotional intelligence, empathy, listening, and resiliency. Many RDNs already possess many of these skills; however, how these skills are utilized may be slightly different when viewed through a sales lens. Understanding these skills and knowing how to use them will help to build confidence and achieve your goals.

### Preparation

Many times, the ability to "make the sale" comes down to the saying: "right time, right place, right service." But, how do you know when the time or the place is right? One word: Preparation.

Being prepared is key to having successful meetings and selling your services. Nearly all individuals who are effective in sales spend a fair amount of time learning about their prospective business partners, reviewing, redefining their goals and objectives, and thinking about potential objections and preparing possible solutions. Good preparation will not only help build confidence going into your meetings but will also help you determine your best opportunity to sell your services and define both long- and short-term goals.

### High Emotional Intelligence

What is emotional intelligence? In its simplest terms, emotional intelligence can be summed up as self and social awareness. Emotional intelligence can be defined as the ability to recognize, monitor, and regulate one's own emotions and to use (or apply) that information to interact effectively and efficiently with others.[1] Individuals with high emotional intelligence are better able to:

- Control their responses in a given situation
- Stay focused on their message in conversations
- Handle objections and challenges[2]

### Empathy

When selling with empathy, the goal is to put oneself in the shoes of the customer to gain a better understanding of the circumstances (or factors) that play a role in business decisions, the motivating actions, or the company goals and philosophy.

Leading with empathy establishes a connection, builds trust, and allows you to better understand the emotions, thoughts, and experiences of your target audience. The process may require you to change your perspective, be more present, listen more actively, ask clarifying questions, or pause before responding; however, in doing so you better position yourself to influence and guide your customer/audience.

### Listening

Highly skilled sales representatives are excellent listeners and conversationalists. Everyone likes to be heard, especially when they have set time aside to meet with you. In a customer meeting, especially those meetings which are limited on time, it can be easy to want to overshare information. But meetings are opportunities to listen and learn. Attentive and active listening during your meetings lead to more natural conversations, which make it easier to customize your message, address any barriers or objections, and position your ask.

### Resilience

Setbacks will happen, obstacles will arise, and rejection will occur at one point or another. However, resilience through the sales lens focuses on understanding the objection (or barrier), learning from it, assessing the opportunity to try again, and then deciding on a course of action.

**That course of action might include:**

- **Focusing on the same intended business,** but now the goal is to find/connect with another internal influential contact.

*For example, you had a meeting with the chief physician in your local medical clinic and while he was interested in your services, he also commented that RDN services could not be added as there was no insurance coverage. You could choose to seek a meeting with the clinic manager. During that meeting, you could focus your discussion on the interest of the physicians in including RDN services, their perceived barrier of lack of coverage and highlight current coverage opportunities.*

- **Restrategize your approach** by focusing on driving interest in your services from external sources.

*Using the example above, are there ways that you can promote your services among the local community to drive the medical clinic to seek your services? Is there an opportunity to involve the community to seek your services via their doctor's office?*

- **Move on.** Recognize that there may not be an opportunity at the time you are ready. This is not a failure, it's acceptance that pursuing this opportunity right now will not help to achieve your goal.

## Understanding the Sales Process

Sales is as much an art as it is a process. A process which is guided by a defined methodology one uses to conduct a "sale," otherwise known as a sales model.[3] There are many different sales models, and each takes its own approach to sales. However, there are key elements that all models include in one way or another. The following framework will help identify and define the steps you want to take.

### Discovery

The discovery stage of the sales process covers everything you would want to learn about your target audience. This stage starts before setting up the first meeting and will continue throughout the entire sales process. Now is your opportunity to engage, ask questions, and listen to their responses to learn who they are, what their goals are, and what they are striving to achieve[4].

**Discovery may include understanding:**

- What is the organization's business model?
- What is the mission/vision statements of the organization?
- What are the greatest obstacles they are encountering in reaching their goals?
- Who is their target population served?
- Who are the key decision maker(s)?
- What or who is the current competition?

## Recognize the Need

Businesses are more likely to seek ways to support services they view as needed and that support their mission. However, in an environment influenced by budgets and competing nutrition messages and services, it can be difficult to find a way to position your proposed services as the best fit for a given business or organization. So, it is crucial to understand both the goals and needs of a business. Your opportunity to "sell" your unique services lies in the gap between what they want and what they need.

In some instances, the gap between goal and need may be obvious, providing your opportunity to discuss your services. In other instances, that gap might not be as clear and there may be an opportunity to "create a need."

**Create the need? What does that mean?**

Creating the need entails identifying and presenting an unrecognized opportunity as something that a business or organization could benefit from that either meets their mission, goals, or overall better patient care. This is not necessarily a time to go full swing into pitching your services, but rather a time to provide information and education about a mutually beneficial topic.

*For example, we know that individuals who lack access to health care in many cases are the same individuals who have nutrition-related chronic diseases. We also know that food security plays an essential role in their ability to eat nutritionally adequate and culturally appropriate foods.*

- Does your target audience actively screen for food and nutrition security? What is the process once food and/or nutrition security is identified?
- Does your target audience provide access to nutrition care? If so, is that nutrition care tailored to meet the individual's medical needs and cultural background?

Your goal here is to help your target audience understand the need and that you have the solution.

## Find the Solution that Creates a Win-Win Scenario

The information gathered during the stages of Discovery and Recognizing the Need can now be used to build a solution that will achieve your goal and meet the need of your business prospect.

During this stage of the sales cycle, you must be flexible and manage expectations. Your prospect may agree to some or all your proposed solutions, or they may have an entirely different solution to using your service. They may also reject your proposed solutions — all these potential outcomes are okay! Not everyone you meet with will be in a position to agree to support your services or purchase your product.

A solution may be incremental, meaning that there are a few or many steps that need to occur before decision makers can agree to act. The opportunity here is to then determine the next step.

- Is there another key decision maker to meet?
- Does the decision maker believe they need more information to make an informed decision?
- What are the remaining obstacles or barriers and how can these be addressed?

## The Close

The "Close" may be the hardest, but one of the most important parts of the whole process. In the world of sales, the close is often referred to as "The Ask." This is the opportunity to gain commitment to the solution(s) proposed during the meeting.[3,4] Depending on your identified solutions, your close may include:

- Asking for contact information or to be put into contact with another key decision maker(s).
- Ask for RDN services to be included as part of the menu of services options offered.
- If the group rejects the solution, your ask may be to find a better time to revisit the conversation.

"The Close" serves as your window to continue to keep the conversation moving and build the relationship between you and your prospect.

P.S. Don't forget to thank them for their time!

## Follow-up

Follow-up usually occurs either a few days after your meeting or at a prescribed time based on the discussion you had during your close. Use this opportunity to check-in on the steps discussed during the close and to thank the prospect for their time and commitment to working with you.

Section II:

# The Value of MNT by RDNs

Throughout the sales process, your proposed solutions to businesses and customers should highlight the value of MNT by RDNs. This section will provide you with the information needed to best communicate the value of MNT by RDNs.

## Effective Messaging: Hook, Bridge, Flag

Flagging, bridging, and hooking are all communication tools that are used during conversations and interviews that skilled communicators use to deliver impactful, key messages in a conversational manner — not as a presentation.

## Hooking

"Hooking" includes making statements or questions that not only grab your audience's attention but also encourages them to ask for more information. These are statements that can encourage dialog and curiosity about your topic; when used well, hooking statements allow you to advance to a more meaningful conversation. You will want to make a statement or ask a question that you will be able to offer a solution or provide an answer. Hook statements/questions should lead the audience to ask a follow-up question.

**Examples of Hooking Statements and Questions:**

1. Here's one of the results we are seeing now with the changes made to the nutrition screening process …
2. We know assisting patients with losing weight is hard. I think there is another way to see improved weight management outcomes.
3. We know that provider time is tight in office visits. I recommend a new approach to addressing nutrition concerns.

## Bridging

"Bridging" is another communication technique and when used effectively, it allows you to control a conversation and stay focused. It gives you the power to direct conversation by shifting topics so that the conversation moves closer to the key message. Bridging can be particularly useful in situations when your audience is taking the conversation in a direction away from where you would like it to go. It can also be used to handle objections to your message. Lastly, bridging can help build rapport and credibility with your audience. Bridging in a conversation can be done by making a statement, asking and answering your own question, or even telling a quick story.

*For example, you are meeting with a clinic administrator about adding RDN services to the practice. While they are eager to provide more preventive care, they are concerned about the cost of supporting the position.*

Yes, I understand that there are additional costs associated with adding nutrition counseling to the menu of services (acknowledge their concerns); however, please let me explain (bridge) what we do know about financially supporting nutrition services.

OR

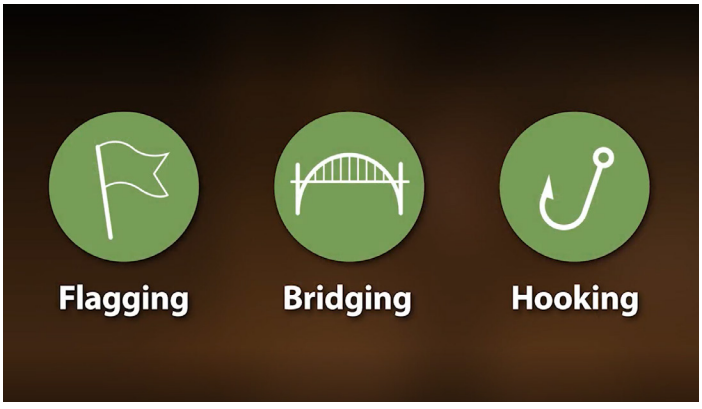
Sure, I absolutely understand the concerns with cost. But I would like to pose this question: what are the costs to both the patient and practice if these services are not available? (Bridge) Let me share with you some information relating to the cost benefit of providing nutrition services for [defined population].

## Flagging

"Flagging" involves making statements that are attention getting, but also indicate that what you are going to say next is important. These are statements that will emphasize the main, most critical points of your message. Bottom line, it cues your intended audience to pay attention to your key message.

**Common Flagging Statements:**

1. The one thing that I really want you to remember is….
2. The biggest take away from today's meeting is …
3. The fact is…
4. It boils down to …



## Be Specific with Supporting Evidence

Strong evidence exists on the effectiveness of MNT along with ROI data demonstrating the value of MNT by RDNs. However, it is equally important to approach a sale at the right time and right place, as well as leverage key information that will resonate with your audience. Your intended key audience will need to hear your information in a way that is both meaningful and purposeful to them. Use the strongest and most current data that supports your efforts, but specific enough that it holds value to your audience. It is important to provide accurate and thorough information; however, it is just as important to avoid overwhelming your audience with information.

**In Appendix C:** Effectiveness of MNT Talking Points, you will find meaningful data to incorporate into your messaging that will assist you when creating a win-win solution to support your efforts and make your case. Additionally, the most convincing and meaningful information has been incorporated into audience-specific flyers you can use as leave behind or supporting materials during your sales efforts.

# Section III:
# Prepare and Take Action

## Now that you understand the sales process and are equipped with the evidence to show the value of MNT by RDNs, it's time to prepare and take action!

Preparation is key to having meaningful and productive meetings. Remember, the best opportunity to "sell" your services occurs when it's the "right time, right place, right service." It's important to have a general understanding of what is occurring in the current healthcare environment. Some crucial steps in the preparation process include developing your plan and building relationships.

## Deciding Your Approach

To promote RDN-provided MNT and identify the most effective strategies, there are several key steps to take. The information you gather should guide the development of your plan. For example, this is the time to start learning and gathering information about your prospective business partner (your target audience), whether that is joining a payer network, working within a community program, or asking for the addition or expansion of nutrition services to a local medical practice.

**Here are some things to research (discover) and consider:**

### Define Your Goal

What is the problem and why is promotion of MNT by RDNs the solution? Framing the discussion in terms of a discrete problem and effective solution is the foundation of a successful plan. To determine your goal, you will need the following information:

- **Identify the current status:** To what extent does your target audience experience health equity through access to MNT by RDNs?
- **Identify the desired standard:** What level of MNT by RDNs is best for your target audience?
- **Conduct a gap analysis:** What is the difference between the standard and the current status of access to MNT by RDNs? What contributes to that difference? How can that gap be decreased?
- **Identify key decision makers:** Who are the people/positions that can make or approve changes within a given company or organization? Who can add services, authorize spending/influence budgets, or promote nutrition care?

### Forming Your Team

Collaborating with other stakeholders around shared goals lends exponential strength to your voice. A group of individuals working together to influence outcomes on a specific problem or issue can expand the impact beyond what an individual may achieve and can be an effective way to consolidate resources to achieve a common goal. Before developing your team, make sure there isn't already an existing group with the same or similar mission that could be used to achieve your desired ends. If forming a new team, consider the following as members of your team:

**Other RDNs**

- Determine which RDNs can provide historical context. What work has been done in the past by other RDNs? Talk to other local RDNs to learn the history of past efforts to promote MNT by RDNs to your target audience.
- Your affiliate or DPG Nutrition Services Payment Specialist brings expertise and resources to the team.
- Take advantage of other resources and connections with pertinent DPGs and/or state affiliates.

**Non-RDN Stakeholders**

- Are there professionals or organizations that your key stakeholder values?
- Do any of the professionals or organizations have values, goals, and/or challenges that overlap with yours?
- Does your goal align with their goals? Does your goal solve any of their challenges?
- Is there a win-win approach you can identify and propose to the other group in order to collaborate?

### Determine Strategies

Discuss goals and strategies with the team early on to help focus your efforts. This will also foster early buy-in and engagement from your team. To determine your strategy, review the information you gathered when defining your goal, including past efforts and identified barriers. You may want to conduct an analysis of strengths, weaknesses, opportunities, and threats (SWOT analysis) to further refine your strategies to work towards your goal.

## Building Relationships

Now that you've defined your goal, the strategies to work towards the goal, and the team, you are ready to begin identifying key decision makers who can help your goal become a reality. But first, it will be important to build relationships with potential business partners and other individuals who can support your efforts. Once you've identified the key decision maker(s), it's time to reach out and connect.

### Fine-tune the Conversation

People prefer to work with or go into business with people they like and trust. Relationships take time to develop and require regular contact over time. Thoughtful and careful conversations are the first step in helping to build a strong relationship. It can be very tempting and easy to start off a conversation in a meeting by telling your audience who you are and what you want. Sometimes that can be effective, but more often this can lead to more of a presentation versus a two-way dialogue. The best and most productive conversations occur when all involved can equally contribute.

A successful sales conversation will focus on your audience and the decision maker with whom you are meeting. Make the conversation about them, start small with a personal-focused introductory question. As the conversation evolves, pivot to pointed questions to learn more about the interests, needs and challenges of the audience. It is also helpful to have prepared a short, personal story to share with your audience that conveys how MNT provided by an RDN has resulted in a positive outcome. This is the opportunity to learn about the nutrition barrier(s)/concerns they are facing, learn about any solutions tried previously to address the barriers/concerns, and whether they have felt successful in addressing their barriers/concerns. Keep in mind the audience may not be aware of any nutrition barriers, and it make take a few conversations to uncover how MNT services will best fit their needs.

**Hopefully this will help you to identify:**

- Your audience's position on nutrition care. Do they believe that they have any concerns or barriers?
- Is nutrition a priority?
- If not, can you identify a way to make it a priority for them?

### Tips to Develop a Relationship with the Key Decision Maker(s)

**Identify the key decision maker(s).** To help determine key decision maker(s), refer to your corresponding target audience in the Targeted Marketing of MNT by Audience section.

**Connect with the decision makers.** The main goal is to get a meeting with the decision makers. You can request the meeting via phone or email. A sample message script is provided in Appendix E.

### Before Getting the Meeting

- It may take time to schedule a meeting. Be vigilant in identifying opportunities to demonstrate your expertise as the nutrition expert and resource to the decision maker.
- Identify and join events and groups, such as conferences, committees, coalitions where the decision maker or someone connected to the decision maker may be present.
- Demonstrate your expertise by being involved in group conversation that involves the decision maker.
- When able, interact directly with the decision maker. If that person is not available, focus on connecting with someone who interacts with the decision maker and can potentially influence on your behalf.
- This is also the opportunity to find out the best time and method (phone, email, etc.) to reach the decision maker(s).
- If your emails are going unreturned, consider following up occasionally by including timely and relevant nutrition information that may benefit the decision maker(s) (e.g., a recent eatright.org article on a current topic; client stories; Academy position papers; etc.).

### After Successfully Scheduling a Meeting

- Follow the steps outlined in the next section, "Meeting with Decision Makers."

## Putting your Plan to Work: Meeting with Decision Makers

Congratulations! You have a scheduled meeting! Preparation and effective execution of each step along the way is key. The following will guide you as you prepare, execute, and follow up from your meeting.

### Prior to Your Meeting

Do your homework! (Refer to Deciding Your Approach.) Preparation will help to anticipate questions and allow time for you to prepare your responses.

**Familiarize yourself with the office function and role of everyone attending the meeting.**

- Be prepared to introduce yourself and other collaborators at the meeting.

**Know the population demographics in your region (rural/urban, race/ethnicity, primary disease burdens).**

- Identify how you can leverage this information so you can link trends in rising health care costs to limitations in access and delivery of MNT.

**Practice the talking points.**

- Identify any studies and references that can serve as talking points to support your "ask."
  - Consider also making outcomes data collection part of the "ask." For example, ask a payer to look at claims data and total cost of care or inquire if an employer would be willing to look at productivity/absenteeism.
- Are there real-life success stories to show medical improvements as a result of MNT? Or, are there stories to share where lack of access to MNT was a barrier and it had a negative impact on outcomes?
  - See Appendix H for reference testimonials (Case Studies)

**Anticipate objections and identify responses/solutions.**

**Prepare any leave behind materials that will support your message.**

- There should be a clear connection between the talking points discussed and any resource materials provided. The flyers in Appendix A that are specific to your audience should be your main leave behind.

**Practice asking for the business.**

- It is important to clearly and effectively ask your target decision maker for your business.

## During the Meeting

- Introduce the team and roles you work in as RDNs.
- Help the decision maker understand what RDNs do, particularly as it pertains to why it's important to them.
- Seek to understand the needs of the stakeholder. What are the health needs of their member population?
- Offer information that is clear, direct, and will link to the identified needs of the target audience. Be concise. You can always provide additional information at a later time.
- Offer solutions, not just critiques. Advocates often make the mistake of pointing out problems without proposing concrete solutions.
- If there is an ask, be sure to ask it!

## After the Meeting

- Continue to stay engaged and focused, complete any tasks required of you to move the process forward.
- After the meeting, be sure to send the following:
  - A thank you note to the individuals you met with.
  - Additional information you promised to share after the meeting.

## After Advocacy Success

If and when you reach your goal, it's important to stay in touch and connected with your point of contact. You can do this with occasional emails with updates and nutrition information that may be of interest to them. Track the outcomes of your services and share the aggregate information with your point of contact to demonstrate success.

# Section IV:
# Payment Models

## As you think about your "ask", you will need to have an understanding of the various options for payment of MNT by RDNs.

We refer to these as "payment models." There are three payment models that RDNs may encounter: Fee for Service (FFS), Alternative Payment Models (APMs), and Value Based Payments (VBPs). APMs and VBPs are similar, but not exactly the same; however, they can be considered the same from the perspective of selling MNT and RDNs.

The 2015 U.S. Congress passed landmark legislation, the Medicare Access and CHIP Reauthorization Act, which accelerated the use of health care payments connected to outcomes, quality and the patient experience — or value — rather than paying for the amount of services provided - or volume. Private and government-sponsored payers have been implementing alternative payment models (APMs) and value-based payments (VBPs) as one strategy to achieve better care at a reasonable cost (i.e., value-based care). Refer to the Academy's website for more information about value based payments and the Patient Centered Nutrition Services Payment Model.

It is important to know which payment model or models are in use at an organization, as they will inform how to shape the message so that it holds value for the stakeholders/key decision maker(s).

### Fee-for-Service

The Fee-for-Service (FFS) payment model is still used widely throughout the U.S. health care system and will remain the dominant or only payment model in some geographic areas, or for specific health care services. Claims are submitted after health care services have been provided, and providers and other organizations are "reimbursed" according to patient benefits, coverage and provider agreements (contracts). There is a financial incentive to increase volume (e.g., more visits) or to provide services that offer the most reimbursement, as the only way to earn more is to do more.

**When Medical Nutrition Therapy is "reimbursed" using the FFS payment model, the key goals (sales objectives) include:**

- Convey the cost effectiveness of MNT. MNT has been shown to be a cost-effective component of treatment for many diseases and conditions.
- Discuss opportunities for successful integration of MNT provided by RDNs. Tailor the message to show how MNT supports specific goals, diseases, or conditions that are important to the stakeholders.
- Provide solutions/examples for successful integration of RDNs.
- Ensure that practices understand MNT is a unique service with its own revenue stream. MNT provided by RDNs can be financially sustainable if practices leverage consumer benefits and coverage. Provide examples: Medicare, Medicare Advantage, and any specific examples of benefits for payer populations (i.e., specific employer groups in your area), if known.
- Convey the potential for MNT to curb other costs: (medication, complications, ER, hospitalization).

### Alternative Payment Models and Value-based Payments

APMs are health care payments tied to quality, outcomes and the patient experience. VBPs are payments tied to quality, outcomes, the patient experience, and when care is delivered at a reasonable cost. The aims are to simultaneously improve care while decreasing the total cost of care, especially "avoidable" care (e.g., emergency care, unplanned hospitalizations, complications). Health care stakeholders (including practices, systems, patients, payers) may be more interested in understanding how MNT and the use of RDNs can help organizations achieve their goals.

There are several types of APMs/VBPs, such as population-based payments, episode payments, and bundled payments. Regardless of the type, RDNs should be prepared to "sell" why a portion of the payments should be allocated for the delivery of MNT. Practices want to know how MNT will help the practice earn maximum payments from the APM/value-based arrangements.

As you speak with and learn from your target audience, it will be key to understand what priorities matter to them and how their current performance impacts their payment. The ultimate goal for RDNs is to align the effectiveness of medical nutrition therapy and other RDN services provided with the intent of the specific quality measures that are a priority for your target audience. One way to demonstrate the value of MNT for APMs/VBPs is through quality measure reporting (UDS, HEDIS and others). There are several quality measures (e.g., diabetes and others) where the effectiveness of MNT aligns with the intent of what is being measured. Population health management is another important "ingredient" of most value-based models and RDNs are able to be a key provider in population health management. When RDNs understand

relevant connections between MNT and quality measures and important goals related to population health, there is an opportunity to customize the sales pitch for MNT and RDNs.

RDNs may encounter physicians, administrators, or other health care teams that are not fully aware of or invested in the benefits and outcomes of MNT. If that is the case, initial conversations with stakeholders will require focusing on discovering the desired goals of the stakeholder and demonstrating how those goals can be supported with MNT.

The overarching goal (sales objective) is to convey that MNT in the context of value-based payments is multi-pronged. The message should emphasize any short-term outcomes, connections to quality measurement, cost-effectiveness, and any demonstrated or potential cost-savings through reductions in "avoidable" health care costs, especially within twelve months.

**Key objectives when seeking to increase patient and provider access to MNT in APMs/VBPs include:**

- Stakeholders determine that MNT and RDNs are integral to improving outcomes and population health management and will allocate a portion of value-based payments (e.g., population-based payments, episodes, bundles) for the delivery of care.
- Stakeholders take steps to factor (or include) the cost of providing MNT into payment methodologies/value-based design.
- Payment streams are adequate to support the delivery of MNT provided by RDNs.

Physician advocacy may be instrumental to elevating the case for routine access to MNT and the inclusion of RDNs in the context of value-based payments. RDNs can use the evidence for MNT for various conditions and populations to build the case for the allocation of a portion of value-based payments for MNT. Ultimately, contracting personnel are instrumental to ensuring that payments are sufficient to cover the cost of providing MNT. RDNs can work with and through others to ensure that decision maker(s) and contracting personnel understand the cost (i.e., interventions and RDN staffing) required to achieve expected outcomes of any proposed delivery models.

## Team-based Care

It is important for RDNs to think about how they can add value in the context of team-based care, whether it is primary care, specialty care, hospital, or other setting. This could include playing a greater role in care coordination or working at an elevated scope of practice.

There are opportunities for RDNs to perform in roles beyond direct nutrition care to patients. For example, RDNs can lead quality improvement teams, help to manage patient panels, and oversee performance measure reporting. As dietitians, our training provides us with such a skill set that can be applied to many roles such as tobacco cessation specialist or even care coordinator. Even in our traditional role of providing nutrition counseling, it is important to think about different ways to provide care that are not only effective but save money (such as group medical appointments and telehealth services).

**In preparation for stakeholder meetings, consider the following:**

- As much as possible, identify where MNT and the RDN fit into the larger organizational picture, both with patient care and payments.
- How do RDNs support goals? Are there other ways to add value?
- What are the opportunities for RDNs in the APMs/VBPs used by the organization?
- It is possible that an organization utilizes more than one type of payment model to deliver services. In some cases, RDNs may need to make the pitch for MNT in both FFS and APMs.

# Section V:
# Targeted Marketing of MNT by Audience

Now that you have an understanding of sales, the value of MNT by RDNs, an overview of building relationships and having meetings with decision makers, and the three common payment models, let's dive deeper into further tailoring your message to the type of audience you are working with. The information in this section is intended to give you a glimpse into approaching your audience based on a specific type of decision maker. While your message may be the same, increasing access to MNT, how you approach each stakeholder may be vastly different. You will need to ensure that you are providing relevant information to the right audience.

## Commercial Payers

Commercial payers have a vested interest in keeping beneficiaries in good health and in a cost-effective way. When evaluating member benefits, payers consider their bottom dollar, while also positioning themselves to offer a benefit package that's appealing to the membership and sales community. Some common deciding factors include cost savings, preventive measures, and access to care. It is also helpful to know if the payer supports value-based programs, and/or if they have their own programs or are part of a multi-payer program, such as CMS Primary Care First, that provides another opportunity for the RDN to insert their worth. Many commercial payers are actively taking action to address health equity and recognizing how social determinants of health financially impact their bottom line. There is a growing trend of payers committing to address health equity in their future value-based payment models.

### Connecting with the Decision Makers

When approaching a payer, the RDN is likely not going to have direct access to their executive leadership, the group that makes the decisions for the company. Therefore, it's important to know how to start these crucial conversations that will hopefully open the doors and provide leverage for further in-depth conversations. The key is starting with the payer's Provider Relations contact.

Every commercial payer is structured differently, but there is usually a contact person dedicated to the provider community. These contacts are often posted on the payer's website. The title of their role ranges from Network Representative to Provider Relations and other similar titles. Most payer websites have a dedicated page for the provider community, and you should be able to find this contact on that page. The goal is to build a rapport with this person and provide detailed information in hopes they will escalate your questions and request to the departments of the decision makers. Often, that involves multiple departments including, but not limited to: Medical Directors, Executives of Claims, Executives of Membership and Sales, etc.

The next step is initiating the conversation. Keep in mind, many staff in this role are not going to be familiar with MNT and may not have much knowledge on RDN services in general. The RDN will need to provide as much detail as possible and ask questions specific to current coverage by providing the MNT codes and diagnosis codes. The goal is to find out what their current credentialing and coverage policies are before inquiring about options for change.

**Key points to consider when initiating the conversation with commercial payers:**

- Call provider relations to inquire about becoming a credentialed provider and establish rapport. Making contact via phone or email opposed to an online enrollment/registration process can make a difference in building a relationship.
- Request to schedule an appointment or phone call to discuss the benefits of nutrition services. Let them know you are interested in sharing what you as an RDN have to offer their members. If unsuccessful with scheduling a visit, write a letter, or send an email.
- Find out if the insurance company covers MNT. What diagnoses are covered? For example, is there coverage for Diabetes and CKD only or other conditions such as HTN, overweight/obesity, lipid disorders?
- Be prepared to show outcome data. Utilize case studies and talking points to support your message.
- A payer may have specific requirements in their policies that guide coverage for services. For example, a payer may only cover diabetes education if it is provided by an accredited ADA program.

### Potential Collaborators

There is importance to the saying "strength in numbers." A request that is presented by a group that involves other paneled providers carries more weight with a payer. Consider a partnership with other RDNs or non-RDN providers in your community, such as primary care providers, mental health providers, and even hospital or health system administration. The suggestion of a pilot is another option if you feel you aren't making progress with the payer. There aren't as many legal or system changes involved in a pilot and the involved parties can agree about a time frame, which means it's not a permanent benefit change. If the pilot program shows a

good return on investment, the payer is more likely to expand that benefit for more beneficiaries over a longer period of time and are more likely to commit the resources to make it a permanent benefit change.

Another suggestion is to reach out to self-insured plans. They are their own policy makers of their plan. They tend to focus and allocate funds to preventive measure in hopes to keep the cost of the plan down. If the commercial payer is a third-party administrator (TPA) for a self-insured plan, it could open discussions for the fully insured member benefits at a later time.

## Access to MNT

Depending on the payer's coverage of MNT, there will likely be room for improvement with expanding access. Many commercial payers use Medicare as a reference for coverage decisions and may choose to only cover MNT for beneficiaries with diabetes and chronic kidney disease. Once you have a better understanding of the current credentialing and coverage for RDNs, you can then request a review of their current policies and make a proposal to expand coverage.

**Questions to consider when asking about coverage:**

- Is there a specific MNT coverage policy that providers have access to?
- Are nutrition services covered under another benefit, such as Patient Protection and Affordable Care Act (PPACA)?
- A payer may have specific requirements in their policies that guide coverage for services. For example, a payer may only cover diabetes education if it is provided by an accredited ADA program. You should ask if they have any other scope of practice edits or requirements for billing nutrition services.
- Do self-insured plans have a different MNT or nutrition benefit? If they do, request a copy of their benefit certificate and/or plan specific coverage policies. At a minimum, ask about the large, self-insured plans in your area.

**Some other questions to consider and build upon include:**

- Does the payer have Medicare Replacement Plans? If so, provide data on the Medicare aged population.
- Ask if the payer follows Medicare coverage for plans or if they provide additional coverage. If their commercial plans cover more than Medicare, do they extend this coverage to their Medicare Advantage members?
- Does the payer cover a rural area? If there are rural areas covered by this payer, access to any provider may be limited.
- This is an opportunity for the RDN to demonstrate they can provide access to MNT in areas that may be underserved. It's likely that a physician can't spend 30 minutes to an hour on MNT, but an RDN can. This is also an opportunity to inquire about their telehealth policy.
- Is the payer a multi-state payer? If a payer has plans in several states, the access can vary from one region to another. This may be an opportunity for RDNs to highlight their ability to be licensed in the states in which the payer has beneficiaries to allow increased access to evidence-based care.
- Is Medical Nutrition Therapy covered if provided via telehealth? Is there payment parity?

## Outside of Coverage Policies, it is also Important to Note how the Payer's Fee Schedule is Determined

- Is the RDN reimbursed the same allowance as other providers of MNT, such as physicians?
- If the RDN is reimbursed at a lesser percentage than other providers, that gives the RDN leverage to demonstrate they are the experts in nutrition services and can provide these services at a rate that will save the payer money.

Once a payer's coverage policies are determined, if findings show that coverage is limited, it may be beneficial to look at state or region-specific statistics regarding chronic disease prevalence and diagnoses that would benefit from increased access to an RDN.

Additionally, if the payer has limited coverage, the number of participating, credentialed RDNs may be low. Refer to the provider directory on the payer's website to confirm the number of participating RDNs. This number may be used to demonstrate that access could be limited due to RDNs' lack of participation per their coverage status. This would also be another opportune time to compare one payer to another payer if there is a discrepancy between the number of participating RDNs among payers.

When a payer makes changes to a benefit plan the process can be time and labor intensive, which means it can also be costly. Therefore, these decisions are not taken lightly and require a solid proposal from the inquirer to make these changes happen. The RDN should be prepared to share information to support the request, including:

- Evidence based literature.
- Supporting documentation from the Academy.
- Personal cases, including results.

- Other payer's coverage. If another payer in the area covers a benefit being requested, this can be used as leverage as payers need to stay competitive in the marketplace.
- Specific member requests or examples. If the payer has members that have been given physician orders or have medical necessity for a service that isn't covered, it is likely to grab the payer's attention. The more examples you have the better the impact can be.
- Provide the number of RDNs in the state to demonstrate the potential impact. A letter or any documentation from your state affiliate can aid in support of a change.

It is vital that RDNs inform commercial payers of the unique skill set of the RDN and the role that MNT plays in cost-effectiveness for certain diagnoses. "Connect the dots" for stakeholders; show them that increasing access to MNT by RDNs can improve outcomes, prevent progression of chronic disease, and improve quality of life while decreasing the financial burden of caring for individuals with chronic disease.

*For Example: The cost attributed to nutrition counseling for Diabetes only makes up 0.03% of the total cost of the disease.*[5]

*"Controlling diabetes, high blood pressure, and elevated cholesterol often requires the use of expensive drug treatments. Studies indicate that medical nutrition therapy provided by nutrition professionals, such as registered dietitians, can be used to help individuals successfully manage their disease conditions through dietary lifestyle changes. As a result, the need for drug treatments can often be substantially reduced or eliminated. Reducing the need for intensive drug therapy may also result in reduced cost and fewer side effects for the patient. This could improve adherence to the overall treatment program."*[6]

## Employers

Employers are in a unique position to influence employee health. Work is so impactful on health that it is included as part of the definition of social determinants of health by the Centers for Disease Control and Prevention (CDC). According to the CDC, social determinants of health are "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.[7] The impact of work on employee health is of particular interest to the employers themselves since employee health directly impacts employee productivity and absenteeism. Additionally, there is an even more direct financial component as most consumers on private health insurance receive their health insurance plans from their employers who often subsidize the cost.

### Connecting with Decision Makers

At most employers, employee wellness programs fall under their own department or human resources. Common positions that may be decision makers or stakeholders in influencing the insurance plan design include people working in human resources, employee benefits, and employee wellness.

### Potential Collaborators

In addition to the decision makers within the employer organization, you may interact with the employer's health insurance broker. If interacting with the broker, you can use the broker-facing promotional piece, "Include MNT on the Benefits Menu," to support your efforts. Together, you can support the employer and broker in ensuring MNT by RDNs is part of the employer's health insurance benefit plan design.

### Access to MNT

There are a variety of strategies that employers can use to positively impact employee health. RDNs are a key part of ensuring those strategies are effective. For example, when RDNs are part of an employee wellness program, participants experience significant positive changes in health outcomes.[6,8,9] There are a variety of approaches for increasing employee access to MNT by RDNs. Consider the following approaches:

**1. Employment of an RDN**

RDNs are uniquely positioned to lead, manage, and staff employee wellness programs. According to the Bureau of Labor Statistics, a wellness program contains three main components: physical fitness, weight control, and nutrition education. These three areas fall directly within the expertise and scope of practice of RDNs. In fact, the list of skills suggested for a wellness director by the Bureau of Labor and Statistics closely mirrors the list of skills expected of an RDN.[10]

According to the authors of Worksite Wellness: An Ideal Career Option for Nutrition and Dietetics Practitioners, "Nutrition and dietetics practitioners need to promote themselves (with support from the Academy) as wellness experts because they possess broad-based training and have the skills needed to meet the need for general wellness and worksite wellness positions. If nutrition and dietetics practitioners are absent from advocacy efforts to promote their profession in the wellness arena, provision of these services may be done by other groups."[11]

Consider applying for positions in employee wellness and/or advocate to employers for the inclusion of RDNs in employee wellness programs. RDNs involved in employee wellness programs can ensure MNT is a key offering of employee wellness programs. The following sections, "Plan Design" and "Increase Utilization of MNT by RDN Benefit," provide background on methods for increasing access to MNT in an employee wellness program.

**2. Plan Design**

Ensure employers include MNT by RDNs in the health insurance plans they offer employees. Including MNT as a covered benefit in group plans gives employees access to RDNs who provide high-quality, cost-effective nutrition services that can improve their quality of life and decrease absenteeism.

In addition to the evidence and return on investment data provided in The Effectiveness of MNT section, employee population specific statistics include employees receiving MNT miss work 64.3% less and take 87.2% fewer disability days than those who do not receive MNT.[12] MNT by RDNs as part of a health plan is an effective, low-cost solution to employee health with the MNT benefit cost around only $0.03 per member per month.[13] As you work with employers to ensure MNT by RDNs is a covered benefit, use the employer-facing promotional piece, "Employee Access to MNT is Smart Business," in your advocacy efforts.

If/when approval is gained to add MNT by RDNs into the plan, you can ensure appropriate implementation by providing coding and coverage best practices and recommendations as outlined in the Talking Points of Fee-for-Service section. For more information on coding and coverage, refer to the RDN's Complete Guide to Credentialing and Billing: The Private Payer Market.

**3. Increase Utilization of MNT by RDN Benefit**

In the event employees already have access to an MNT by RDNs benefit in their employer-provided health insurance plans, consider efforts to increase the utilization of the benefit by providing employers with information they can push to their employees about the MNT by RDNs benefit, and how to access it. For more information and materials to support these efforts, refer to the Targeted Marketing of Nutrition Services by Audience section on Consumers.

## Hospital Administrators

Adapted, in part from Malnutrition Quality Improvement Initiative Yields Value for Interdisciplinary Patient Care and Clinical Nutrition Practice.[14]

Hospital Systems often have a complex, multi-layered administration. When advocating for expanding access to MNT services, it is important to understand how the organization is structured and how to identify the key positions that oversee ambulatory (or outpatient) services. These individuals are stakeholders who will make financial decisions, including whether to hire RDNs and provide nutrition services.

### Connecting with Decision Makers

The "C-Suite" is composed of several high-level executive members of a hospital staff. It has this nickname as this group of people usually have titles that start with "Chief", such as "Chief Executive Officer" or "Chief Nursing Officer." This is particularly true in smaller hospitals with smaller budgets; for example, the Chief Quality Officer may also fulfill the role of Chief Safety Officer, or the Chief Nursing Officer may also fulfill the role of Chief Operating Officer.

RDNs should meet with hospital administrators on a regular basis to build relationships and provide brief, written reports that include departmental highlights about services provided by RDNs. The templates for these reports can be developed over time based on the requests and changing needs of the health care system. The goal is to position or further strengthen the view that both MNT and nutrition counseling services are instrumental in improving patient outcomes, helping the health care system achieve quality rating standards, reducing risk of readmission and improving patient satisfaction and access to care. These meetings can also be used to advocate for new nutrition services.

## Access to MNT

In both the in- and outpatient settings, RDNs support and provide care that is cost-effective and patient-centered. Nutrition therapy often starts during hospitalization, so to be most effective a care plan should be implemented to continue nutrition interventions after discharge until the problem, as documented by the nutrition diagnosis, is resolved. Hospital-based RDNs can help to improve transitions of care, support care coordination (e.g., home health, outpatient care), and address social determinants of health (i.e., food insecurity). Hospital outpatient clinics provide a method to refer patients for MNT by RDNs for ongoing care once discharged. RDNs continue the nutrition care plan, expand upon education that was started during the hospital stay, and provide critical self-management skills for clients/patients at home. Additionally, RDNs may have the opportunity to provide services via telehealth.

Many outpatient services beyond nutrition clinics should include a nutrition component. For example, cardiac rehabilitation programs are comprised of physician services, a monitored exercise program, and an education component that can include MNT by an RDN. Similarly, bariatric surgery programs require nutrition counseling pre- and post- surgery. Other examples of clinics that may utilize RDNs are multi-disciplinary outpatient clinics such as transplant, dialysis, and oncology. RDNs should advocate for inclusion in these types of bundled payment services whenever possible (see section Connecting with Stakeholders).

## Nutrition Services Payment

Payment systems differ for inpatient versus outpatient services. Most hospital stays are not paid using a fee-for-services (FFS) model, but rather a lump sum using a classification system that predicts the resources required to treat patients with the same principal diagnosis and similar secondary diagnoses and procedures. An example of this type of inpatient payment model is Medicare's diagnosis related groups (DRGs). Similarly, many outpatient services are paid using a value-based payment model. An example of this type of outpatient payment model is a population-based health program, discussed earlier in this toolkit. These types of alternative payment models are used to incentivize cost efficient, quality care. It is relevant to note that some outpatient services, such as MNT by a RDN for Medicare beneficiaries, is still paid using a FFS payment model with a risk/reward adjustment based on the quality of care provided. Regardless of payment methodology, the U.S. health care system incentivizes quality care provided economically through the use of quality rating systems and incentive or penalty payments based on patient outcomes. RDNs need to convey the value of their services within each of these payment systems. This ensures stakeholders understand that payments received include MNT services which support not only reducing cost of care but also other common hospital goals of reducing/preventing readmission rates and decreasing length of stay. Bottom line, in conversations with stakeholders, it is imperative that MNT by RDNs provided in the hospital outpatient clinic setting is seen as an opportunity for additional revenue and potentially has a positive impact financially for both the inpatient and hospital system as a whole.

Since payment for services is different in the inpatient and outpatient settings and can vary by insurance provider, it is critical to understand how a hospital system submits claims and receives payment for services based on the location where those services are provided, the type of health care provider rendering the services, and the insurance plans accepted.

Specific evidence relating to MNT and chronic disease should be shared during discussions with stakeholders. The evidence shared should be relevant to patient populations commonly served by that hospital or health system. For example, if a hospital is renowned for providing excellent cardiovascular care, then RDNs should share studies showing improvements in heart disease outcomes in patients receiving MNT. If possible, they should also be prepared to show how they will track similar outcomes in the hospital's patients if outpatient nutrition services are provided for this population in both the inpatient and outpatient settings. It is important to show how optimizing RDN staffing and nutrition-related services support patient needs, increase access to care, meet quality assurance/performance improvement benchmarking requirements, and impact payment through a traditional fee for service model and/or through value-based payment models. For summaries

of evidence that can be shared with the stakeholders, RDNs can use the Academy's Evidence Analysis Library and position and practice papers.

Hospital billing departments can be a key ally in discussions with stakeholders, as many billers understand how payment for services flows within a hospital system. In addition, other members of the hospital system staff can be collaborators to improve nutrition care. For example, department managers and nurses may be able to speak to the value proposition of MNT by highlighting patient care and satisfaction scores. As discussed in the Commercial Payers section, this group of professionals may help convince hospital administration to advocate for increased MNT coverage in commercial insurance plans on behalf of the facility or health system.

## Primary Care

Primary care health professionals can improve the health and outcomes of their patients by offering nutrition services by RDNs. Incorporating RDNs in a primary care setting can benefit not only the providers but the patients. Studies have shown that RDNs providing MNT can improve health outcomes and reduce costs related to physician time, medication use, and hospital admissions for people with obesity, diabetes, and disorders of lipid metabolism, as well as other chronic diseases. There are numerous benefits to the practice including dissemination of patient care. RDNs can share in the patient care workload which can improve patient satisfaction. Practices should consider how the use of an RDN will positively impact their patients.

**For RDNs that wish to partner with primary care practices, the questions that need to be explored before the first meeting should include:**

1. **Does the practice value nutrition services?**
   - Any mention of nutrition on their website?
   - Any practitioners mention an interest in nutrition in their bios?
2. **What are the demographics of the patients served by the practice?**
   - Seniors
   - Medicaid managed care
   - Pediatric/adolescents
   - Women's health
3. **What insurance does the practice participate with?**
4. **What initiatives does the practice have in place to address health care access?**

Once these questions are answered, the RDN can develop their ideas on tailoring an individualized nutrition services program for that practice.

### Connecting with Decision Makers

Identify the key decision makers. For small practices it may be the lead MD, or office manager. For large practices it can be a chief medical officer or practice administrator. The practice's website can supply this information.

The key message should convey that by allowing for MNT provided by RDNs, primary care offices can see improved outcomes such as prevention of the progression of chronic diseases and improved quality of life, while also seeing a decrease the financial burden of caring for individuals with chronic disease. Overall, the benefits of nutrition services apply to many chronic diseases including kidney disease, overweight, obesity and lipid disorders, to name a few.

**Highlight the following points when making the case for RDN services to primary care practices and key decision makers:**

- According to the CDC, chronic disease is the leading cause of death and disability and the leading driver of the nation's $4.1 trillion in annual health care costs.[15]
- In the U.S., six in 10 adults have a chronic disease, while four in 10 adults in the U.S. have two or more chronic diseases.[15]
  - Poor nutrition is one of the key lifestyle risks for chronic disease.
  - Treatment of these conditions are costly including medications, ongoing testing, and monitoring.
  - Individuals dealing with food insecurity often struggle with nutrition-related chronic diseases and conditions.
- RDNs can and do deliver MNT services via telehealth. This can be advantageous for practices looking to provide services to rural populations or populations that traditionally face challenges attending visits.

### RDNs are Cost-efficient Providers:[16]

The use of RDNs can help free up the time for other health care providers that can be used more effectively. Collaborating with the RDN on the patient care plan can provide the patient with additional support to achieve their health goals.

- RDNs provide MNT and have experience and training in behavior counseling and weight management.
- RDNs 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 RDN for diabetes and chronic kidney disease is a covered benefit by Medicare Part B and many private health insurance companies. During a meeting, if available, share the names of commercial payers who cover nutrition services and are the ones that the primary care participates with.
- Many RDNs are certified diabetes educators and can provide and bill for Diabetes Self-Management Treatment.
- Nutrition services are cost effective and less expensive than other modalities or interventions including drug therapy.
- RDNs can be licensed to provide MNT in multiple states, where applicable, at a lower cost than physicians and other health care professionals. This is important if the practice provides telehealth services or other services across state lines.

### Access to MNT

There is a common belief among providers that there is not coverage for MNT, and if there is, locating an RDN is challenging at best. While MNT coverage will vary among payers, there is still opportunity to provide MNT services and seek payment.

Medicare Part B covers MNT for the diagnoses of diabetes, non-dialysis kidney disease, and 36 months post kidney transplant when a Medicare beneficiary has been referred by a physician, and when provided by an RDN who is enrolled as a Medicare Provider.

Learn more about Medicare and MNT visit:
https://www.eatrightpro.org/career/payment

Commercial Payers, Medicaid and Medicare Advantage plans may also provide coverage for MNT services, and go beyond coverage provided by Medicare Part B. Each payer will define its own policies regarding MNT, determine what providers are eligible to bill for MNT services, and if needed, determine their own criteria for medical necessity.

The key takeaway is that there are many options for the RDN to partner with primary care practices to support access to MNT services to patients. Often many providers and practices underestimate the financial viability of adding an RDN to their practice. Whereas, in reality, more opportunities for RDNs to generate revenue exist than practices recognize. RDN involvement drives value-based care by supporting better patient outcomes and lowering total cost of care, which ultimately can lead to a positive impact on revenue for physician practices.

**RDNs can:**

- Independently contract with a primary care office.
- Be employed by a primary care office.
- Establish a fee-for-service payment model if insurance will not reimburse for MNT.

To learn more, see the "RDNs in the New Primary Care: A Toolkit for Successful Integration" on the Academy's Payment Page.

## Consumers

One key audience to consider when seeking to increase access to MNT is the consumer; the consumer is the one who will directly receive services and benefit from better access to nutrition care provided by the RDN. Consequently, consumers play an important role in driving better access to and coverage of MNT services provided by RDNs. Consumers drive demand and thus motivation for not only physician referrals for MNT, but also positive changes in MNT-related payer policies. The message to consumers is three-pronged:

- Increase demand for MNT provided by RDNs.
- Increase referral requests for MNT provided by RDNs.
- Request MNT by an RDN from their health insurance.

### Empowering Consumers to Increase Demand for MNT by RDNs

Consumers may be unaware of their access to receive MNT services and they may not have a clear understanding of what MNT is or how or why they would benefit from seeing an RDN. The RDN has a responsibility to educate consumers on which conditions are not only diet-related, but also link those conditions, with positive outcomes, when MNT services are delivered by RDNs.

Prompt consumers' interest by asking them questions whenever directly speaking to consumers or in written consumer-focused materials. Again, consumers may not be familiar with the RDN credential. When communicating with consumers, either in groups, virtually, or with written or digital materials, asking them specific questions about familiarity with RDNs and MNT awakens their curiosity and interest, and ultimately triggers a request for MNT services.

**Examples of initial questions to gauge consumer knowledge of MNT and RDNs:**

- You probably know an MD and RN, but do you know an RDN?
- Do you know what an RDN does?

- Do you know the difference between someone who calls themselves a nutritionist and someone who identifies as an RDN?
  - This provides a perfect opportunity to distinguish the RDN's extensive and unique education, qualifications, and credentials. Highlight that no other professional can claim this level of education and training in the field of nutrition.

## Empowering Consumers to Request a Referral

Between all the nutrition myths and misinformation everywhere, it's no wonder that consumers are confused on where to find reliable and credible nutrition information. Confusion and mixed nutrition messages can frustrate consumers. That frustration can diminish motivation to seek nutrition care and, in some cases, even drive consumers to follow poor nutrition advice. Proactive RDNs can seize this as an opportunity to showcase the RDN expertise and provide consumers with evidence-based, sound nutrition information.

Consumers can effectively advocate for nutrition services when they both value the RDN credential and the impact that MNT provided by RDNs has on outcomes.

When reaching out to consumers of any demographic, it's important to speak professionally, but also in plain language. RDNs should be prepared to demonstrate their value and credibility to consumers in order to build trust and eventually drive referrals. After connecting with a consumer, they should leave the interaction with a better understanding of the breadth over services an RDN provides as well as how a RDN can support their health goals.

**Key messages to consider when initially meeting with consumers:**

- RDNs routinely provide care for most of the top chronic health problems (such as heart disease, hypertension, stroke, diabetes, obesity) as well as health and wellness promotion.
- Inform consumers that RDNs are important members of the medical team.
- Emphasize that it's part of your professional and ethical standards to provide evidence-based recommendations backed by credible science.
- It is important to accept that a consumer may be following or hold unfounded or inaccurate nutrition information and that they may have some success following that information.
  - The aim here should be to understand what their needs are and show how working with an RDN can best support them.
- Acknowledge any frustration and confusion related to nutrition information and RDNs. Consumers can be their own best advocates. Tell them this!
- Remind consumers of the Academy and the Academy's campaign during National Nutrition Month®, which occurs in March ever year.

Educate consumers that there are conditions not only appropriate for an RDN to address but also having one of more such conditions means a medical referral to an RDN is indicated and can help to optimally treat and manage them.

**Questions such as:**

- Have you asked your medical provider for a referral to a registered dietitian nutritionist?
- You have [high cholesterol/hypertension/type 2 diabetes/osteoporosis, high triglycerides, etc.] and you still haven't asked your medical provider for a referral to a registered dietitian nutritionist?
- You haven't been able to lose weight and you haven't asked for a referral to an RDN yet?

## Empowering Consumers to Access an RDN

When it comes to who consumers trust for accurate nutrition information, RDNs continually rank highest, along with physicians. But while consumers trust RDNs, it can be difficult to locate an RDN in their area or insurance plan. They can't find them as easily as they find their physicians. The Academy's Find a Nutrition Expert Tool can help.

Medicare approves RDN services for several conditions, but many seniors and medical providers are not aware of this. Consumers may also have the opportunity to access MNT by RDNs via their commercial or private insurance plan.

RDNs seeking to increase access and utilization of MNT benefits should reach out to populations that have an interest in nutrition care or would benefit from nutrition services, such as senior centers, youth, church, or community groups. Focus on building a relationship within that community, which will require more than introducing yourself and dropping off educational materials. Seek opportunities to increase visibility and allow for personal contact with your target group who might use MNT services. For example, offer to speak to groups of seniors at a community event. This is also an opportunity to dispel myths and misinformation about what MNT is and why RDNs are uniquely qualified to provide MNT.

## Empowering Consumers to Request MNT by an RDN from their Health Insurance

Private payer policies relating to MNT and RDN providers will vary from payer to payer. Consumers can advocate for better access to MNT by connecting with their commercial health insurance and/or by working with their employer and asking to have MNT benefits added to the health plan.
When consumers express discontentment if they do not have MNT by RDNs as a covered benefit under their health insurance plan, encourage them to express those feelings to the health plan. A sample letter to aid in this process can be found here.

## Connecting with Consumers

Reaching a wide array of consumers means meeting them where they are, not just with your messaging, but literally going to where they are.

**Getting to consumers can be done through a variety of avenues:**

- Speaking to local and community groups.
- Addressing school and parent organizations. Reaching parents means you reach entire families – adults and children. Parents may seek a referral to an RDN for themselves, or for their child through a pediatrician.
- Health fairs reach people already primed to learn about health and wellness. This may make such audiences more receptive to learning about what the RDN credential is, what RDNs do, and how they can help consumers.
- Church or religious organizations.

All the above may involve non-paid time but are part of advocating for increased access and opportunities. If you're in private practice, consider the time spent targeting consumers with your advocacy part of your marketing budget.

# Conclusion

Advocating for better access and payment for MNT services can take place anywhere. No matter the location — a local community center or physician's office — timely nutrition information is needed. Former U.S. Rep. Shirley Chisholm, the first African American woman elected to U.S. Congress once said:

## "If they don't give you a seat at the table, bring a folding chair."

Her words have inspired many and encouraged those seeking opportunity or facing challenges to not wait to be invited to share their message but rather to make space for their issue, to put their message front and center and on the table, and seize or create opportunities to advocate for what is important.

RDNs bring a lot to the health care table. We possess a unique set of skills that incorporate nutrition expertise that is essential to the prevention, management and treatment of many chronic diseases/conditions. With all the "noise" surrounding nutrition and the continued increased demand for nutrition information and care, RDNs have the opportunity to rise above the noise, and create opportunities, create space for our message that MNT by RDNs is safe, cost-effective and has the ability to positively impact health outcomes.

## Thank you for the role you play in spreading the message that MNT Works!

# Resources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# Appendix

## Appendix A: Stakeholder Flyers

Stakeholder flyers can be used to promote the value of RDNs and MNT to you target audiences.

### Audience-Specific Marketing Flyers

RDNs Can Benefit Your Practice
- Key Audience: Medical and Primary Care

RDNs Bring Value to Your Organization
- Key Audience: Health Care Administrators

RDNs Support Value-Based Payments
- Key Audience: Payers and ACOs

Employee Access to MNT is Smart Business
- Key Audience: Employer Groups

Include MNT on the Benefits Menu
- Key Audience: Benefits Consultants

Access to MNT by RDNs is Good Policy
- Key Audience: Policymakers and Legislators

RDNs Help Build Healthier Communities
- Key Audience: Community-based Programs

### Tips for Leveraging the Leave Behinds

Leave behinds, such as the stakeholder flyers and other written materials, can be highly effective tools to share specific information about services or products (e.g., RDN Services and MNT), without running the risk of getting too detailed or off-track during meetings. Think of the leave behinds as a visual aide to make key parts of the message memorable.

Keep these concepts in mind when using a leave behind:

- Take time to give a brief overview of the leave behind and explain why it's important to read and what information it contains.
- Avoid reading the leave behind to an audience but leverage it to emphasize keys parts of your message.
- Highlight any important details on the flyer that are of specific interest or importance for your target audience.
- Use the leave behind to support a story or testimonial that illustrates the value of the RDN and MNT.

## Appendix B: Additional Resources

1. Academy Payment Page: https://www.eatrightpro.org/career/payment
2. Nutrition Services Payment Specialist:
   i. Access via the Leadership Directory: https://www.eatrightpro.org/leadershipdirectory
3. Find a Nutrition Expert: https://www.eatright.org/find-a-nutrition-expert
4. CNM DPG RoadMap: https://www.cnmdpg.org
   *Resource available for members of CNM DPG
5. Contact the Academy's Nutrition Services Coverage Team:
   i. Attend Payment and Reimbursement Office Hours
   ii. Complete the Payment and Reimbursement Inquiry
6. RDNs in the New Primary Care: A Toolkit for Successful Integration: https://www.eatrightpro.org/career/career-resources
7. *Journal of the Academy of Nutrition and Dietetics* Articles:
   i. Diabetes Self-Management Education and Medical Nutrition Therapy: A Multisite Study Documenting the Efficacy of Registered Dietitian Nutritionist Interventions in the Management of Glycemic Control and Diabetic Dyslipidemia through Retrospective Chart Review – JAND 2018, Retrospective Chart Review which found positive correlation between DSME provided with integrated nutrition education and RDN-provided individualized or group MNT for weight, BMI, HbA1c, TG, HDL, and TG-to-HDL ratio that are consistent with or exceed those previously described in observational studies and RCTs that can be achieved in the real-life setting. Confirmed previous study outcomes which demonstrated the efficacy of MNT and RDN services which could have future applications across the spectrum of chronic disease.
   ii. Position of the Academy of Nutrition and Dietetics: The Role of Medical Nutrition Therapy and Registered Dietitian Nutritionists in the Prevention and Treatment of Prediabetes and Type 2 Diabetes – JAND 2018, Position Paper providing a thorough review of the cost effectiveness of RDNs providing MNT to individuals with pre-diabetes and Type 2 diabetes. Reviews Roles and Responsibilities of RDNs in Diabetes Care as well as integrating nutrition care in DSME.
   iii. Registered Dietitian Nutritionists Bring Value to Emerging Health Care Delivery Models – JAND 2014 White paper that focuses on defining the role and promoting the value of the RDN in the context of several payment models, specifically focusing on PCMHs and ACOs.

iv. Medical Nutrition Therapy for Adults in Health Resources Services Administration-Funded Health Centers: A Call to Action – JAND, Dec 2020. Article Advocating for HRSA to designate MNT as an expanded service in primary care and establish a reporting requirements for MNT and registered dietitian nutritionists. The Article further advocates for the expansion of MNT and RDN services in State Medicaid Programs.

8. EAL Link (www.andeal.org)

9. FNCE® 2016 Presentation (PDF)

10. Coding for MNT Document (PDF)

## Appendix C: Effectiveness of MNT Talking Points

### Effectiveness of Medical Nutrition Therapy Points

Medical Nutrition Therapy (MNT) is an evidence-based application of the Nutrition Care Process that can include nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation. MNT is provided by a Registered Dietitian Nutritionist (RDN) with the goal of preventing, delaying, or managing diseases or conditions.

### Cancer

**Evidence:** MNT as part of a comprehensive treatment strategy can improve outcomes in adult oncology patients for many types of cancer including breast, ovarian, lung, leukemia, colorectal, gastrointestinal and head and neck.[1]

**Clinical Guidelines:** European Society for Clinical Nutrition and Metabolism; American Cancer Society; Academy of Nutrition and Dietetics Standards of Practice in Oncology Nutrition; Academy of Nutrition and Dietetics Oncology Practice Guideline

### Cardiovascular Disease including Hypertension and Dyslipidemia

**Evidence:** Individual or group sessions utilizing MNT resulted in a reduction in blood pressure for those with hypertension and pre-hypertension with improvements reported as quickly as after 1 month of working with an RDN according to a systematic review of 70 research studies.[2] A systematic review of 34 studies determined that patients who participated in multiple MNT sessions were able to substantially lower their total cholesterol, low-density lipoprotein cholesterol and triglyceride levels.[3,4,5,6,7,8] MNT interventions led to improved blood sugar levels, weight, blood pressure and quality-adjusted life years and reduced the need for lipid-lowering medications which resulted in cost-effectiveness and even cost savings in some cases.[9,10,11,12,13,14,15]

In terms of cost-effectiveness/cost savings of MNT, studies note the following:

- An estimated annualized cost savings from the avoidance of lipid medications of $60,561.68 with 3-4 individualized dietitian visits of 50 minutes each over 7 weeks.[9]
- A cost-effectiveness ratio for MNT of $36 per 1% decrease in cholesterol and LDL level. "The ongoing cost of $98 per 3-month period to sustain reductions in saturated fat intake and total cholesterol and LDL levels appears to be worth the benefits when one compares an annualized cost of MNT of $511 to the $2,648.59 annual cost of statin therapy."[10]
- An annual medication cost savings of $27,449.10 or $638.35 per patient. A cost savings of $3.03 in statin therapy was realized for each dollar spent on MNT.[12]

**Clinical Guidelines:** VA/DoD Clinical Practice Guideline; American Heart Association; Academy of Nutrition and Dietetics Hypertension Practice Guideline

### Celiac Disease

**Evidence:** MNT administered by a RDN can improve gluten-free diet adherence, self-reported general health and wellbeing, anemia, and gastrointestinal symptoms such as indigestion, diarrhea, constipation, abdominal pain, and reflux.[16,17,18,19,20,21,22]

**Clinical Guidelines:** Canadian Association of Gastroenterology

### Eating Disorders

**Evidence:** MNT provided by RDNs as part of an interdisciplinary care team helps patients with restoring body weight, achieving adequate nutrient intake to meet daily requirements through regular meal patterns and portions, and reducing negative beliefs and fears surrounding food.[23,24,25,26]

**Clinical Guidelines:** American Psychiatric Association (Draft Guideline); American Psychiatric Association; Academy of Nutrition and Dietetics Standards of Practice in Eating Disorders

### HIV/AIDS

**Evidence:** Early MNT intervention can improve oral intake, symptoms, cardiovascular risk, and prevent progressive weight loss. Nutrition counseling can support weight gain, as well as CD4 white blood cell levels that help to measure the immune system and quality of life.[27,28,29,30,31,32,33,34]

**Clinical Guidelines:** HIV/AIDS: A Guide for Nutrition Care and Support

### Malnutrition

**Evidence:** Malnourished older adults have longer periods of illness, longer hospital stays and increased readmission rates.[35] MNT provided in the outpatient setting to patients with malnutrition increases overall nutrition status, cognitive function, functional status and overall food intake, and significantly decreases primary care physician costs.[36,37,38]

A partially randomized clinical trial conducted by Maccabi Health Services sought to determine the impact of an intensive nutritional intervention program led by a dietitian on the health and nutritional status of a malnourished community dwelling older adults. Over the 6-month follow-up, the DIT (Dietary Intervention Group [led by a dietitian]) group had a significantly lower cost of physician visits than the other 2 groups ($172.1±232.0 vs. $417.2±368.0 in the Medical Intervention and $428.1±382.3 in the Untreated Nutrition Group.[37]

**Clinical Guidelines:** American Society for Parenteral and Enteral Nutrition; Academy of Nutrition and Dietetics/ American Society for Parenteral and Enteral Nutrition

### Obesity

**Evidence:** A systematic review of 139 studies found that MNT interventions resulted in a reduction in body mass index, significantly greater weight loss and increased likelihood of achieving 5% weight loss compared to those not receiving MNT, reduction in fasting blood sugar levels, likely increase in quality of life, and reduction in waist circumference.[39] Weight management interventions can be cost effective programs that have been shown to increase quality of life.[40,41,42,43]

Individuals who received MNT in an obesity-related health management program were about twice as likely to achieve a clinically significant reduction in weight. The MNT benefit cost only 3 cents per member per month.[43]

In adults with overweight and obesity receiving MNT, studies reveal an average cost savings of $52,000-$99,000 using incremental cost-effectiveness ratios.[44]

**Clinical Guidelines:** Obesity Canada and the Canadian Association of Bariatric Physicians and Surgeons; Academy of Nutrition and Dietetics Standards of Practice in Adult Weight Management

### Prediabetes

**Evidence:** MNT is effective treatment for prediabetes that can result in a significant reduction in fasting blood sugar, blood sugar 2 hours after meals, and waist circumference.[45,46,47,48,49,50,51,52] MNT is a cost effective and potential cost-saving intervention for the prevention of diabetes in gained cost per quality-adjusted life years.[53,54]

"A study examining the feasibility of cost savings and/or cost effectiveness of prediabetes lifestyle interventions, including MNT, demonstrated that compared to other treatment options, such as medication, diet and exercise lifestyle modification programs give the payer the best return on investment."[55]

**Clinical Guidelines:** American Diabetes Association; Joslin Diabetes Center; Academy of Nutrition and Dietetics Standards of Practice in Diabetes Care

### Diabetes

**Evidence:** MNT significantly shows (18 studies) that it is effective in lowering HbA1c in adults with either Type 2 diabetes or Type 1 diabetes (by 0.3% to 2.0% and by 1.0% to 1.9%, respectively) during the first 6 months of routine nutrition care.[56] Additionally, 11 studies showed that MNT provided by RDNs resulted in decreases in doses or the number of glucose-lowering medications used. Studies longer than 6 months report that continued MNT encounters resulted in maintenance and continued reductions of A1C for up to 2 years in adults with Type 2 diabetes, and for up to 6.5 years in adults with Type 1 diabetes.[56]

Research has shown that for every $1 invested in an RDN-led lifestyle modification program, there has been a nearly $15 return.42 The same trial shows mean health plan costs were $3,586 lower with individual and group MNT and support provided by RDNs compared to usual care.[42]

Franz et al. evaluated the cost effectiveness of implementing MNT in Type 2 diabetes. The cost of unit of change in fasting plasma glucose (1 mg/dl) from entry to 6 months was determined. The intensive nutrition intervention had a cost-effectiveness ratio of $4.20 compared with usual nutrition care with a cost-effectiveness ratio of $5.32.[57]

**Clinical Guidelines:** American Diabetes Association; Joslin Diabetes Center; Academy of Nutrition and Dietetics Standards of Practice in Diabetes Care

### Chronic Kidney Disease

**Evidence:** MNT is an effective treatment for individuals with chronic kidney disease (CKD) and its use has been shown to both improve glucose and blood pressure control and slow the disease progression thus delaying the need for dialysis. For individuals with CKD who have not yet progressed to kidney failure, diet is a modifiable factor that may be altered at a low cost. Health care expenditures significantly increase per beneficiary per year as an individual moves from mild to severe CKD. Additionally, MNT can mitigate the impact of associated comorbid conditions such as Type 2 diabetes, obesity, hyperlipidemia, and hypertension.

"Nutrition management is a key intervention for slowing CKD progression and delaying or preventing ESRD.[40] For patients with dyslipidemia and HTN, MNT by an RDN reduced medication use, which led to a cost savings of $638 to $1,456 per patient per year."[3]

**Clinical Guidelines:** Kidney Disease: Improving Global Outcomes; Academy of Nutrition and Dietetics and Kidney Foundation Standards of Practice in Nephrology Nutrition

### Pediatric Weight Management

**Evidence:** A recent systematic review demonstrated that pediatric weight management interventions involving a dietitian or international equivalent were more efficacious than those without. MNT, as part of a multicomponent intervention, improves outcomes (as demonstrated by a decrease in BMI and BMI Z Scores).[58,59]

**Clinical Guidelines:** Academy of Nutrition and Dietetics Pediatric Weight Management Practice Guideline; American Academy of Pediatrics Expert Committee Recommendations

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## Appendix D: Tips of Effective Messaging (PDF)

## Appendix E: Sample Scripts/Vignettes

### Commercial Payers

In this case, Blue Cross Blue Shield is a large payer in an RDN's city/state, providing coverage to 40% of the covered lives. They are part of the Blue Cross Blue Shield Association in Chicago and have fully-insured, self-insured, Federal Employee and Medicare Advantage plans in your area. A recent graduate RDN reaches out to Blue Cross to inquire about credentialing and member benefits. They are aware that Blue Cross credentials RDNs because some of their classmates have already started the process. However, this RDN is unsure what their credentialing process entails and if their coverage is similar to Medicare. The RDN finds the Provider Relations email on the payer's website and reaches out to initiate the credentialing process.

After the provider knows they are in touch with the appropriate contact, the provider asks additional questions about the credentialing process and the networks. The follow up was done via email; however, if there was a phone number available for the provider relations contact, it may be best to schedule a call or request a meeting to cover more information and build a rapport.

Once credentialing has been initiated, the RDN inquires about member benefits. The benefits can vary from fully insured plans and self-insured plans (Blue Cross is the third party administrator). Sometimes it can be difficult to differentiate between these plan types, so the RDN inquiries about provider resources.

### Sample Email Script – initiate correspondence:

Hello, I'm _____, a registered dietitian nutritionist located in _____and I'm inquiring about becoming an in-network provider. I have included my provider information below for your review. Does your company use a credentialing database, such as CAQH, or does your organization have a different process? I'm hoping you can assist me or direct me to an appropriate person.

NPI:1234567890
Tax ID: 98-7654321
Practice Location: 555 Main Street, Little Rock AR

I look forward to hearing from you.

### Sample Email Script – follow up with additional credentialing questions: *(if not provided in the payer's response)*

Thank you for your response. I read online that you have multiple networks and plans, such as Federal Employee Plans and Medicare Plans. I'm interested in participating in all networks, so I've included some additional questions below.

- Will this process allow me to participate in all networks or do you have limited networks as well? What are the criteria for participating in limited networks if you do have them? Where can I find a list of the networks and plans?
- Do all networks reimburse at the same rate? I've heard the plans on the marketplace/ACA may reimburse at a lower rate.
- Where can I find the fee schedule?
- Do I need to wait until the credentialing process is complete to provide services to your members, or am I able to start providing services?

I appreciate your assistance. I look forward to providing services to your members.

### Sample Email Script – Member Benefits:

Hello,

I appreciate your assistance with the credentialing process. Now that I'm ready to accept patients, I was wondering about the most efficient process to check a member's benefits. Do you have a provider portal or is it best to call customer service?

I was also wondering if you have an outline or provider resource for member benefits related to Medical Nutrition Therapy (CPT codes 97802-97804)? I'm specifically requesting information on how many visits are covered, are these services limited to a certain diagnosis, and is a physician referral required? If this coverage varies by plan, what's the best way to verify this information?

If there are plans that do not have dedicated nutrition coverage, is there a way to determine if they have wellness benefits (PPACA) that cover nutrition counseling provided by an RDN?

If there is a plan that doesn't have nutrition benefits, is there a process for submitting an exception for a member who has a referral for MNT from their PCP or specialist? I would like to provide peer reviewed literature to support coverage for nutrition services by an RDN if there's a Medial Director or plan liaison that I reach out to.

Thank you in advance for your assistance.

### Employers

***Example:*** *Carla Thompson is the human resources director working for a manufacturing company. In her scope of work, she provides oversight for the health benefits for the organizations. She is open to improving the health of the employees and their families through their self-funded health plan. In this case, she works with a benefits committee to identify which services are covered under their company health plan that is administered by their health insurance partner. Although she is aware of nutrition and weight loss services provided through the health plan's wellness vendor, she is unaware of the role of the RDN and medical nutrition therapy (MNT). Because she is interested in improving health, managing health care costs, and creating more value for the health plan, she is open to learning more about the value and impact MNT has on quality of life for this population.*

*In your discussion, you share data from Managed Care (2013), "The Incremental Value of Medical Nutrition Therapy in Weight Management" describing that MNT delivered by RDNs at a cost of approximately $0.03 is an effective, low-cost solution to improving health. You also share the "Employee Access to MNT is Smart Business" document that outlines the health conditions and coverage opportunities for the RDN to become a provider in their self-funded health plan.*

***Example:*** *Luis Ramos is the chief human resources officer for a large financial organization that is based in Tampa, Florida with operations in thirty states. Luis and his HR team are seeking the services of a wellness director to lead the efforts for an employee wellness program. This is a new position, and they are working with a consultant and their health benefits broker to develop the job description. Although the consultants, health benefits broker, and HR team are aware that they are looking for a business or health care professional, they are not aware of the scope of knowledge and skills of the RDN.*

*In your submission for application, it is important to share the extensive background, knowledge, and training that has prepared you for the role of the Wellness Director in your cover letter. As the core focus on the wellness program will be nutrition, physical activity, and health risk reduction, the RDN is uniquely qualified for the position. It will also be beneficial to review the 2014 Journal article, "Worksite Wellness: An Ideal Career Option for Nutrition and Dietetics Practitioners." You may also wish to connect via LinkedIn to RDNs who are working in the workplace wellness space and gain insight into the work that they are doing and network with them on current and future opportunities. If an interview opportunity presents itself, this is the time to share the scope of work of an RDN, colleagues that are working in this area (cite their work if available), and the benefits of having an RDN lead the employee wellness program.*

### Hospital Administrators

***Example:*** *The hospital is starting a new program aimed at reducing readmissions for patients with congestive heart failure (CHF). You reach out to the nursing administrator responsible for outpatient cardiovascular clinics and share evidence from the Systematic Review that supports the 2017 Heart Failure Guideline, available from the Academy's Evidence Analysis Library. This information indicates the value that MNT by RDNs can contribute towards reducing readmissions for patients with CHF.*

*After the hospital agrees to provide space and RDN staffing for a nutrition component in the CHF clinic, you track the associated outcomes. This includes the readmission rate of patients with CHF who receive MNT compared to those who do not. It also includes a study of the medications required pre- and post- nutrition interventions, weight management changes, and patient satisfaction with the RDN. This information is presented monthly to the Quality Committee to demonstrate the value of RDNs providing services in hospital-based clinics.*

### Primary Care

***Example:*** *Dr. Smith is a local physician working for a small private practice group. She cares for individuals who struggle with weight management and pre-diabetes. She is open to working with the RDN as she understands the value and impact appropriate nutrition care has on quality of life for this population but knows that coverage for nutrition care for pre-diabetes is not a Medicare covered service and believes her patients will not be able to pay out of pocket for nutrition care.*

*In your discussion, you share information and data from the 2021 Adult Weight Management Systematic Review, which strongly supports that routine contact (as defined as a minimum of 5 visits over a duration of one year) with an RDN resulted in significantly greater weight loss and fasting blood glucose. You also mention that Medicare Part B allows for RDNs to provide care "incident to the primary care physician" using the Intensive Behavioral Therapy for Obesity Benefit for beneficiaries with a BMI > 30 and that there may be additional benefits for coverage with Medicare Advantage Plans as well as private payers.*[1]

***Example:*** *Senior Health is a primary care practice that caters and advertises to seniors. Reviewing the practice's website, it reveals the following:*

*"Senior Health is a group of primary care physicians with 10 conveniently located, full service medical centers throughout the county. The group dedicates its attention to patients over 65 years of age, allowing for the full focus on the needs of seniors. Our team of experienced physicians, nurse practitioners, medical assistants and staff are all dedicated to providing compassionate and caring, personalized, primary care."*

*Senior Health offers many unique services to their patients including a Silver Sneakers® exercise class and transportation to and from appointments. There is no mention of nutrition services or counseling. There is a list of "lunch and learn" sessions but none on nutrition or healthy eating.*

*Yet, the founding MD talks about the benefits of a healthy lifestyle, exercise, and eating healthy to stay young in his bio. This patient population are covered under Medicare or Medicare Advantage plans. From your previous research on MNT coverage, you know that Diabetes and CKD are covered under Medicare and these plans. You are a Medicare provider but not a provider of the Medicare Advantage plans advertised on Senior Health's website.*

1. *Contact the Medicare Advantage plans to find out if you can become a provider.*
2. *Do research on the benefits of MNT for improved outcomes in individuals with Diabetes and CKD. Summarize key points that can be presented to the practice manager.*
3. *Put together a packet of information to include the Academy's marketing handout for primary care facilities along with a brief bio, the benefits of MNT, and how the rest of the health care team can become engaged in promoting nutrition services. Show how it can relieve their burden and provide better care.*
4. *Arrange an appointment with the practice manager to discuss providing services to their patients. Why the practice manager? Practice managers are the gate keepers to the Health Care Provider (HCP) in the practice. If this meeting goes well, the next meeting could be with the senior HCP. Ask the practice manager about previous experiences with RDNs and nutrition services.*
5. *Before you meet with the practice manger determine what kind of arrangement are you interested in having and develop a business plan. Are you interested in the practice referring patients to your office, do you want to see patients in their office? Once you determine what you are willing to do, it will be easier to negotiate.*
6. *Do your homework, be prepared, and put together a list of questions you may have and what you think they may ask you.*
7. *If the practice is apprehensive, suggest a 3-month pilot to determine outcomes and popularity of the services.*
8. *Your goal is to eventually get a meeting with the founding MD to engage him in talking about his passion for a healthy lifestyle for healthy aging.*

[1] Academy of Nutrition and Dietetics Evidence Analysis Library. AWM: Adults with Overweight or Obesity BMI> 25 (2020-21). https://www.andeal.org/topic.cfm?cat=6157&pcat=6110&menu=5276. Accessed February 16, 2023.

**The tools in the MNT toolkit will assist you every step of the way.**

**Primary Care Script**

Preparatory Call to Office Manager: *Hi, my name is _____ and I am a registered dietitian nutritionist. I have been practicing in this area for the last 5 years. I was hoping I could meet with you to discuss my services and how nutrition services and counseling may be a good addition to the current services you offer seniors. I read Dr. B's words of wisdom on the website and can see he has a passion for nutrition.*

Office Manager: *We used an RDN some time ago, but it was too expensive.*

RDN: *If you allow me a few minutes, I can show you how these services can be billed through insurance and would not be a cost to the practice.*

Office Manager: *Okay, can you come by tomorrow? I have 15 minutes at 12:00.*

RDN: *Great. Thank you. I will see you then.*

Arrive to Practice. *Check proper pronunciation of the practice manager's name. Have your card ready for the receptionist. Arrive 5 minutes before appointed time. Dress in business attire.*

RDN: *Greet the office manager and thank them for their time. Have your packet ready. Start your pitch with the benefits of nutrition services, highlight the outcomes and the low cost of MNT. Have a patient scenario in mind.*

*"I want to tell you about one of my patients LS who had a hemoglobin A1c of 10 when she was referred to me. She had a number of comorbidities: high blood pressure and obesity. After 3 visits that were covered by Medicare her HgA1c is down to 7, and her weight has declined by 15 lbs. This is the benefit of MNT. No copay or deductible for patient and no expense to the MD that referred the patient."*

*I hope that I can bring this value to this practice.*

Office Manager: *How can we use your services? Can we just refer our patients to you, and you bill? Or are there other scenarios?*

RDN: *I prefer if you refer patients to my practice and I will send you reports. I would also like to set up a "lunch and learn" monthly in your office for the patients on various topics on nutrition and to market the services.*

Office Manager: *I like the idea. Let me have you come back to meet Dr. B. I will advise him I think our patients would like these services offered to them.*

RDN: *Thank you!*

**Next Steps**

Develop a process in which the office can easily refer patients. Provide the practice with business cards or a referral template. Follow up after all referrals. Check in with the team on a regular basis to evaluate if the services are getting good reviews and the outcomes desired. Document outcomes.

## Consumers

You've been asked to give a talk at a health fair, workplace "Lunch & Learn", or community group about either a "hot topic" such as gut health, or one especially appropriate for the group, such as hypertension for a senior citizens group, Type 2 diabetes in middle aged adults, or "women and heart disease".

Whatever the topic, it is an opportunity to tell consumers what RDNs do, why they're uniquely qualified to do it, and emphasize that it may be covered by their health plan. Then rally the group to find out if MNT can be offered in their health benefit packages, ask their primary care physicians for referrals to RDNs, and promote the unique services of RDNs.

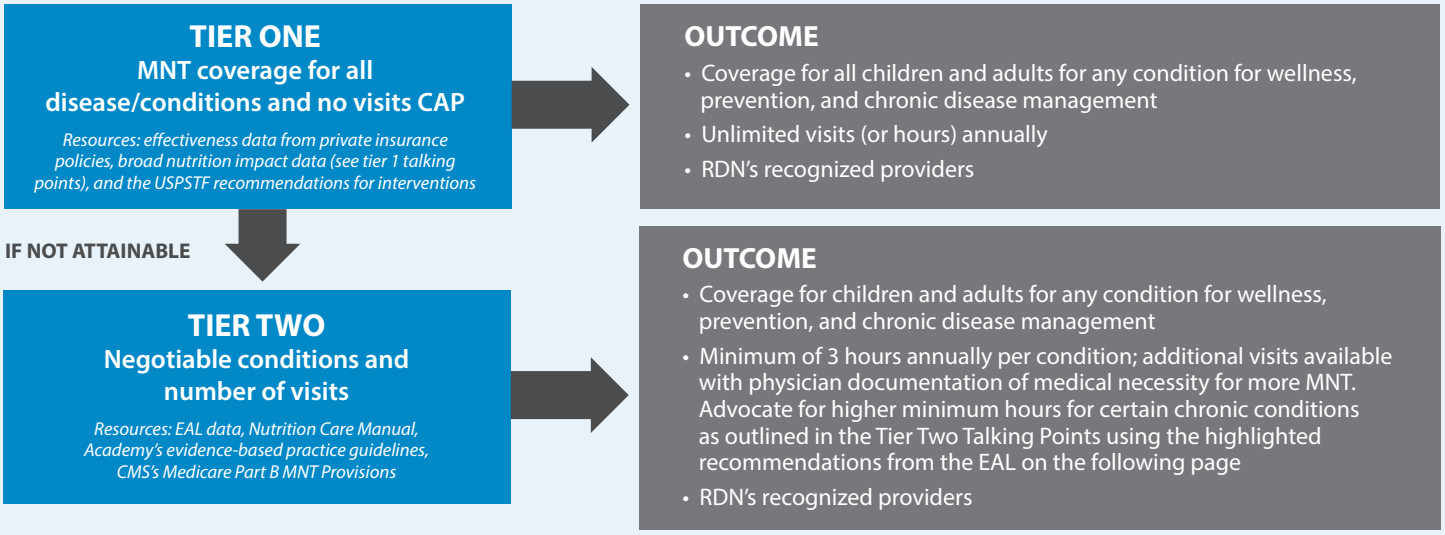
After you speak on your topic, plan enough time – ideally right before you open the floor to questions – to ask the group if MNT is covered by their health plans. If they don't know, that's step 1. Then remind them of the many conditions for which an RDN referral is indicated Ask how many people with these conditions have asked their primary care physician for a referral to an RDN. Here are some examples of questions to ask and prompt consumers:

- Do you know if your health plan covers medical nutrition therapy? Many plans cover a variety of health problems, like hypertension, diabetes, heart disease, even obesity, when you're referred by your physician.
- Have you asked your physician for a referral to an RDN? Most chronic health conditions are impacted by diet and lifestyle, so if you have any chronic health issues, seeing an RDN is actually indicated.
- RDNs take time with you – most first visits are between 30-60 minutes, so you'll have lots of time to have all your questions answered.
- On Medicare? Medicare covers a number of conditions and most RDNs are Medicare providers.

## Appendix F: Talking Points

### F.1 Payment Models: Options when advocating to payers, employers, and brokers

The flow chart below outlines steps for incorporating MNT services (Tier One) as well as details to address MNT's impact on disease/conditions and frequency of intervention (Tier Two). This information will be critical to consider as you finalize your talking points for your meetings.




### Talking Points to Support Tier One or Tier Two MNT Coverage

Clearly define the ideal language as well as acceptable parameters in case of necessary compromise. Your ultimate goals are to ensure nutrition services provided by RDNs are covered. Your point of contact will most likely request information on the diseases and/or conditions where MNT services are effective, and the number of MNT visits needed to positively impact health outcomes. Make sure you have this information available for your meeting. Talking points for the two tiers of coverage are presented below to frame your negotiations. The goal is to be successful in achieving Tier One coverage, but you may need to fall back to negotiate MNT coverage outlined in Tier Two.

### Talking Points – Tier One

**RDN-Provided MNT Services – Coverage for All Diseases/ Conditions, No Cap on Visits[1]**

The Academy encourages coverage of cost-effective MNT provided by RDNs for obesity prevention and all nutrition-related chronic diseases and medical conditions, including hypertension, obesity, cancer, and prediabetes, consistent with United States Preventive Services Task Force (USPSTF) recommendations and national clinical guidelines. Refer to the evidence outlined in Effectiveness of MNT (Appendix C).

### Talking Points – Tier Two

**RDN-Provided MNT Services – Disease Specific, Recommended Number of Visits**

If the all-encompassing Tier One cannot be achieved, all conditions for wellness, prevention, and chronic disease management for both children and adults should be covered but the number of visits or hours allowed should be negotiated. To determine the number of visits or hours to recommend, refer to the information from the Academy's Evidence Analysis Library (EAL) noted below and national clinical guidelines. You may also use information on the benefits typically covered by employers and private insurance carriers in your state as a guide to a reasonable negotiation level.

The number of hours to advocate for under Tier Two should align with the recommendations outlined in the EAL. Of note, the number of hours should not fall below the Centers for Medicare & Medicaid Services' (CMS) minimum number of hours allowed per year under the Medicare Part B for MNT benefit under Medicare (3 hours per condition in the first year, 2 hours in subsequent years, with additional hours allowed if there is a change in diagnosis and/or medical condition that makes a change in diet necessary). Only use CMS's standard as a minimum level of inclusion if others inquire about level of coverage from various government programs. However, do ensure that the level of coverage in your state is at least or above CMS's standard.

| Summary Table of Tier One and Tier Two Coverage for Medical Nutrition Therapy[2] | | | | |
|---|---|---|---|---|
| | **Tier 1** | **Rationale** | **Tier 2** | **Rationale** |
| **Component** | Any condition for wellness, prevention, and chronic disease management in children and adults | MNT is a proven, effective service for the prevention and treatment of a wide range of conditions/diseases in both children and adults. (supported by USPSTF recommendations) | Any condition for wellness, prevention, and chronic disease management in children and adults | MNT is a proven, effective service for the prevention and treatment of a wide range of conditions/diseases in both children and adults.(supported by USPSTF recommendations) |
| **Cost-sharing requirements** | Waive | Consistent with preventive services under ACA; MNT has Grade B rating from USPSTF | Waive | Consistent with preventive services under ACA; MNT has Grade B rating from USPSTF |
| **Number of visits covered** | Unlimited visits (and hours) annually | Based on the Academy's EAL; overall, greater frequency of visits may lead to more success in implementing and sustaining behavior change[1] | Based on recommendations outlined in the EAL. At minimum, 3 hours annually per condition; additional visits available with physician documentation of medical necessity for more MNT | EAL<br><br>Consistent with Medicare Part B MNT benefit |
| **Qualified providers of MNT services** | RDNs | RDNs are the most cost-effective, qualified healthcare professional to provide MNT (supported by the Institute of Medicine, who recognizes the RDN as "the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.") | RDNs | RDNs are the most cost-effective, qualified healthcare professionals to provide MNT (supported by the Institute of Medicine, who recognizes the RDN as "the single identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to be directly reimbursed as a provider of nutrition therapy.") |
| **Referral requirements** | Self-referral and referral from licensed health care professional | Self-referral promotes access to preventive services and individual self-management of health | Referral from licensed health care professional with order writing privileges | Referral supports "medical necessity" of service. Broad definition of "health care professional" supports access to services in rural and medically under-serviced areas. |

### F.2. State Specific Information

Tailoring MNT talking points with state specific information will add credibility to your conversations when meeting with targeted audiences such as payers and medical groups. Below are suggested links to help find state-specific statistics.

#### Age Demographics

- Population Reference Bureau: Which U.S. States Have the Oldest Populations (December 22, 2001)
- Kaiser Family Foundation: Population Distribution by Age (Use refine results feature to navigate desired information)
- Centers for Medicare and Medicaid (Data.cms.gov) – Medicare Monthly Enrollment (click "State" tab and use "Original Medicare" numbers)

#### Conditions

**Heart Disease and Stroke**

- American Heart Association: Quality Systems of Care Across the U.S. (Scroll through the list to view the mortality, heart disease and stroke statistics for each state)
- Centers for Disease Control and Prevention: Heart Disease Mortality, by State (Interactive Map: Click on each state to find mortality rate; you can also sort by year)

**Obesity**

- America's Health Rankings: Senior Report (Access data specific to obesity among US Seniors. Click on far-right tab "National Obesity Ages 65+")
- Centers for Disease Control and Prevention: Adult Obesity Prevalence Maps (The CDC's Data and Statistics pages provides state specific detailed information about the prevalence of obesity among U.S. adults)

**Prediabetes**

- Centers for Disease Control and Prevention: Prediabetes (Access information such as the Diabetes Report Card along with National and State Trends Percentage of adults who have been told they have prediabetes, by state)
- American Diabetes Association: Statistics (Find information such as data specific to the cost of diabetes as well as access fact sheets to state specific data)

**Malnutrition**

- Defeat Malnutrition Today (Access DMT's State Legislative toolkit to identify estimated annual coast and per capita costs of disease associated malnutrition)

#### References

[1] Evidence Analysis Library. Academy of Nutrition and Dietetics. 2022. www.andeal.org

[2] State Health Insurance Exchanges Toolkit. Nutrition Services Coverage Team and Policy Initiatives and Advocacy Team. American Dietetic Association. August 2011.

## Appendix G: Glossary of Terms

| Glossary of Terms | |
|---|---|
| **Accountable Care Organization (ACO)** | A group of health care providers who give coordinated care and chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. |
| **Centers for Medicare & Medicaid Services (CMS)** | CMS, formerly known as HCFA (Health Care Financing Administration), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. |
| **Children's Health Insurance Program (CHIP)** | The Children's Health Insurance Program (CHIP) provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage. |
| **Cost-Sharing** | The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for nonnetwork providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums. Reference: Centers for Medicare & Medicaid Services' Healthcare.gov |

| Glossary of Terms | |
|---|---|
| **Current Procedural Terminology (CPT code)** | A comprehensive, descriptive list of terms and numeric codes used for reporting diagnostic and therapeutic procedures and other medical services performed by dietitians and other health care providers; published and updated annually by the American Medical Association. Some of the frequently used MNT CPT ©codes used by third party payers, including Medicare, that best describe the MNT services that RDNs provide to patients are:<br>• 97802: Medical nutrition therapy*; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.<br>• 97803: Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.<br>• 97804: Group [2 or more individual(s)], each 30 minutes.<br>• G0270: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.<br>• G0271: Medical Nutrition Therapy reassessment and subsequent interventions(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes |
| **Deductible** | An amount of money that is required to be paid by the insured under the insurance contract before any payment is made by the insurer. Deductible amounts can change every year. |
| **Fee for Service** | A method of payment for health services and procedures (CPT/HCPCS codes) in which a health care provider is paid for each service. |
| **Fee Schedule** | A set payment of reimbursement developed by a third-party payer to be paid for specific health care services and procedures based on CPT codes. |
| **Managed Care** | Any arrangement for health care in which an organization, such as a third-party payer, acts as an intermediary between the person seeking care and the medical care provider. |
| **Managed Care Organization (MCO)** | In the context of Medicaid, MCOs contract with state Medicaid agencies and accept a set per member per month (capitation) payment to deliver Medicaid health benefits and additional services to enrollees. Reference: Centers for Medicare & Medicaid Services Glossary and Acronyms |
| **Medicaid** | Medicaid is the United States health program for U.S. citizens or legal permanent residents, including low-income adults, their children, and people with certain disabilities. It is jointly funded by the state and federal governments and is managed by the states. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States. |
| **Medicare** | The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). |
| **Medicare Advantage Plans** | A Medicare program that gives patients more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare advantage plans used to be called Medicare + Choice Plans. |
| **Medicare Part B** | Part B is synonymous with medical insurance and covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. Recipients pay a monthly premium for this coverage. RDN services fall under Part B. |
| **Primary Care Provider (PCP)** | A physician (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services. Reference: Centers for Medicare & Medicaid Services' Healthcare.gov |
| **Prior Authorization or Pre-authorization** | Prior authorization: Also called "pre-authorization" or "pre-approval." A restriction placed on coverage by private health plans and Medicare private drug plans. If a service or medication is covered with "prior authorization," the doctor or provider must get special permission from the plan to prescribe the service or medication before it will be covered. Failure to get prior authorization before a service can deny coverage for the service. |
| **Private Insurance** | Insurance provided through either a for-profit or not-for-profit company rather than by the federal or state government. |
| **Self-insured/Self-funded** | A type of health care plan used by companies. The company contracts with a third-party administrator (can be a commercial or private insurer) or self-administers the health care plan. The employer decides the premiums from enrollees, the coverage for services and takes on the responsibility of paying employees' and dependents' medical claims. |
| **Telehealth** | The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth will include both the use of interactive, specialized equipment, for such purposes as health promotion, disease prevention, diagnosis, consultation, therapy, and/or nutrition intervention/plan of care, and non-interactive (or passive) communications, over the Internet, video conferencing, e-mail or fax lines, and other methods of distance communications, for communication of broad-based nutrition information. |
| **Value Based Payment (VBP)** | Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. Reference: Center for Health Care Strategies, Inc. |

## Appendix H: Case Studies/Testimonials/Personal Stories

*"As a clinical nutrition manager who answers phones for the outpatient clinic, I have daily conversations with patients regarding insurance coverage and nutrition counseling. Many doctors refer patients to registered dietitian nutritionists for pre-diabetes treatment.*

*Prevention of pre-diabetes is crucial. Diabetes is a disease that has many costly secondary complications to patients and our society. Patients are frequently admitted to the hospital losing limbs, and experiencing kidney failure and heart issues, and many other complications due to diabetes. These outcomes could be avoided with help from RDNs."*

*"I had a client who was referred to me when she was 85 for help with weight loss prior to double knee surgery. She had been identified for the first time as having a binge-eating disorder, even though it had occurred throughout her life. Over the course of our nutrition counseling sessions, this client revealed that she was binge-eating due to her fear of not waking up from anesthesia, which of course prevented the weight loss that she was being asked to achieve. After speaking with her surgeon about the risks of anesthesia and her life-long eating disorder that was being exacerbated by the request to lose weight, this client was able to proceed with the surgery (without losing weight), and over additional MNT sessions was able to diminish her binge-eating symptoms."*

*"A young father was referred to me by his primary care physician for medical nutrition therapy after a heart attack. Needless to say, his family was terrified. Thankfully, this patient had insurance that would cover medical nutrition therapy, so we have been working together to improve his diet specifically around his medical conditions. He has lost more than 30 pounds in two months and feels his health has significantly improved as well as his chances of preventing another cardiac event. He feels more at ease since working with a dietitian and is now running around the soccer field coaching his daughter's team."*

*"I work in a cardiology office and primarily work with older patients who often have heart conditions. Although the cardiologist would prefer I see every patient, he knows I am limited to working with patients that have a certain diagnosis, which means the majority of patients who have obesity and hypertension don't get the care they need.*

*I worked with one patient who was seeking medical nutrition therapy due to prediabetes – he was very obese, had high cholesterol, and very high blood pressure. This patient had nowhere to turn and was frustrated because he knew if he didn't change his lifestyle, he would likely develop diabetes, or have a heart attack; both of these scenarios would be more expensive than MNT services provided by an RDN. These are the kinds of patients that need our help. The U.S. population is aging, and many people have chronic conditions that can be prevented with diet and lifestyle changes."*

*"Medical nutrition therapy improves the quality of life for seniors. I worked with one woman who, when I first met her, was the embodiment of the phrase "skin and bones. She was extremely weak and needed help walking to the bathroom because she wasn't able to do so on her own. One of the happiest days of my career was when I saw this patient again three months later – her family worked diligently to ensure she was following the meal plan and taking her oral nutritional supplements. The transformation was amazing – this patient's cheeks had filled out, she could go to the bathroom unassisted and best of all, I got to witness her tenderly holding and cuddling her great-grandbaby! This would have been impossible for her to do three months earlier because of her weakness and frailty."*

*"I worked with a client who had Type 2 Diabetes and was non-compliant with her diet – she drank two to four liters of sugar-sweetened soft drinks every day and had very high blood sugar levels. She had been having numbness in her hands and feet but did not associate it with her blood sugar levels.*

*After a routine review of her medical history and performing a nutrition evaluation, I explained both that the numbness in her feet and hands could be due to her high blood sugar levels and the mechanism for this diagnosis. For this client, soda was a huge part of her dietary pattern and she felt she did not want to exclude it from her diet, so I suggested she switch to a no-calorie soda, which would reduce her added sugar intake to near zero and help bring her blood sugar levels under control. She could even introduce it gradually, with "every other glass" being the no-calorie cola.*

*During her follow-up appointment a month later, she said had switched completely to sugar-free drinks and also discovered she enjoyed seltzer water. This client also reported that the feeling in her hands and feet had returned and her blood sugar levels were within normal range."*

# RDNs Can Benefit Your Practice

## Adding an RDN to Your Practice is Good Medicine

**IMPROVE**
Patient Health Outcomes

**DECREASE**
Medication Use

**ACHIEVE**
Increased Patient Satisfaction

**INCREASE**
Physician Time, Allowing More Focus on Patient Care

## Registered Dietitian Nutritionists Improve Patient Outcomes

Studies of Registered Dietitian Nutritionists (RDNs) using medical nutrition therapy (MNT) show improved patient outcomes in diabetes, hypertension, lipid metabolism disorders, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults.[1] Additionally, RDNs have demonstrated improved outcomes related to weight management.[2] RDNs deliver care that supports higher performance in value-based models of care.

## RDNs = Positive ROI

MNT results in improved clinical outcomes and reduced costs for physician time, medication use, and hospital admissions for people with obesity, diabetes, and lipid metabolism disorders, as well as other chronic diseases.[3]

Find an RDN by visiting **www.eatright.org**.


[1] Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015*. http://www.andeal.org/mnt.

[2] Academy of Nutrition and Dietetics. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.

[3] Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Evidence Analysis Project 2008*. http://www.andevidencelibrary.com/topic.cfm?cat=3949; http://www.andevidencelibrary.com/mnt.

# RDNs Bring Value to Your Organization

## RDNs Lower Costs and Boost Patient Satisfaction

**IMPROVE**
Patient Health Outcomes

**DECREASE**
Hospital Admissions and Total Cost of Care

**ACHIEVE**
Improved Payment Metrics

**INCREASE**
Patient Satisfaction

## Registered Dietitian Nutritionists Improve Patient Outcomes

Results of studies of Registered Dietitian Nutritionists (RDNs) who use medical nutrition therapy (MNT) show improved patient outcomes in diabetes, hypertension, lipid metabolism disorders, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults.[1] Additionally, RDNs have demonstrated improved outcomes related to weight management.[2]

## RDNs = Positive ROI

RDNs are key members of care teams who use their extensive training and expertise to deliver coordinated, cost-effective care that supports higher performance in value-based care models. They help patients achieve significantly improved outcomes with lower total cost of care.[3]

Find an RDN by visiting **www.eatright.org**.

[1] Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015*. http://www.andeal.org/mnt.
[2] Academy of Nutrition and Dietetics. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.
[3] Academy of Nutrition and Dietetics Evidence Analysis Library. https://www.andeal.org/topic.cfm?menu=5284&cat=4085.

# RDNs Support Value-Based Payments

## Include MNT on Your Menu of Care Options

**IMPROVE**
Health Outcomes

**DECREASE**
Total Cost of Care

**ACHIEVE**
Increased Satisfaction

**INCREASE**
Focus on Prevention


## Registered Dietitian Nutritionists Improve Patient Outcomes

Results of studies of Registered Dietitian Nutritionists (RDNs) who use medical nutrition therapy (MNT) show improved patient outcomes in diabetes, hypertension, lipid metabolism disorders, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults.[1] Additionally, RDNs have demonstrated improved outcomes related to weight management.[2]

## RDNs = Positive ROI

MNT results in improved clinical outcomes and reduced costs for physician time, medication use, and hospital admissions for people with obesity, diabetes, and lipid metabolism disorders, as well as other chronic diseases.

In adults with overweight and obesity receiving MNT, studies showed average cost savings of $52,000-$99,000[3] using incremental cost-effectiveness ratios, with only 2.8% inpatient hospital admissions vs. 22.5% for patients not receiving MNT, and an average 17 years of quality of life gained.[4]

Find an RDN by visiting **www.eatright.org**.

[1] Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015*. http://www.andeal.org/mnt.
[2] Academy of Nutrition and Dietetics. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.
[3] Academy of Nutrition and Dietetics Evidence Analysis Library. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.
[4] RT, Vijgen SMC, Engelfriet PM. Cost-effectiveness of a low-calorie diet and Orlistat for obese persons: modeling long-term health gains through prevention of obesity-related chronic disease. *Value Health*. 2008; 11(7):1033-1040.

# Employee Access to MNT is Smart Business

## Studies Show MNT Boosts Employee Health and Presenteeism

**ACHIEVE**
Improved Employee Health

**DECREASE**
Total Cost of Care

**INCREASE**
Presenteeism

**IMPROVE**
Employee Satisfaction

## Registered Dietitian Nutritionists Improve Outcomes

Including medical nutrition therapy (MNT) as a covered benefit in group plans gives employees access to high-quality, cost-effective nutrition services that can improve their quality of life and decrease absenteeism. Studies show that individuals with obesity, diabetes, and lipid metabolism disorders who receive MNT from a Registered Dietitian Nutritionist (RDN) have better outcomes than those who receive traditional care. They miss work 64.3% less and take 87.2% fewer disability days than those who do not receive MNT.[1]

## RDNs = Positive ROI

In adults with overweight and obesity receiving MNT, studies reveal an average cost savings of $52,000-$99,000 using incremental cost-effectiveness ratios,[2] with only 2.8% inpatient hospital admissions vs. 22.5%[3] for patients not receiving MNT, and an average 17 years of quality of life gained.[3] In a study, MNT was cited as costing $0.03 per member per month. MNT is a valuable adjunct to health management programs that can be implemented for a relatively low cost.[4]

Find an RDN by visiting **www.eatright.org**.


[1] Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med.* 2009;51(2):139-145. doi:10.1097/jom.0b013e3181965db5.

[2] Academy of Nutrition and Dietetics Evidence Analysis Library. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.

[3] RT, Vijgen SMC, Engelfriet PM. Cost-effectiveness of a low-calorie diet and Orlistat for obese persons: modeling long-term health gains through prevention of obesity-related chronic disease. *Value Health*. 2008; 11(7):1033-1040.

[4] The Incremental Value of Medical Nutrition Therapy in Weight Management, *Managed Care*, January 2013.

# Include MNT on the Benefits Menu

## MNT Improves Employee Health, Satisfaction and Attendance

**IMPROVE**
Access to High-Value Nutrition Services

**DECREASE**
Absenteeism

**ACHIEVE**
Improved Employee Health

**INCREASE**
Employee Satisfaction


## Registered Dietitian Nutritionists Improve Health Outcomes

Including medical nutrition therapy (MNT) as a covered benefit in group plans gives employees access to Registered Dietitian Nutritionists (RDNs) who provide high-quality, cost-effective nutrition services that can improve their quality of life and decrease absenteeism. Studies show that patients with obesity, diabetes, and lipid metabolism disorders who receive MNT have better outcomes than those who receive traditional care. On average, they miss work 64.3% less and take 87.2% fewer disability days than those who do not receive MNT.[1]

## RDNs = Positive ROI

Individuals who have access to MNT enjoy improved quality of life and better clinical outcomes[1]. MNT is shown to significantly lower HbA1c by 0.3%-2.0% in adults with Type 2 diabetes. The average savings for each 1% decrease in A1C is $246-$1,640 per patient per year.[1] In a study, MNT was cited as costing $0.03 per member per month. MNT is a valuable adjunct to health management programs that can be implemented for a relatively low cost.[2]

Find an RDN by visiting **www.eatright.org**.

[1]Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med*. 2009;51(2):139-145. doi:10.1097/jom.0b013e3181965db5.

[2]The Incremental Value of Medical Nutrition Therapy in Weight Management, *Managed Care*, January 2013.

# Access to MNT by RDNs is Good Policy

## Better Patient Health, More Treatment Options and Lower Costs

**IMPROVE**
Health of the Nation

**DECREASE**
Costs

**ACHIEVE**
Improved Social Determinants of Health

**INCREASE**
Consumer Choice

## Registered Dietitian Nutritionists Improve Health Outcomes

Results of studies of Registered Dietitian Nutritionists (RDNs) who use medical nutrition therapy (MNT) show improved patient outcomes in diabetes, hypertension, lipid metabolism disorders, HIV infection, pregnancy, chronic kidney disease, and unintended weight loss in older adults.[1] Additionally, RDNs have demonstrated improved outcomes related to weight management.[2]

## RDNs = Positive ROI

MNT results in improved clinical outcomes and reduced costs for physician time, medication use, and hospital admissions for people with obesity, diabetes, and lipid metabolism disorders, as well as other chronic diseases.[3] By using their expertise and extensive training, RDNs deliver care that is coordinated, cost-effective, and supports higher performance in pay-for-value models of care. They help patients achieve significantly improved outcomes with lower total cost of care.

Find an RDN by visiting **www.eatright.org**.


[1] Academy of Nutrition and Dietetics Evidence Analysis Library. *Medical Nutrition Therapy Effectiveness Systematic Review 2009, 2013-2015*. http://www.andeal.org/mnt.

[2] Academy of Nutrition and Dietetics. MNT: Weight Management. https://www.andeal.org/topic.cfm?menu=5284&cat=5230. 2015. Accessed December 3, 2019.

[3] Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med*. 2009;51(2):139-145. doi:10.1097/jom.0b013e3181965db5.

# RDNs Can Benefit Your Programs

## RDNs Help Build Healthier Communities

**IMPROVE**
Health Outcomes

**DECREASE**
Medication Use

**ACHIEVE**
Improved Social Determinants of Health

**INCREASE**
Effectiveness of Diabetes Prevention Programs

## Registered Dietitian Nutritionists Improve Health Outcomes

Studies show that individuals with obesity, diabetes, and lipid metabolism disorders who receive medical nutrition therapy (MNT) from Registered Dietitian Nutritionists (RDNs) have better outcomes than those who receive traditional care.[1] RDNs partner with community service providers to help children and adults improve their quality of life and achieve better overall health.

## RDNs are Essential for Community Health Programs

**Intensive lifestyle programs to prevent diabetes led by RDNs get better results,** according to a systematic review by the Community Preventive Services Task Force.[2,3] RDNs are also uniquely qualified to provide training and oversight to other staff who may be delivering such programs to ensure program integrity.

**RDNs are a critical component of effective community-based medically-tailored meal programs.** Providing medically tailored, therapeutic meals and nutrition counseling by RDNs decreased monthly healthcare costs by an average of 31% and cut hospitalizations in half compared to patients not receiving these services.[4] This translates to an average savings of $13,000 per month, highlighting the efficacy and importance of comprehensive, community-based nutrition services for people with serious illnesses.

Find an RDN by visiting **www.eatright.org**.


[1] Wolf, AM; Siadaty, MS; Crowther, JQ; et al. Impact of lifestyle intervention on lost productivity and disability: improving control with activity and nutrition. *J Occup Environ Med.* 2009; 51(20:139-145.

[2] Balk, E.M., Earley, A., Raman, G., Avendano, E.A., Pittas, A.G., and Remington, P.L. Combined diet and physical activity promotion programs to prevent type 2 diabetes among persons at increased risk: A systematic review for the Community Preventive Services Task Force. Ann Intern Med. 2015; 163: 437–451.

[3] Briggs Early, Kathaleen et al. Position of the Academy of Nutrition and Dietetics: The Role of Medical Nutrition Therapy and Registered Dietitian Nutritionists in the Prevention and Treatment of Prediabetes and Type 2 Diabetes. *J Acad Nutr Diet.* 2018; 118 (2):343 – 353.

[4] Gurvey, J. et al. Examining Health Care Costs Among MANNA Clients and a Comparison Group. *Journal of Primary Care & Community Health.* 2013; 4(4):311-317.


# Proof in Numbers: Making the Business Case for RDN Services

**October 16, 2016**
**10:00 AM-11:30 AM**
**Boston, MA**

## Moderator

**Ingrid Knight, RD, LD**
Chair, Nutrition Services Payment Committee
President, Ingrid Knight, RD and Associates, Inc.

## Speakers

**Sharon K. Hull MD, MPH, FAAFP, FACPM**
President and CEO
Metta Solutions, LLC
Durham, NC

**Becky Sulik, RD, LD, CDE**
Director of Education
Rocky Mountain Diabetes & Osteoporosis Center
Idaho Falls, Idaho

## Learning Outcomes

*At the end of this session, the participant will be able to…*

- Explain how value-based health care delivery and payment models work.
- Identify key factors to consider when quantifying the value of RDN services in a variety of practice settings.
- Make a business case for incorporating RDN services into various practice settings.

## Disclosure

**Sharon K. Hull MD, MPH, FAAFP, FACPM**

- Executive Coach and Consultant
  - Metta Solutions, LLC (President and CEO)
- Employee
  - Duke University School of Medicine
- Research Support
  - Association of American Medical Colleges
- Board Member/Advisory Panel
  - Medical Education Cooperation with Cuba

## Polling Question

How comfortable are you that you could explain the value of the RDN in <u>your</u> health care system?

1. Not comfortable at all
2. A little bit comfortable
3. Mostly comfortable
4. Very comfortable

## Overview

- Volume to value transition
- Organizations and decision makers
- Opportunities to generate income
- Opportunities to reduce expenses
- What does it mean to "break even?"

## Volume to Value Transition

Health care reform under the Affordable Care Act (ACA)

- Primarily insurance reform
- Has increased access to insurance
- Is changing payment structures
  - Widgets vs outcomes
  - Carrots and Sticks
- Priority given for
  - Improved outcomes
  - Reduced costs
  - Improved patient experience of care


## Show of Hands

- How many of you feel that you understand the ways ACA changed payment structure
- How we get paid for value NOW? – largely PMPM
- How many of you feel you understand where we are going in terms of value payment in the future? Quality metrics with incentives and risk-based payments.

## This is Not Just "Behind the Scenes" Information

- How do you improve the value of care
  - Less health care dollar spend
  - Better patient outcomes


- What do I know from private practice?

## Organizations and Decision Makers

Who are the organizations you work with who are impacted by this transition?

## Organizations and Decision Makers

- Who controls the resources in these organizations?
- If you don't know, how could you find out?
  - Start with your immediate supervisor
  - Business managers/practice managers
  - Financial officers
- What impacts their decisions?
- What matters to them, and who matters to them?
- Scanning the environment
- Finding a champion (may or may not be a physician champion, but needs to have ability to influence decisions)

## Opportunities to Increase Income

- Direct billing
- Quality metrics payments
- PMPM lower cost visits
- Increased provider productivity


## Opportunities to Decrease Expenses

- Avoidable hospitalizations
- Reduced readmissions
- Emergency Department avoidance


## What Does it Mean to "Break Even?"

- Direct and Indirect Costs
  - Direct costs are things you can write a check for
  - Indirect costs are things that cause you to "lose money" without a bill
- Overhead costs
  - Rent
  - Insurance
  - Utilities
  - Other
- Break even must take into account all of these things


## Disclosure

**Becky Sulik, RD, LD, CDE**

- Consulting agreements:
  - Lilly Diabetes, Abbott Diabetes Care
- Training Fees or Stipends:
  - Medtronic Diabetes, Animas Corporation, Tandem Diabetes, Insulet, Roche
- Honorarium received for this presentation from the Nutrition Services Payment Committee

## Strategic Failure?


## Healthcare is changing!

# How do you show value?


FNCE 2016 Food & Nutrition Conference & Expo

# Team Environment

The Challenge

- Collaborate and work as interdisciplinary teams
- Still being able to show the RDN value on the

FNCE 2016 Food & Nutrition Conference & Expo

# The Value Worksheet

| Value Type | Examples | Examples from your setting | What kind of data do you need? | Who can help you? |
|---|---|---|---|---|
| Financial: Revenue Directly-billed | - Fee for service<br>- Contracted fees | | | |
| Financial: Enhancing facility revenue | - How do you help the team bring in more revenue? | | | |
| Financial: Reducing costs | - Reduced admissions<br>- Reduced ED visits<br>- Length of stay | | | |
| Better Patient Care/Quality of care | - Outcome measures<br>- Incentive payments/bonus | | | |
| Reputation | - Patient/client<br>- Public<br>- Payers<br>- Referring organizations | | | |

FNCE 2016 Food & Nutrition Conference & Expo

# Hospital/ACO:

## Malnutrition and Length of Stay

Source:
Young Hee Kim, MS, RD, LDN, CNSC
Manager Clinical Nutrition, Baystate Health

FNCE 2016 Food & Nutrition Conference & Expo

# Hospital/ACO Example

| Value Type | Examples | Examples from your setting | What kind of data do you need? | Who can help you? |
|---|---|---|---|---|
| Financial: Revenue Directly-billed | - Fee for service<br>- Contracted fees | | | |
| Financial: Enhancing facility revenue | **- How do you help the team bring in more revenue?** | | | |
| Financial: Reducing costs | **- Reduced admissions**<br>**- Reduced ED visits**<br>**- Length of stay** | | | |
| Better Patient Care/Quality of care | - Outcome measures<br>- Incentive payments/bonus | | | |
| Reputation | - Patient/client<br>- Public<br>-Payers<br>- Referring organizations | | | |

FNCE 2016 Food & Nutrition Conference & Expo

# Potential Financial Value

| Value | Data? | Who? |
|---|---|---|
| Enhance Revenue<br>**Malnutrition identification** | - Average reimbursement<br>- Additional reimbursement for malnutrition<br>- Number of cases | - Informatics<br>- Billing/Finance<br>- Clinical documentation improvement team<br>- Nursing |
| Reduce Costs<br>**Length of stay** | - Average LOS | - Informatics<br>- Billing<br>- Quality management |

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## Plan of Action

Why diagnose malnutrition?

- Improve patient care/outcomes
  - Reduce length of stay
  - Reduce readmission
  - Both could reduce cost!
- Capture reimbursement related to malnutrition

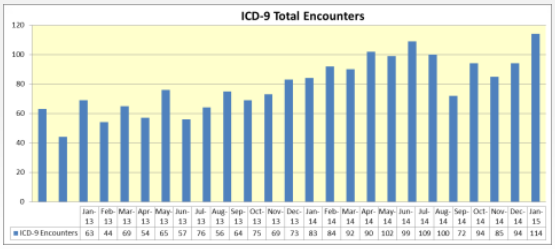
How?

- Interdisciplinary partnership
- Physician champion
- Appropriate training
- EHR

## Show me the value!

| | Pre-Implementation | Post-Implementation |
|---|---|---|
| Volume Malnutrition Dx/Mo | 3.2 cases | ? |
| Dollar Impact/Mo | $26,010 | ? |

## ACO: Identify Malnutrition

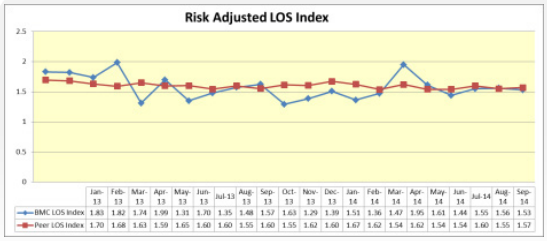



## Show me the value!

| | Pre-Implementation | Post-Implementation |
|---|---|---|
| Volume Malnutrition Dx/Mo | 3.2 cases | **83.1 Cases** |
| Dollar Impact/Mo | $26,010 | **$116,169** |

$116,169 x 12 months = **$1.39 million**

## Length of Stay Index




US Hospital adjusted expenses per patient day: $2,212*

*Kaiser Family Foundation, 2014

## Physician Practice/PCMH

## Physician Practice/PCMH

- 4 Prescribing Practitioners
- 2 FTE (RDN, CDEs)
- 1 office manager

Constantly challenged to produce revenue via fee-for-service billing.

## Physician Practice/PCMH

Physicians

- Limited time with patients
- FFS; volume of patients important.

Other office staff limits

IMPACT:

- RDN's allow physicians to see more patients while still providing quality care
  - How to quantify?

## Physician Practice/PCMH

| Value Type | Examples | Examples from your setting | What kind of data do you need? | Who can help you? |
|---|---|---|---|---|
| **Financial: Revenue Directly-billed** | - Fee for service<br>- Contracted fees | | | |
| **Financial: Enhancing facility revenue** | **- How do you help the team bring in more revenue?** | | | |
| **Financial: Reducing costs** | **- Reduced admissions**<br>**- Reduced ED visits**<br>**- Length of stay** | | | |
| **Better Patient Care/Quality of care** | - Outcome measures<br>- Incentive payments/bonus | | | |
| **Reputation** | - Patient/client<br>- Public<br>-Payers<br>- Referring organizations | | | |

## Financial

| Value | Data? | Who? |
|---|---|---|
| **Financial: Enhance Practice Revenue** | - Average HCP patients per day<br>- Average RDN per day cost of RDN<br>-Average HCP revenue per visit | - Billing<br>- -IT |
| | | |

## Gathering Data

Average patient number per HCP per day

- Showed variation on days with 1 or 0 RDN
  - Looked at patients per HCP per day over 4 months
  - Days with 0 RDNS, average patients per HCP per day: 27
  - Days with 1 RDN, average patients per HCP per day: 29
  - Days with 2 RDNs, average patients per HCP per day: 33

Average charge per patient (clinic, HCP)

- Obtained from billing department
- Average payment obtained per patient: **$80**

## RDN Cost: $275

**Calculation for salary/benefits cost:**

Cost per RDN per day + percentage used for benefits = **$230**

**Overhead cost**

*(space, computer, utilities, support staff, cleaning):*

Office formula for assigning per department per month, translated to daily cost per office = **$40**

**Materials:**

Average cost of patient education materials given to the patient per day = **$5**

$230
$ 40
$ 5

**Total Cost: $275**

## "Show me the Money!"

| | |
|---|---|
| RDN FFS revenue: $346.50 x 2 | $693.00 |
| Additional Revenue generated by HCP because of 2 RDNs | +$640.00 |
| Total Income | $1333.0 |
| RDN costs: $275 x 2 RDNs | -$550.00 |

**Net revenue: $783**


## Hospital/ACO: Emergency Department Visits and Readmissions

Source:

Cindy Horrocks, RD, LD, CDE

Manager, Saint Alphonsus Diabetes Care & Education Clinics

## ACO: ED Visits and Readmission

- Problem – Patients with diabetes
  - More frequent, recurring ED visits
  - Readmission
- Team Involvement
  - Diabetes Care Team – multidisciplinary
  - Administration, data management, hospital staff

## ACO: ED Visits and Readmission

| Value Type | Examples | Examples from your setting | What kind of data do you need? | Who can help you? |
|---|---|---|---|---|
| Financial: Revenue Directly-billed | - Fee for service<br>- Contracted fees | | | |
| Financial: Enhancing facility revenue | - How do you help the team bring in more revenue? | | | |
| Financial: Reducing costs | **- Reduced admissions<br>- Reduced ED visits<br>- Length of stay** | | | |
| Better Patient Care/Quality of care | **- Outcome measures<br>- Incentive payments/bonus** | | | |
| Reputation | - Patient/client<br>- Public<br>-Payers<br>- Referring organizations | | | |

## Potential Financial Value

| Value | Data? | Who? |
|---|---|---|
| Reduce Costs<br>**Readmissions**<br>**ED Visits** | -ED Visits (diabetes)<br>- Readmission (diabetes) | - Data Team<br>- Finance |
| Outcome (bonus)<br>**Patient Satisfaction** | -Patient Satisfaction Scores | - Data Team<br>- Quality management |

## ACO: ED Visits and Readmission

GOAL

- shift target patient utilization away from ER services and inpatient settings
- Utilize comprehensive diabetes clinics more
- Impact patient satisfaction

## ACO: ED Visits and Readmission

Intervention

- Workflow
- Scheduling and access barriers
- Training
- Marketing
- Measure additional outcomes
  - Satisfaction
  - A1c


## ACO: ED Visits and Readmission

Results

- 276 Patients transitioned from ER or inpatient to clinics
- Total estimate of patients impacted within the system: 1115
- Grant money invested: $245,000
- Cost savings:
  - 23 Patients avoided ED: $253,000

## ACO: ED Visits and Readmission

Results

- Potential cost savings:
  - Readmission savings: $11,000 x 276 patients = just over $3 million
  - Savings predicted on 1115 patients who had A1c > 9% = $12,265,000

## ACO: ED Visits and Readmission

Additional Outcomes

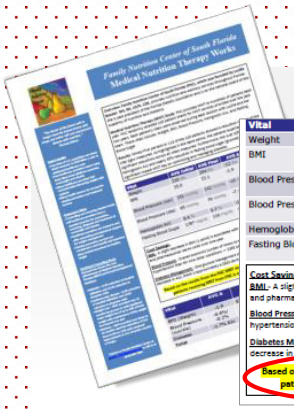
- Reduced A1c – additional quality measures
- Patient Satisfaction Improvement
  - Percentile rank affects payment


## Outcomes for Income!

- Incentive payments for quality
  - Reporting outcomes
  - Improving outcomes
- Incentive payments for reducing cost
  - Emergency Department Example
- Patient Satisfaction Data
  - Being used to affect payments
  - Compared against other "similar" facilities


## Outcomes for Marketing


| RDN Visits | A1c (%) |
|---|---|
| No Visit (Baseline) | 9.54% |
| 1 Visit | 9.14% (-0.40) |
| 2 Visits | 8.82% (-0.72) |
| 3 Visits | 8.60% (-0.94) |
| 4 Visits | 7.56% (-2.02) |



| Vital | AVG Initial | AVG Final | AVG Δ | % Δ |
|---|---|---|---|---|
| Weight | 216 lbs | 204 lbs | -12 lbs | -5.6% |
| BMI | 35.0 | 33.1 | -1.9 | -3.0% |
| Blood Pressure (sys) | 151 mmHg | 142 mmHg | -10 mmHg | -6.6% |
| Blood Pressure (dia) | 85 mmHg | 78 mmHg | -7 mmHg | -8.2% |
| Hemoglobin A1C | 8.4 % | 6.7 % | -1.7 % | -20.2% |
| Fasting Blood Sugar | 178* mg/dL | 116 mg/dL | -62 mg/dL | -34.8% |

**Cost Savings:**

**BMI** - A slight decrease in BMI (1 point) is associated with a $202.30 decrease in medical and pharmaceutical claims costs over one-year.

**Blood Pressure** - Overall economic burden of illness to employers was higher for hypertension than for nine other conditions — $392 per eligible employee per year.

**Diabetes Management** - One glucose management study showed that for every 1% decrease in A1c, there was approximately a $620 savings per year per person.

**Based on the results from the FNC MNT study, the annual cost savings for patients receiving MNT from FNC is estimated to be over $2,100.**

## Reputation Impact

More and more, we expect our impact to move outside the traditional framework of healthcare

- Patient satisfaction
- Public reputation
- Payers
  - Contracts
- Referring organizations
  - Employer groups

## Take a step forward!

- Learn more about models of care
- Strategize using the value worksheet
- Join or form a team
- Get involved with quality management
  - Outcomes and facility priorities
- Develop a relationship with your billing/reimbursement personnel
- Seek opportunities to learn more about payment models/value based payments
- Propose a pilot project to test your ideas


## Academy Resources


**Visit:**
www.eatrightstore.org

## Academy Web Resources

www.eatrightpro.org/resources/practice/getting-paid

www.eatrightpro.org/resources/research/projects-tools-and-initiatives/andhii

**E-mail us:** reimburse@eatright.org

## What will **you** do?

*"Some people want it to happen, some wish it would happen, others make it happen."*

Michael Jordan

## Questions

# CODES FOR SERVICES PROVIDED BY RDNs

The medical nutrition therapy (MNT) CPT codes are used by many payers, including Medicare. These codes best describe the MNT services that registered dietitian nutritionists provide to patients.

**97802**: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, *each 15 minutes*.
**97803**: reassessment and intervention, individual, face-to-face with the patient, *each 15 minutes*.
**97804**: group (2 or more individual(s)), *each 30 minutes*.

Some payers will require a second referral and the use of these G codes when additional hours of MNT services beyond the number of hours in the standard benefit are indicated.

**G0270**: Medical nutrition therapy; reassment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, *each 15 minutes*.
**G0271**: group (2 or more individual(s)), *each 30 minutes*.

For RDNs providing Diabetes Self-Management Training (DSMT) as part of an accredited program, the following G codes should be used for billing.

**G0108**: DSMT services, individual, *per 30 minutes*.
**G0109**: DSMT services, group session (2 or more), *per 30 minutes*.

These codes may be used by approved suppliers of a Medicare Diabetes Prevention Program (MDPP) providing services to eligible beneficiaries with Medicare Part B coverage.

**G9873-85**; **G9890** & **G9891**: MDPP services; for information about MDPP services, supplier enrollment, and billing codes, visit the Academy's MDPP page.

**Additional Codes Recognized by Medicare:**

RDNs may be qualified to provide the following services under Medicare; these codes may also be recognized by some private payers. Refer to individual payer policies for use of code and specific coverage parameters.

**G0438-39**: Annual Wellness Visit
**G0447** & **G0473**: Intensive Behavioral Therapy for Obesity
**G0511**: General Care Management (exclusively for use by rural health clinics and federally qualified healthcare centers)

# CODES FOR SERVICES PROVIDED BY RDNs

Academy of Nutrition and Dietetics

**Additional Codes Used by RDNs (refer to CPT book for full code description):**

**0403T** & **0488T:** Diabetes Prevention Programs

**0591T-0593T:** Health and Well-being Coaching

**94690:** Oxygen uptake, expired gas analysis; rest indirect (separate procedure)

**95249-95250:** Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours

**98960-62**: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family).

**98966–68**: Telephone assessment and management service provided by a qualified nonphysician health care professional.

**98970-98972:** Qualified nonphysician healthcare professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.

**99366** & **99368**: Medical team conference, with and without the patient and/or family.

**99401-04**: Preventive medicine counseling and/or risk factor reduction intervention(s);

**99411-12**: Preventive medicine counseling and/or risk factor reduction intervention(s);

**99406-07**: Smoking and tobacco use cessation counseling visit;

**99487** & **99489**: Complex chronic care management services;

**99490**: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

## Hooking, Bridging and Flagging

These are several simple and effective communication techniques you can use to keep your conversation focused or help you get back on track. Mastering hooking, bridging and flagging will help you remain in control of any conversation in dialogue.

### Hooking

Set up a question that you want to be asked, leading the conversation in the direction you want to go. For example, lead with "That's just one of the many benefits of this policy." This sets the stage for the follow-up, "What are the other benefits of this policy?"

### Bridging

Transition smoothly from off-topic questions back to the focus of your 'ask' by shifting the conversation. Use language like, "I hear your concerns, but the real problem is…" or "If we take a step back and look at the big picture…"

### Flagging

Emphasize the main points of your message by drawing attention to the importance of what you have said or are going to say. For example, start your sentence with "The more important thing to remember is…" or "I can't underscore enough…" This will help to reinforce the main message you are trying convey.

## Sharing Your Story

It is often said on Capitol Hill that, "Facts make you credible. Stories make you memorable." Policymakers do not always make decisions based on facts alone. There are multiple influences on the decision-making process and as legislators are inundated with information on a variety of topics, the right story can be very effective in highlighting your issue and influencing legislators. Some tips for telling effective stories include:

- **Be purposeful.** Use your story to illustrate a key success or challenge in your work. For example, if advocating for legislation ensuring adequate supply of medical foods, a story of a local patient at the Veterans Administration hospital impacted by a shortage of tube feeding formula can be easily understood. To make sure the purpose of your story is clear, follow this by saying, "I'm telling you this story because…"

- **Be strategic.** In the above example, a story from a veteran may be particularly salient to a member on the Veterans' Affairs Committee. For example, if your legislator was an educator and you are advocating for child nutrition programs, telling a story about the impact of school breakfast and lunch on a student's academic achievement may also garner more interest. Develop stories of economic benefit and impact as well. For example, if you provided MNT counseling for a client who was able to manage their diabetes well enough to be able to return to work, that is a powerful story.

- **Tell an effective story** Use the storytelling worksheet to craft an engaging and impactful story that your legislators will want to hear.

- **Make an emotional connection.** Members of Congress and their staff rely heavily on real constituent stories. Be judicious in your approach, as you don't want to bring policymakers to tears or have them feel that the problem is insurmountable. But the right emotional connection can bring them to understand the real-life consequences of inaction or action regarding the issue for which you are advocating.

- **Focus on one person or family.** While it is extremely important to educate legislators on what RDNs do, remember to focus on the impact of your work and not just a description of your work. Telling a story of an individual, family or even a community that you have helped and how you helped, allows policymakers to better understand the on-the-ground impact of the work of RDNs.

- **Justify their involvement.** The stories you tell should clearly connect with your "ask" and should convey how the policymaker's action will lead to concrete improvement in the lives of their constituents and within their community.

*Adapted from the Robert Wood Johnson Foundation Connect Resource Manual for Project Connect: http://www.rwjf.org/en/grants/grantee-resources/connect-project.html.*

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