LIFESTYLE MEDICINE TEAM-BASED MODELS OF CARE

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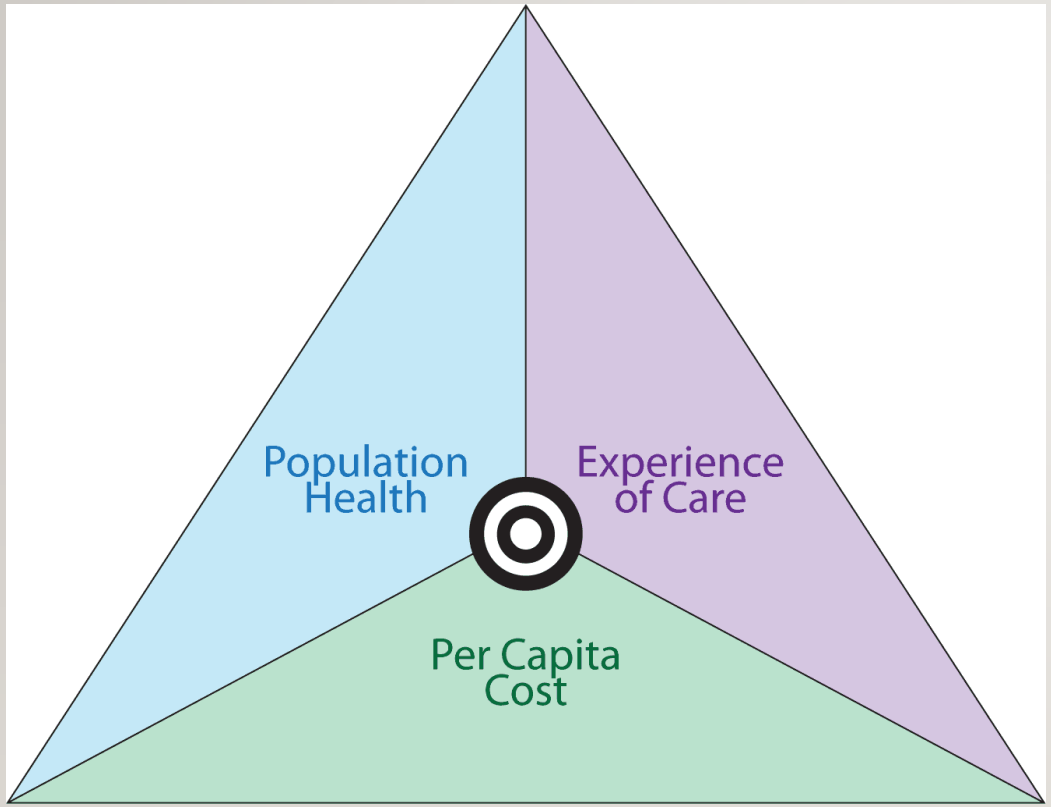
DISCLOSURES

- Board member of the American College of Lifestyle Medicine
- Advisory board member for Nudj Health

LEARNING OBJECTIVES

- Explore effective team-based models of care for delivering Lifestyle Medicine.
- Discuss clinic operations and team member roles which support team-based models of care.
- Review cases of patients treated in a Lifestyle Medicine team-based model.

WEST MICHIGAN RELAYS



WHY TEAM-BASED CARE?

- Triple Aim framework described by Don Berwick, Tom Nolan and John Whittington (*Health Affairs*, 2008)
- Move from the Triple to Quintuple Aim with the addition of workforce wellbeing and health equity (*JAMA*, 2022)
- Each aim or point amplifies the others, creates synergy
- Taking care of the team means taking better care of the patient

WHY TEAM-BASED CARE?

- Team-based care is a collaboration among health care providers to improve specific health outcomes for patients (*Health Affairs*, 2021)
- Team-based care promotes:
  - Better post-operative outcomes (*BMJ Open*, 2019)
  - Increased patient and provider experience of care (*Fam Prac Mgmt*, 2022)
  - More cost-effective care (*Health Affairs*, 2018)

TEAM-BASED CARE IS BETTER FOR MANAGEMENT OF CHRONIC DISEASE IN PRIMARY CARE

- Study of team-based vs solo practitioner care on main outcome of disease control within one-year of disease onset for diabetes, hyperlipidemia, and HTN (*Health Affairs*, 2021)
- Disease control defined as HbA1c≤7.0%, LDL≤100, and SBP≤140
- Retrospective review of data obtained from over 12 M de-identified primary care visits which included over 250 PCP practices and >2 K PCPs

DISEASE CONTROL TEAM VS SOLO

- Team-based care provided statistically significant % improvement in disease control for:
  - T2DM (9.2%)
  - Hyperlipidemia (2.3%)
  - Hypertension (6.1%)
- Physician teams (compared to nonphysician teams) tended to have best outcomes irrespective of team composition

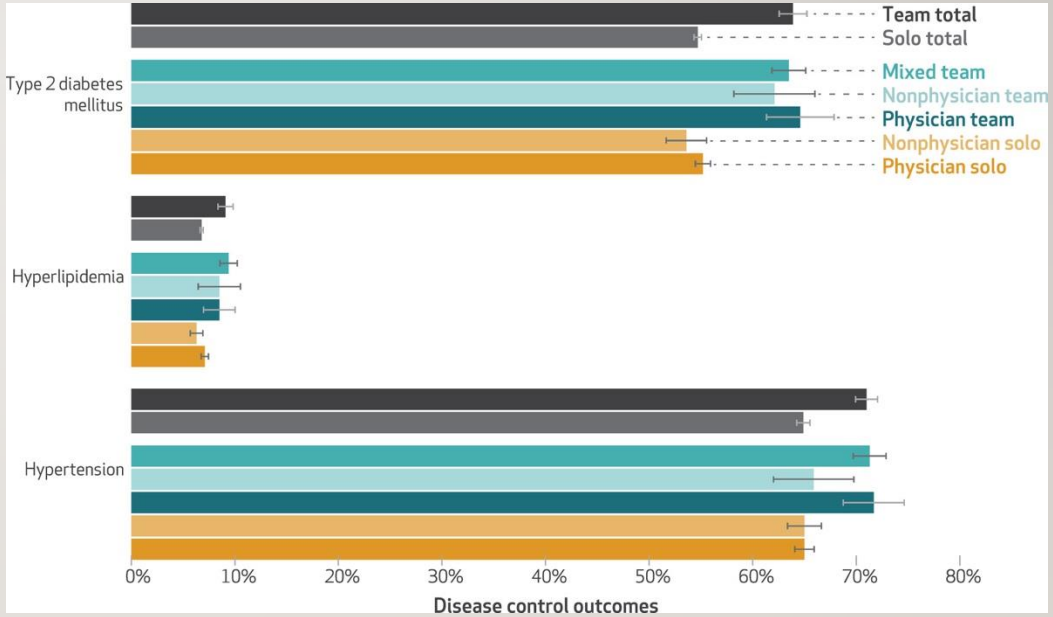
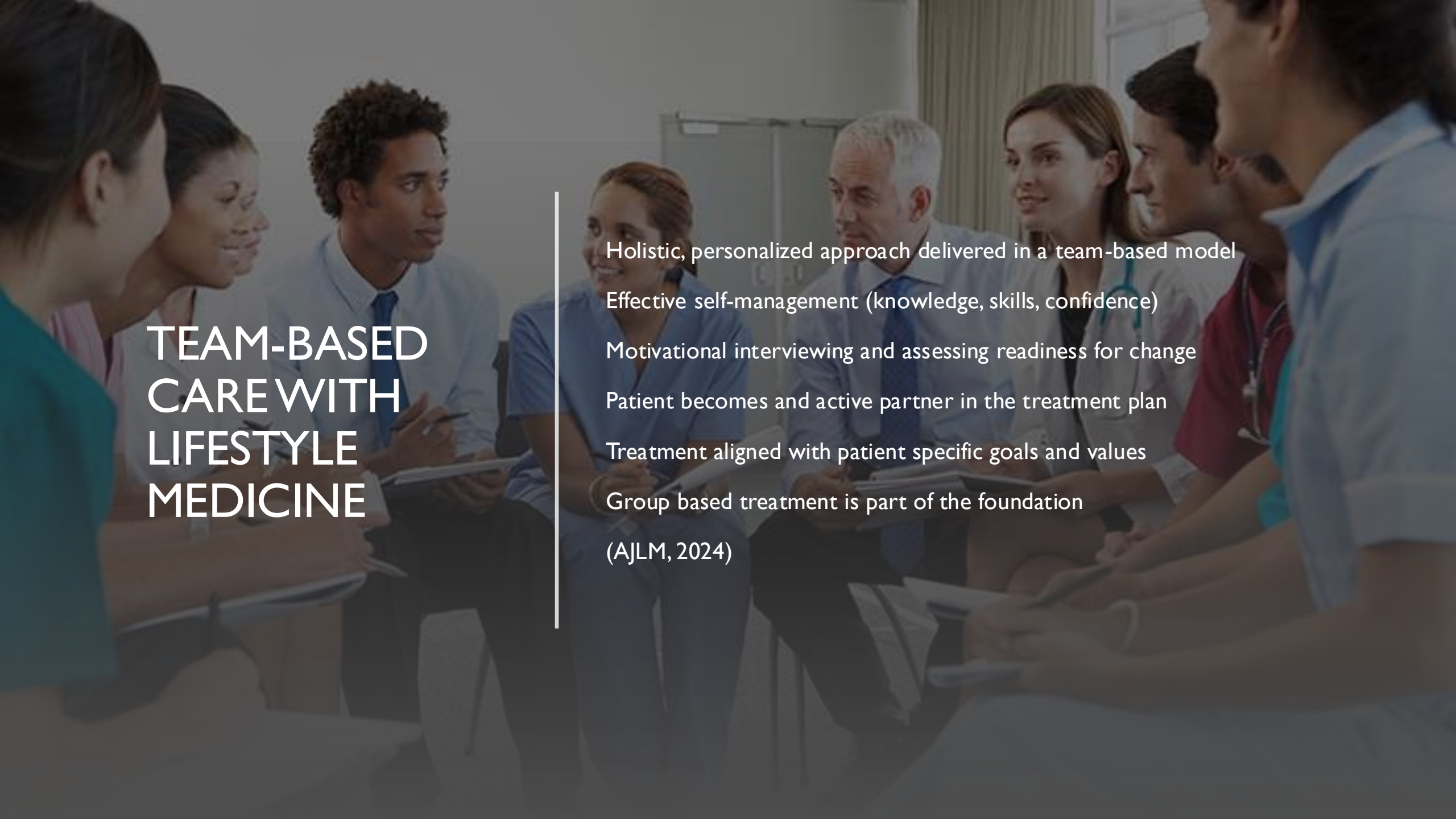


Exhibit 4 Adjusted biomarker-based disease control outcomes for patients with new onset of type 2 diabetes mellitus, hyperlipidemia, and hypertension, by team-based care and provider type, 2013–18

Maximilian J. Pany et al. *Health Affairs*



TEAM-BASED CARE WITH LIFESTYLE MEDICINE

Holistic, personalized approach delivered in a team-based model

Effective self-management (knowledge, skills, confidence)

Motivational interviewing and assessing readiness for change

Patient becomes and active partner in the treatment plan

Treatment aligned with patient specific goals and values

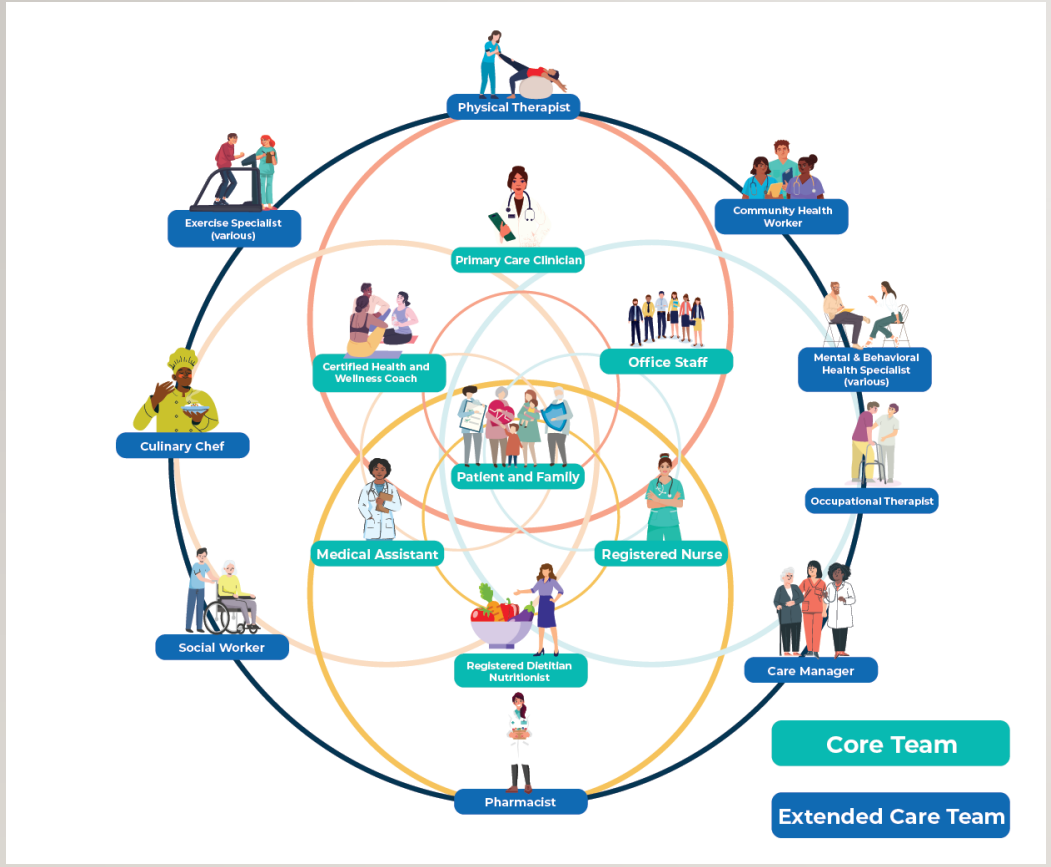
Group based treatment is part of the foundation

(AJLM, 2024)

LIFESTYLE MEDICINE PRINCIPLES

- 6 KEY DOMAINS OF HEALTH BEHAVIOR:
  - Nutrition
  - Physical activity
  - Restorative Sleep
  - Stress management
  - Social connection
  - Avoiding risky substances

LIFESTYLE MEDICINE INTERPROFESSIONAL TEAM



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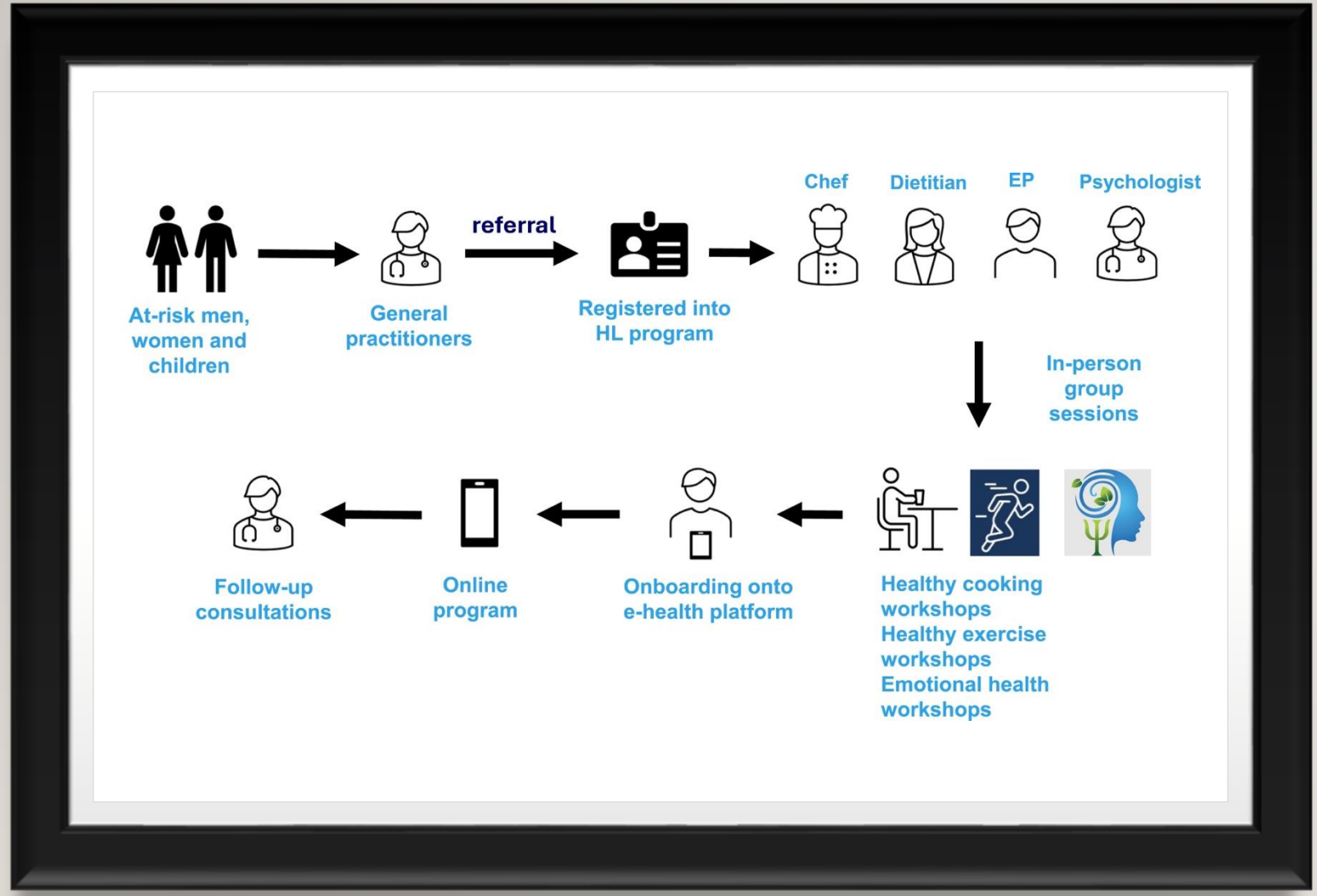


LIFESTYLE MEDICINE CLINICAL SERVICES INTEGRATED WITHIN COMPREHENSIVE, TEAM-BASED CLINIC MODELS

Eur Heart J, Volume 45, Issue 29, 1 August 2024, Pages 2584–2586,
https://doi.org/10.1093/eurheartj/ehae173

OVERVIEW OF EFFECTIVE TEAM-BASED MODELS

Shared medical appointments

Collaborative care

Medical nutrition therapy

Health and Wellness coaching

SHARED MEDICAL APPOINTMENTS

- Benefits
  - Time – with provider, care team and other patients
  - Support – improves confidence and self-efficacy
  - Inspiration – rapport and improved self-management
  - Peer Learning – sharing what works
  - Access – expands clinic capacity
  - Efficiency – say the same thing one time to 12 people
  - Cost-effectiveness – for the team and the practice

SHARED MEDICAL APPOINTMENTS

- The American Academy of Family Practice states that "group visits are a proven, effective method for enhancing a patient's self-care, increasing patient satisfaction and improving outcomes."
- "To achieve optimal health, patients require a team-based approach, sufficient time with providers, and education." Lacagnina et al (2021)

- The Team
  - Physician or APP
  - Medical Assistant
  - Facilitator (Health Coach, Social Worker, etc)
  - Patients!

LIFESTYLE MEDICINE = PATIENT SATISFACTION

Lifestyle Medicine Shared Medical Appointment Patient Testimonials

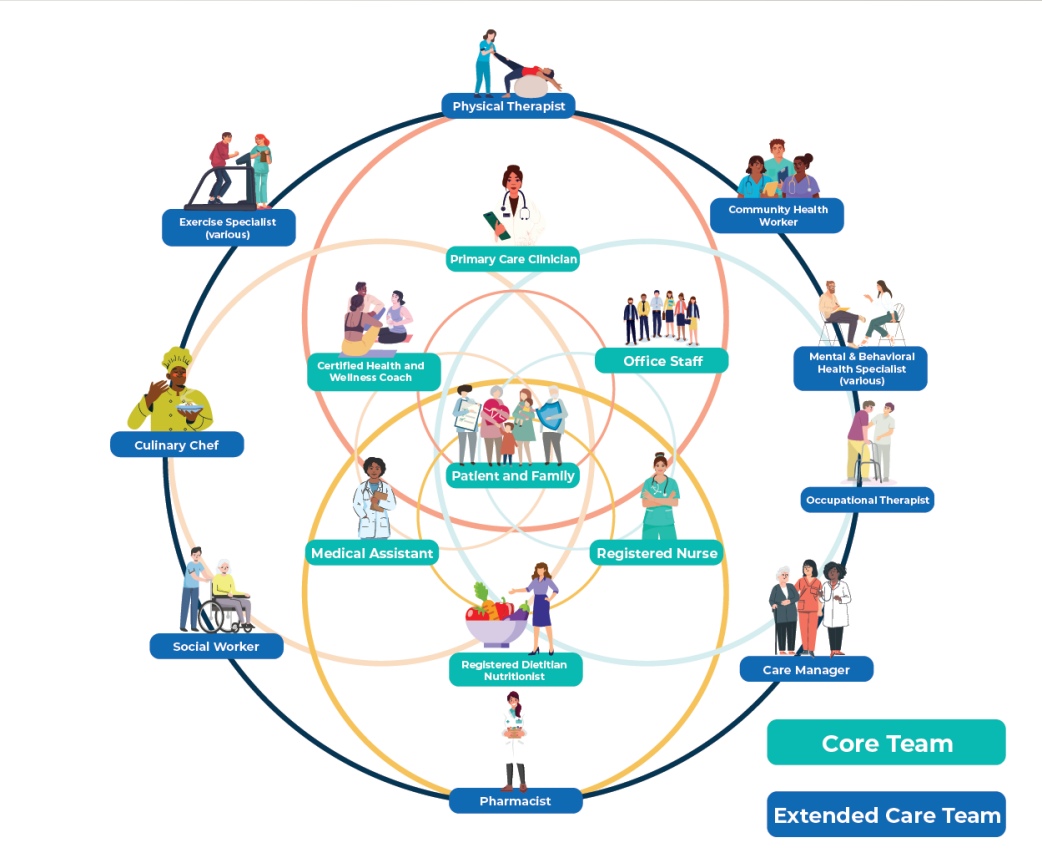
- *"I am not the same person I was prior to taking part in Lifestyle. I always had the tools but did not use them effectively. I have always been a positive person but I did not take care of myself. I felt everything and everyone came first. I always gave good advice but did not take my advice.*

- *I now take time for my needs, I say no when it compromises my self care needs. This has been a process with encouragement from my Lifestyle family. Who would have guessed, that during Covid, a group of strangers via zoom, would be the best medicine for each other. Learning from each other, helping each other and challenging each other to be better people. Lifestyle is a process and it has changed me for the better. Continuing to share with others is the best part because, I am not a shy person, I want to share the message with others.*

- *Thank you for giving me the opportunity to share my thoughts, my success and my process to become the better me. Feel free to share my words and my story with others."*

COLLABORATIVE CARE

- Evidence-based model of care with integrated behavioral health support with care managers and consulting psychiatrist (retrieved from *American Psychiatric Association*, 2024)
- Features of the CoCM:
  - Patient-centered: shared care plans between PCP/Lifestyle Medicine provider and behavioral health specialists with a focus on patient specific goals
  - Population-based: registry tracking of a population of patients for proactive, supportive care
  - Measurement-based treatment to target: typical goal of 50% improvement from baseline
  - Accountable care: payment often tied to clinical outcome rather than volume



COLLABORATIVE CARE

- Lifestyle Medicine in CoCM
  - Applies behavioral activation and motivational interviewing techniques to support changes in health behaviors
  - Aims to treat rising, co-occurring behavioral health conditions such as depression/anxiety
  - Regular panel review via weekly treatment team
- Billing
  - CPT codes specific to CoCM billed every 30 days based on minutes of care provided to the patient from the team of providers (codes 99492-94) (CMS.gov, 2024)

MEDICAL NUTRITION THERAPY

- Group or individual visits with a Registered Dietitian Nutritionist
- Focus on sustainable diet quality improvement
- Evidence-based dietary patterns may include DASH, Med Diet, WFPB
- Ideally schedule 1-3 monthly Medical Nutrition Therapy (MNT) visits prior to 4-6 month follow up with physician/APP
- CPT codes for MNT include 97802 (Initial) and 97803 (follow up)

DIETARY RECOMMENDATIONS IN CLINICAL PRACTICE GUIDELINES

ELSEVIER

Advances in Nutrition

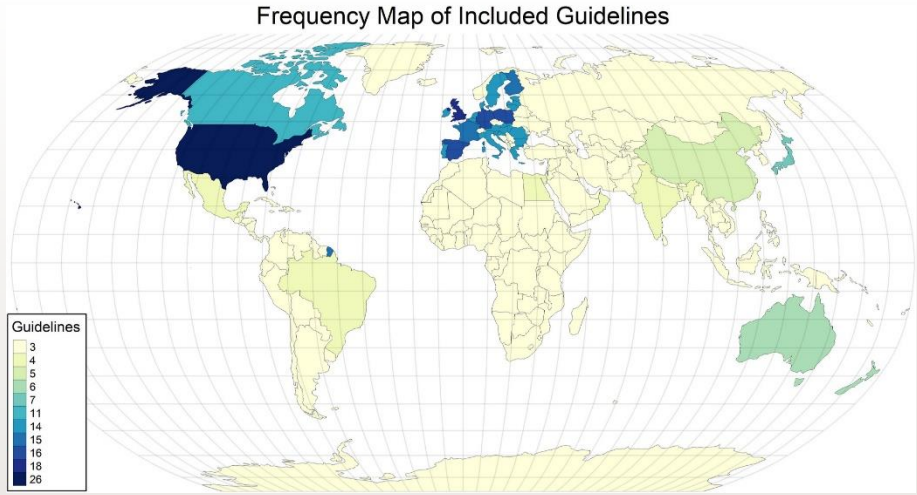
Available online 20 March 2023

In Press, Corrected Proof ⓘ What's this? ↗

Review

Commonalities among Dietary Recommendations from 2010 to 2021 Clinical Practice Guidelines: A Meta-Epidemiological Study from the American College of Lifestyle Medicine

Kelly C. Cara [1 2], David M. Goldman [3], Brooke K. Kollman [4], Stas S. Amato [5], Martin D. Tull [1], Micaela C. Karlsen [1 6]



REVIEW AND SYNTHESIS OF 78 CLINICAL PRACTICE GUIDELINES FOR COMMONALITIES

- **Included studies**
  - 78 clinical practice guidelines published between 2010 and 2021 that address nutrition for a variety of health conditions, as well as general health promotion, were included in this study.
    - 83% major medical professional societies.
    - 12% governments.
    - 5% large health stakeholder associations
- **Recommendations for:**
  - Overall dietary patterns
  - Major food groups such as increase in vegetables, fruits, legumes/pulses, whole grains, nuts/seeds; reduce red and processed meats and refined grains

HEALTH AND WELLNESS COACHING

- Definition-
  - "a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability…within the context of an interpersonal relationship with a coach."
  - Board-certified HWCs having training which includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories which are used to assist patients to develop intrinsic motivation…for improved health and well-being (Wolever et al., 2013)
  - These definitions apply to HWCs who are board-certified through the National Board of Health and Wellness Coaches (NBHWC https://nbhwc.org)

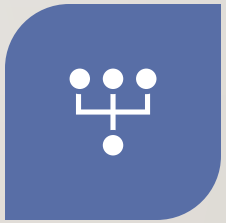
PAYMENT FOR HEALTH COACH SERVICES

(DABRH ET AL, 2024)

DIRECT BILL/SELF-PAY FOR SERVICES

WITHIN VALUE-BASED BUNDLED PAYMENTS

ALIGNED WITH CURRENT CPT CODES FOR CHRONIC CARE MANAGEMENT OR PREVENTIVE COUNSELING



NEGOTIATE USE OF CPT CODES SPECIFIC FOR HWC (CURRENTLY CATEGORY 3 CODES)

USE OF HSA/FSA ACCOUNTS

SETTING YOUR NORTH STAR FOR PROCESS AND OUTCOMES METRICS

CLINICAL OPERATIONS

HOW WILL YOU MEASURE SUCCESS?

Experience & Patient-reported

Financial

Clinical

Health behavior change

PATIENT EXPERIENCE AND REPORTED OUTCOMES

- Consider aligning with other patient experience surveys currently in use
- Align with pay-for-performance metrics
- Qualitative and quantitative metrics are both very useful
- Use of validated Patient Reported Outcomes Metrics (PROMS) is increasing; can be embedded in EHR

LEADING AND LAGGING METRICS

- Health behavior and QOL:
  - Diet quality
  - Exercise days and minutes
  - Sit-to-stand times
  - Sleep quality
  - Depression and anxiety scores
- Clinical biomarkers & anthropometrics
  - HbA1c
  - Lipid panel
  - LFTs
  - %weight loss
  - Waist circumference
  - Body composition

CHOOSE THE RIGHT MODEL FOR YOUR CLINIC

- Patient population
  - Generally healthy or high prevalence of chronic disease?
  - Geography – rural, urban; is technology a barrier?
  - Health-related social needs (SDOH)
- Success metrics
  - Some combination of clinical, health behavior, patient reported, and financial metrics
  - Pay for Performance
- Payment model
  - Government or commercial health plan?
  - ACO/risk contract/full capitation?

ESTABLISHING A CONTINUOUS PROCESS IMPROVEMENT MINDSET

PDSA cycles

Run charts

PATIENT CASE #1
TYPE 2 DIABETES REMISSION

- 55 y/o employed male with new diagnosis of T2DM HbA1c 14.4%
- Pharm D initiated treatment with metformin and insulin, CGM, referral to Lifestyle Medicine
- Team included Pharm D at PCP office + health coach and RD at Lifestyle Med office; had previously established care with social work therapist
- Patient's stated goal was T2DM remission, no diabetes medication
- Staggered monthly visits with team members over 18 months
- CGM TIR improved from 20-98%
- HbA1c change from 14.4->6.5->5.8% off all meds for almost a year

PATIENT CASE #2 HEALTHY AGING

- 71 y/o female with T2DM, HTN, HFrEF, single kidney and obesity.
- PCP Pharm D working with patient on GDMT for HF, started on mounjaro after intolerance to SGLT2 therapy, also on glimepiride and metformin
- Team included Pharm D and RN at PCP office + fitness specialist/health coach through Lifestyle Med clinic
- Patient's goal was to be more active with her grandchildren, decrease fall risk.
- Med mgmt. by Pharm D (dc glimepiride, titrate mounjaro)
- Lifestyle exercise intervention with guided strength exercise + progressive walking; monitor 5x STS pre/post
- Feels supported by team and noticing health improvement; most visits via telephone and video

PATIENT CASE #3
WEIGHT MANAGEMENT

- 28 y/o female with obesity and anxiety/depression
- PCP Pharm D anti-obesity medication management, started on zepbound
- Team included Pharm D at PCP office + RD and social work care manager at Lifestyle Med clinic
- Patient's stated goal was weight loss and avoidance of chronic diseases common in her family.
- Collaborative care stress management pathway + MNT with RD; AOM management by Pharm D
- Diet quality improvement, meeting exercise guidelines, improved GAD7/PHQ9

LIFESTYLE MEDICINE ACHIEVES THE QUINTUPLE AIM

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ADDITIONAL RESOURCES

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CERTIFICATION

AMERICAN BOARD OF LIFESTYLE MEDICINE

Demonstrate your knowledge related to implementing therapeutic lifestyle interventions in clinical practice:

Join over 5,000 physicians and clinicians globally who have become Diplomates of ABLM/ACLM

THANK YOU!

WWW.LINKEDIN.COM/IN/KRISTI-ARTZ-MD

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