BUSINESS OF LIFESTYLE MEDICINE

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Lifestyle Medicine in an Academic/Hospital Context

Abstract: *The effective integration of lifestyle medicine into allopathic practices is an evolving necessity driven by limited resources and escalating costs. Efforts in the Florida Hospital system graduate medical education (GME) department to meet this challenge may be instructive to others. Efforts include the hiring of an experienced dietician with a focus on a whole food plant based diet and a patient engagement tool to identify areas where patients are ready to make change. Billing is done using existing finance structure with the goal of decreasing the overall cost of providing care within a Clinically Integrated Network (CIN) context. Additionally, one GME clinician's experience in clinical lifestyle based intervention identifies and comments on several practical clinical factors for bringing effective behavior change to individual patients: patient readiness, a knowledgeable health care provider, adequate time, as well as the effectiveness of the intervention.*

Keywords: Diabetes, CAD, Stories, Lifestyle Change, Graduate Medical Education

At Florida Hospital (FH) in the Orlando area, we face the same challenge that many other health

systems face nationwide—to rein in unsustainable health care costs by increasing efficiency while simultaneously improving outcomes. Efforts have been made at FH to set up a Clinically Integrated Network (CIN) where physicians and the hospital are sharing potential risk and reward. Initial efforts are focused on ensuring the appropriate use of high-cost medical procedures, optimizing emergency department use, minimizing iatrogenic complications, and minimizing length of stay. These are viewed as “low hanging

approach, FH efforts have increased toward providing similar efficiency to the surrounding primary care practices it oversees. *This is where the application of lifestyle medicine has a chance to prove its potency.*

From a hospital system perspective, multiple projects that seek to improve the health of FH employees, particularly those with diabetes, are underway. The allopathic Family Medicine residency (FMR) is reviving the Wellspring Diabetes program as a shared medical appointment.¹ An experienced Registered

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fruit,” with the potential to provide the most cost savings in the shortest amount of time.

Eventually, outpatient chronic disease management will need to be addressed. In keeping with this quality of care

Dietician with a plant-based dietary focus, who is also experienced in coaching, has been hired into the practice. She is directly contacting patients with diabetes and involving them in the Diabetes Undone program.

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This program provides either a group experience or a one-on-one phone coaching of the online version. The focus is on low glycemic, plant-based, whole-food diets. This is being piloted for 1 year (2016+) with the main outcome being cost of care, as tracked by the health insurance provider.

Another project being piloted in the FMR practice is utilization of an iPad as a patient engagement tool. This tool identifies key lifestyle changes needed and ascertains the patients' level of readiness for change. Subsequently, the patient is given resources to choose from that are available through their health insurance provider, the hospital, medical practice, or a community delivered programs such as The Depression Recovery program.²

Our FMR practice sees patients of all ages for traditional primary care issues, including chronic disease management, as well as prenatal care and women's health. *All billing is done using the standard 99213, 99214, 99215 CPT codes within the limits placed on a graduate medical education (residents cannot bill for time, faculty need to see all Medicare level IV visits, etc).*

Based on my experiences, *an effective lifestyle office-based intervention requires several important factors: patient readiness, a knowledgeable health care provider, adequate time, and an effective intervention.* Each of these factors is reviewed in more detail below.

Patient Readiness

In "Reversing the Twin Cycles of Diabetes," Roy Taylor³ identifies patients drawn to lifestyle interventions as Health-Motivated people. These patients are internally motivated and willing to "do whatever it takes" in order to improve their health status. They tend to rely on word of mouth for referrals and are upfront about the type of medical intervention that is preferred. For these motivated individuals, often all that is necessary is to point them in the right direction and provide encouragement along the way.

Conversely, there are patients who are unaware that lifestyle modifications can

give better results than medication alone. To ascertain a patient's readiness, I present the lifestyle option and share the potential effectiveness of appropriate lifestyle change. I have learned that facts are often not as effective as stories when it comes to motivating change. Stories may be third person, first person, or even the framework of a randomized controlled trial told as a story. Giving the patient a relatable story can bring understanding and hope to their situation. This method, with a patient's vision of a better future, can be a potent stimulus for behavior change.

Finally, there are patients who know the facts, but lack the internal desire to change. I treat these patients with standard allopathic care. I utilize a coaching approach and offer them an occasional invitation to consider making changes. I am always mindful that a crisis of some kind is often a motivator for change and, should that happen, I want to be ready to help them make choices.

Knowledgeable Health Care Providers

More and more medical schools are strengthening their nutrition, exercise, and behavior change curricula. It is my observation that newly graduated medical students often have a bias toward nondrug therapies, but this preference weakens as their acute care skills mature. Guidelines used by providers often focus on drug or measure-based goals. Unfortunately, these measures do not actually address the causative pathophysiology. I provide articles supporting these therapies when I instruct a resident in lifestyle intervention. It is important to provide continuing education on the importance of lifestyle modifications, so that residents become more comfortable incorporating these into their everyday practice. I am grateful to have a medical librarian who can provide these for me easily and I have a growing selection filed in my computer for e-mailing to residents. I find many appreciate having the supporting documentation and begin

to move toward being health care providers who prescribe effective lifestyle treatments.

Time

Time is a precious commodity, and is often a limiting factor in medical practice. The shared medical appointments referenced above are an excellent way to bring time and emotional efficiency to the caregiving environment, while simultaneously harnessing the effectiveness of the group process in improving lifestyle choices.

We created standardized lifestyle medicine templates for our electronic medical record, which has helped increase documentation efficiency. I have also found utility in providing patient instructions that contain evidence-based lifestyle medicine treatment approaches.

I often like to provide patients with a variety of materials from multiple sources. Take, for example, a patient with heart disease who needs to reverse his atherosclerosis. I will spend much of the visit trying to build an understanding of the reversibility of the disease and the inability of lipid numbers to predict disease risk. Going back to the importance of providing patients with a story they can relate to, I often share the unexpected death of Tim Russert.⁴ He was a well-known newscaster who visited his cardiologist, had a normal exercise stress test, and perfect lipid numbers (attributed to statin use). Despite all of this, he still died of a myocardial infarction a week later. I also share Dean Ornish's work from the early 1990s. Finally, I recommend Caldwell Esselstyn's book, *Prevent and Reverse Heart Disease*.⁵ I instruct them that if they really want to reverse the disease, reading and implementing the measures in this book will be helpful. Should they desire, I offer to discuss it at their next visit.

Another way to be more efficient with time is to "split" the office visits. Do not try to get everything done at the first visit. Pace the visits—build rapport, hope and patient motivation first. Then, provide data and an effective treatment plan. Follow this with continued support,

repetition, and refining of lifestyle choices.

For example, if a patient comes in with the new diagnosis of type 2 diabetes, I spend the first visit focusing on stories of individuals or groups (scientific studies) that have successfully reversed the disease. I perform a short physical examination and order appropriate laboratory tests. These include those necessary to provide a full picture of peripheral and liver insulin resistance, as well as the level of pancreatic function (homeostatic model assessment [HOMA]-Beta, HOMA insulin resistance [IR]).⁶ I arrange for them to learn how to use their own glucometer and explain the plan for their next appointment. Depending on the initial hemoglobin A1c and presenting pathophysiology, insulin or metformin may also be started at this time.

The second visit then uses the measures of pancreatic function and insulin resistance to explain the pathophysiology of diabetes. Interventions are focused on appropriate lifestyle modifications and medication management if necessary. These 2 visits can easily be billed as 99214 or 99215, depending on the complexity of documentation. Thereafter, patients are seen in less intense visits at short intervals of every 1 or 2 weeks. This is done until they stabilize their new behaviors and understand their own disease process.

Each visit increases the patient's knowledge base about effective lifestyle choices. For example, when finding a high blood sugar sometime during the day, a patient may be encouraged to walk for 10 to 15 minutes and then take his or her blood sugar again. This provides patients the opportunity to discover for themselves how exercise lowers their blood sugar and insulin needs. I have never had an insurance company complain about excessive return visits. Early intensive lifestyle interventions bring obvious improvements and do much more to motivate long-term change.

Effective Interventions

Sometimes, physicians are not as forthcoming about the potential reversibility of heart disease or diabetes. This may be due to skepticism that patients will be able to do what is required. I have learned over time that I am not a good judge between those who will actually make the changes and those who will not. I have taken it as my moral obligation to let individuals know what can be done and then leave them to make the choice for themselves. I can offer good, better, and best (or most effective). Ultimately, the choice on how to proceed with their health is in the patient's hands.

It is my observation that for most individuals, early intensive lifestyle interventions seem to provide the best results. The intensive interventions do much more to motivate long-term change than "easing" into change by making a series of minor changes. Success breeds success. It is true that some may not be ready for dramatic changes and will require a gentler, encouraging approach. However, the lives of those who make the more dramatic changes are the most satisfying in my professional career.

As a clinician I have a responsibility to continually grow in my knowledge of effective lifestyle interventions. My biases must continually be challenged by the new information from scientific literature. As new information becomes available, I share it with my patients and together we find ways to apply the new knowledge effectively.

While there are a wide variety of approaches to providing medical care, there appears to be a growing openness to non-drug, lifestyle treatments for chronic disease. There is still a long way to go before effective, evidence-based, lifestyle treatments are recognized as the standard-of-care treatments for chronic disease. It will take time for the health system and general public to fully appreciate that for many chronic diseases, pharmaceuticals are often not

curative, but only temporizing interventions. It is likely that appropriate, outcome-based compensation for lifestyle medicine will be the driving force that actually changes provider behaviors.

I am thankful to be part of an energetic team passionate about growing these lifestyle modification-focused changes. The support of the hospital system administration has been key in moving these efforts forward. Together, we will continue to both create, and experience, the stories of effective lifestyle change. In the telling of these stories, we trust that our community and nation will progress to a healthier, happier, and more sustainable future.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. **AJLM**

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