

Group Visits for Diabetes: An Innovative Way to Overcome Barriers and Achieve Quality Care

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ABSTRACT: Group visits empower patients to better self-manage their diabetes. The visits provide a supportive setting where patients feel safe asking questions and expressing their concerns about their disease. Studies show that group visits result in improved metabolic control, health behaviors, quality of life, and knowledge of diabetes. Patients who will benefit most from group visits are those whose diabetes is not well controlled (hemoglobin A_{1c} level higher than 8%, an LDL-cholesterol level higher than 130 mg/dL, or blood pressure higher than 140/90 mm Hg). Group visits are usually 2 hours long; the first hour is conducted by the nurse or medical assistant, and the second hour is led by the physician.

Key words: diabetes, group visit

Diabetes is a demanding and difficult chronic disease. Life changes dramatically for a patient and his or her family once the diagnosis is made. Nutritional food choices, increased physical activity, multiple medications, visits to a physician, and blood tests are no longer optional. They now are a means of changing the length and quality of life. The patient has to rapidly become knowledgeable about nutritional content of any food he eats, different ways to be active, blood glucose testing, medication doses and side effects, and new words and abbreviations, such as A_{1c}, LDL, HDL, and triglycerides.

Multiple barriers exist to the patient's becoming knowledgeable

about all of these factors. The most formidable is health literacy. Even if the patient has a high school diploma or college degree, the complexity of diabetes makes it difficult to understand and self-manage the disease. Numeracy, or the ability to use numbers in daily life activities, is another significant barrier because diabetes is all about numbers.¹ A large survey revealed that 61% of adults in the United States were deficient in numeracy skills.² Additional barriers include costs of medication, depression, transportation, and lack of confidence in the ability to adequately control diabetes.³

With all of these barriers, it is not surprising that fewer than 50% of patients achieve American Diabetes Association (ADA) goals for hemoglobin A_{1c} (HbA_{1c}), low-density lipoprotein (LDL) cholesterol, and blood pressure (BP).⁴ These barriers for patients also create barriers for their health care providers. Additional barriers are created by a broken health care system. The rewards of the current system promote uncoordinated care with a disconnect between quality and cost.

Clinicians and office staff feel there is little they can do to overcome these barriers and resort to a practice of blaming patients by calling them "noncompliant." Noncompliant is a dysfunctional term that serves little purpose.⁵ Newer and more innovative ways to address these barriers are needed. A redesign of the reimbursement system and the primary

care office forms the eventual solution. But redesign is complex. It will take time and a change in physician attitudes and the political will of our elected officials.

A simpler solution that can be immediately implemented is group visits. The reimbursement for these visits is similar to that for an office visit and can be income-positive. In this article, I will review evidence that group visits are effective for diabetes, offer suggestions for planning and conducting these visits, provide patient and clinician views about group visits, and discuss lessons learned from my 10-year experience of conducting these visits.

DO GROUP VISITS MAKE A DIFFERENCE IN DIABETES?

Multiple studies demonstrate the value of group visits for diabetes and other health problems. Results indicate improved patient and clinician satisfaction^{6,7} along with better quality of care and reduced use of the emergency department and other specialist visits.^{8,9} Studies in the diabetes setting have demonstrated improved metabolic control; prevention of deterioration of diabetes care; and improved learning, problem-solving ability, and quality-of-life modifications.¹⁰⁻¹² A recent 4-year trial that included 815 non-insulin-treated patients younger than age 80 who were randomized to either group or individual care demonstrated significant changes. Patients who received care in group visits had lower HbA_{1c}, LDL-cholesterol, and BP levels and improved health behaviors, quality of life, and knowledge of diabetes.¹³

Surveys of 350 group visit patients indicate that group visits strengthen the trust between the physician and the patient; patients feel they know their physician and nurse better and have the power to

control "their diabetes." (Available at www.fafp.org/diabetes_mc.html.) Confidence is a powerful tool.

WHAT'S DIFFERENT ABOUT GROUP VISITS?

Group visits are different from group education classes or support groups. They provide similar support for self-management skills, but they also provide medical evaluation, medication adjustment, care coordination, and preventive services. Education classes offer information through lectures. Educators believe that knowledge changes behavior. Unfortunately, knowledge alone does not provide the fuel needed to change behavior.^{5,14} Patients' experiences with their diabetes mold their behavior. These experiences are based on culture, values, and the emotions that accompany diabetes.

Group visits are not lectures. The visits provide a setting where patients feel safe asking questions and expressing their concerns about their diabetes. Being able to express feelings in a supportive environment is therapeutic. Group visits are more effective if they are conducted by a clinician and nurse or medical assistant team who have an established relationship with the patient. The prior trusting relationship with the primary care clinical team makes it easier to express feelings, achieve goals, conduct more effective group visits, and achieve sustainable results.

Diabetes knowledge is still conveyed but not in the traditional way. Each group visit may have a focus, such as nutrition or exercise. But instead of starting with the usual lecture, the visit starts with asking the patients for their questions and concerns about the topic. Not all clinicians are comfortable with this method of teaching, and they may implement it differently. The key is to remember that knowledge alone does not change behavior.

You can learn a great deal about the effectiveness of the group visit by asking patients what was most helpful about the session. The answers reveal what behaviors may change. The knowledge gained as a result of a patient's questions or comments is what is remembered, and it has a sustained impact on behavior.

PREPARING FOR GROUP VISITS

Meet with all your office staff and let them know why you are doing group visits and share your excitement about the potential benefits. If you are excited, the staff will convey that excitement to your patients. If you are not, they will also convey any perceived concerns and doubts.

Explain that group visits are not support groups; there will be a charge, as with a regular visit, and the group visit will replace some of the routine diabetes visits. You will still perform yearly preventative visits and see patients for urgent problems in the examination room one-on-one. Be sure your office staff understands what a group visit is. Patients rely on staff to answer lingering questions and obtain more information. A well-informed, enthusiastic staff is key to successful recruiting.

The next issue is who to invite to the meeting. Patients whose diabetes is not well controlled will benefit most from group visits. Identify those who have an HbA_{1c} level higher than 8%, an LDL-cholesterol level higher than 130 mg/dL, and BP higher than 140/90 mm Hg. This group usually has multiple chronic problems and can be billed as a 99124, a moderate complexity visit with minimal physical examination (vital signs). Further details about coding, charging, and documenting are provided in the **Box**.

Your first group visit may be a little anxiety-provoking, so including your favorite patients may give you

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more confidence. After you start to feel more comfortable, invite the more challenging patients. Some patients may not want to come to group visits, and some patients who are not mentally stable should not be invited. An ideal number is 10 to 12 patients.

Having more than 12 in a group session may discourage interaction, and the session becomes a lecture. Patients should feel free to bring family members. Also invite a few patients with well-controlled diabetes to every visit, so they can offer advice to the

others. Mixing patients of different races, cultures, gender, and ages usually presents no problems; however, teenagers do better in a group of their peers.

Initial invitation is best done one-on-one by the clinician or nurse or

Coding, Charging for, and Documenting Group Visits for Diabetes

Group visits are for patients whose diabetes is not well controlled and who are not at goal. The ICD-9 codes for the diagnosis should reflect the level of control and complications. 250.00 is the code for type 2 diabetes well controlled with no complications and would not usually merit a 99214 E & M code. ICD-9 codes such as 250.62 indicate uncontrolled diabetes with complications. The fifth digit indicates the level of control: 0 is type 2 diabetes in control, 1 is type 1 in control, 2 is type 2 not controlled, and 3 is type 1 not controlled. The 4th digit is for complications. An example would be diabetic neuropathy (fourth digit of 6). A patient with type 2 diabetes not in control with renal disease would be an ICD-9 code of 250.42. Some CPT codes may be downgraded by the insurance company from a 99214 to a 99213 because the ICD-9 code did not reflect a diagnosis that required moderate complexity care.

DOCUMENTING AND CHARGING

Documentation is the key, and most patients qualify for a 99214 if they are established patients whose diabetes is not controlled, and they have at least 3 chronic problems. Patients with controlled diabetes are usually 99213.

99213 documentation. You will need the CC, 1 to 3 questions about their diabetes, 1 ROS question and low complexity care of diabetes, an assessment of control, and plan. Use a controlled diabetes ICD-9 code such as 250.00 or 250.01. An examination is not always needed as long as you document other aspects.

99214 documentation. Most of your patients in a group visit are the most difficult to control and have an HbA_{1c} higher than 7%, an LDL-cholesterol level higher than 100 mg/dL, or a systolic BP greater than 140 mm Hg. All numbers should be documented. Other items that require documentation include a chief complaint, 2 review of systems questions, and review of and 1 question about past medical history and/or social history. Be sure to document you are dealing with an *uncontrolled diabetic* patient not at target. Other items that may be documented include:

- Any and all items that are not at goal or yearly items that are overdue.
- Modifications in care, such as increased exercise, diet, eye examination, urine testing, etc.
- Increasing a medication dosage or starting a new medication, or increased adherence to the medication regimen.
- Discussion of side effects of medications or changes made because of medications.

Be sure to document any of the above that indicate the patient is not controlled, so the decision making is considered moderate.

A moderate complexity visit that has 3 chronic problems does not require a physical examination other than measurement of vital signs. Medicare code requires a face-to-face visit, not a one-on-one visit or visit in the examination room.

More information about group visits can be found online at http://www.fafp.org/diabetes_mc.html#P. The first article listed is a review of group visits in diabetes, and the second is the training manual I use to teach group visits.

medical assistant. After the clinician and staff become comfortable with group visits, other strategies, such as letters, posters, phone calls, and e-mails, can be used for invitations.

Set the date far in advance to avoid conflicts. Timing of the group visit can vary depending on availability of space and staff and clinician schedules. Group visit frequency varies from 1 a month to 1 every 3 to 6 months.

A typical session lasts about 2 hours. In our practice, the nurse or medical assistant conducts the first hour of the meeting, and the clinician conducts the second.

The day before the group visit, the lead staff person meets with the clinician to review the list of patients who have confirmed attendance. All necessary prescriptions, laboratory tests, and immunizations are listed by the staff person, and the clinician gives the go-ahead to have all these functions performed before he or she enters the room for the second hour. The staff person performs much of the documentation for the visit. The clinician reviews what the staff person has done, edits it, and adds key information.

We ask the same group to stay together for 3 group visits 6 weeks apart. The first visit focuses on signing all forms, including a HIPAA agreement; an explanation of the group visit; and a review of recent laboratory data and adherence to other quality criteria, such as eye and foot examinations and immunizations. The second visit focuses on physical activity and nutrition, and the third visit on medications and complications.

This is how we do group visits, but it is not the only way. Some clinicians ask all their patients with diabetes to come to group visits for all their routine diabetes care, and others use different strategies. Do the group visits your way, and measure

success by how many patients see improvement in their HbA_{1c}, LDL-cholesterol, and BP levels.

ROLES OF NURSE OR MEDICAL ASSISTANT DURING THE GROUP VISIT

During the first hour of the group visit, the nurse or the medical assistant obtains vital signs, provides patients with a report of their recent laboratory values, gives them an interim history questionnaire, and sends them to the group visit room, where a healthy snack may be provided. Other duties include obtaining signatures for privacy agreements, explaining the need for payment or co-pay, and confirming necessary prescription refills.

In addition, the nurse or medical assistant conducts a 30- to 40-minute interactive educational session. The sessions have themes, such as physical activity, nutrition, medications, and prevention of complications. The session begins with a brief introduction of the topic, and patients are asked how the topic relates to them. Their questions will generate additional need for information and clarification about the topic. Some of the questions will be referred to the physician for the second hour. Other questions may be referred to the “parking lot,” a place where non-diabetes health-related questions are listed. If time permits, these may be addressed. Placing a question in the parking lot permits continued focus on diabetes without discounting the patient’s question.

Other activities for the staff person during the first hour might be a discussion of how to read food labels and restaurant eating, demonstration of chair exercises, and sharing fears and concerns. If patients are given the chance, their questions will fill all the allotted time. Occasionally, a guest speaker, such as a nutritionist or exercise instructor, may be invited

for 20 to 30 minutes of the visit. Medical assistants and nurses who are involved in group visits gain more confidence in diabetes care and self-management and are more satisfied with their jobs; in addition, patients see them as “critical members of the health care team.”¹⁵

ROLE OF THE CLINICIAN DURING THE GROUP VISIT

The clinician enters the group visit in the second hour. He or she welcomes the group, reviews the parking lot list, and asks the assistant if there are any questions or issues that arose during the first hour that should be addressed. Next the clinician asks the patients what they learned during the past hour and facilitates a discussion generated by the comments and questions.

The clinician’s style in a group visit is more facilitative than in the usual office visit. When someone asks a question, the clinician first asks other patients how they might answer the question. The clinician may eventually need to answer the question or just affirm the answer given by another patient. No matter what answer or comment patients provide, a thank you is always in order. Diplomatic rephrasing of answers encourages more questions, decreases chances of demeaning the patient, and creates an atmosphere of trust and caring.

The clinician also asks patients to review their “report cards” (sheets of paper with goals, dates, and individual values). Patients are asked what the importance is of reaching hemoglobin A_{1c}, LDL-cholesterol, and BP goals and completing a yearly activity such as an eye examination. Individual patients are then asked about their goal achievement. If numbers are not at goal, the patient is asked whether he would like to achieve goal and if so what option he would choose. This makes the pa-

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tient, not the physician, accountable for the results.

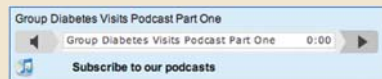
The group can also be asked whether they faced a similar situation and how they handled it. Nutrition and physical activity are always part of the solution, but a change in medication may be needed. An example may be a gradual rise in hemoglobin A_{1c} after one medication has been used for a prolonged period. Other patients are asked if they have had a similar experience. If they have, they are asked to share how they addressed this issue. This usually opens a discussion about additional medications and increased attention to nutrition and physical activity. A prescription for additional medication can be written at that time. Questions and answers about that medication may follow. The physician asks the nurse or medical assistant to write the prescription that will be signed at the end of the group visit. Involving the other patients in the discussion and asking for their suggestions creates a positive atmosphere for the group visits.

Patients will bring up multiple issues that create opportunities for fruitful discussions. Questions may arise about sensitive issues, such as erectile dysfunction and emotional problems. Most of the time the group will provide excellent suggestions if given the opportunity. An example may be a patient who says he “feels he is going to die.” Handling this in the examination room one-on-one is different from in the group setting. Asking other patients if they have or had similar feelings validates the feeling. Solutions for addressing the feeling can be shared. This forms the background for the physician to address the fear or myth that created the feeling.

An example arose during a discussion of foot examinations. One patient began to cry and said she was afraid the numbness in her feet

Online Exclusive Feature

In his podcast, “Group Visits for Diabetes: How to Help Patients Better Control Their Disease,” Dr Shahady elaborates on how to make group visits work in your practice and offers additional real-life examples from his own experience.



Listen at <http://www.consultantlive.com/diabetes/content/article/10162/1542902>.

would lead to her death because her father had a similar problem, required an amputation, and died 6 months later. The group reassured her that it would not happen if she did a better job of “getting her numbers under control.” She then asked the physician how she could do that. The group again told her about nutrition, physical activity, and medications. She did require a medication adjustment. In the past, she had great difficulty in controlling her numbers, but after this group visit, she made a dramatic turnaround in her care and now has all of her numbers at goal.

Our job is to create an atmosphere of trust and a feeling that “you can do it.” Most patients do not believe they can control their diabetes, and our job is to empower them to take control. ■

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