Group Visits Manual for Training

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Ed Shahady MD
Clinical Professor of Family Medicine
Medical Director
Diabetes Master Clinician Program

Patient education traditionally has been based on providing information (knowledge) with the belief that knowledge alone changes behavior. Unfortunately knowledge alone does not provide the needed fuel to change behavior. Patient's experiences with their illness molds their behavior. These experiences are based on the emotion and feelings that accompany their chronic disease. Combining knowledge with the patient's own experiences can change behavior. Group visits are not lectures to provide information. The visits provide a setting where patients feel safe asking questions and expressing their concerns about their chronic disease. These questions and concerns stimulate the sharing of information that is specific to the patients concerns and has a greater chance of changing behavior.

Being able to express feelings in a supportive environment is therapeutic. Group visits have the advantage of being conducted by a clinician and nurse/MA team that have an established a relationship with the patient. Once the practice team learns the skills of facilitating group visits their prior trusting relationship makes it easier to conduct a group visit.

Chronic disease knowledge is still conveyed but not in the traditional way. Each group visit may have a focus like nutrition or physical activity 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 and nurses are comfortable with this method of teaching and different teachers implement it differently. Teachers can learn a lot about the effectiveness of their session by asking patients what was most helpful about the session. They will usually find that the knowledge that was shared after a patient's specific question or comment is what is most remembered.

Group visits and discussing emotions.

Negative emotions play a significant role in each patient's perception of chronic disease (2, 3). Clinicians have been trained to be logical and rationale. They are not usually trained to be comfortable discussing patient's emotions. Negative emotions are not pleasant for the untrained ear. Clinicians feel they have to fix or change the feeling so they are reluctant to encourage expression of something they can not change or fix. More experienced clinicians approach negative emotion by providing a safe non judgmental environment for the patient to express negative feelings. These clinicians facilitate group member's use of their negative emotions to discover barriers to achieving chronic disease goals.

Group visits are ideal settings for dealing with negative emotions. Patients are anxious to express their emotions in the presence of other patients with similar problems. They benefit from hearing the stories of other diabetics by learning they are not the only ones who are experiencing emotional struggles. They also benefit by reflecting on what they have learned about themselves and others. Solutions generated by patients and their peers have a greater chances of success because they are their solutions to their problems not theoretical problems.. They own the solution just like they own the problem. The clinician's role is not to create solutions but to listen, facilitate discussion and encourage reflection. Clinicians provide information not solutions. It is challenging for many clinicians to accept this new role and it will take time to for clinicians to change their behaviors.

Patient evaluation of group visits

About 350 patients from the Diabetes Master Clinician Program completed questionnaires evaluated the effectiveness of group visits. Patients gave an average rating of 4.7 on a scale of 1 to 5 with 5 being the highest. The advantages of group visits according to many patients is the opportunity to share information with other diabetics and also have more time with their family physician than a hurried 15 minute visit.

The following comments were made by patients evaluating group visits.

- I like the group visits because you learn so much from other people with diabetes
- I really appreciated the open air environment for discussion and the education on the disease
- Relaxed atmosphere. I got to know the people present in the group.
- Learn from others some of the things you can do.
- The fellowship of the group education is very helpful
- I like that personal visit with my Dr.
- In the group I liked the communication with the members. The group interaction helps me to see myself in a different perspective as for my diabetes.
- I liked being able to discuss the types of food and drinks that are good for diabetics and when to check your sugar
- Liked group discussions, good materials, helpful information
- I won't feel alone with this condition.
- The group idea is absolutely great. It was very informative.
- Group participation was very informative. I am still trying to make the necessary adjustments for my diabetic situation and appreciate the group participation.
- I like it when everybody talks about their own diabetes

Preparing your office staff for group visits

1. Have a meeting with everyone in your office to explain that these are visits not support groups that are optional
2. Tell them the group visit will replace some of the routine diabetes visits that the patient makes.
3. Not every patient wants to come and some only come to one visit. 30% never opt to come and of those that come about 70% like them and will come back.
4. Tell staff why they are helpful for chronic diseases and help you better care for chronic disease
5. The staff needs to talk it up and encourage patients.

Whom to invite.

The group visit will have the most benefit for the patients who are not well controlled. Try to also involve a few patients who are well controlled so they can offer advice to the not well controlled patients. About 10 patients is a good number for a group visit. More than 10 to 12 individuals in a group session promotes the chance of less interaction and the session being more like a lecture. Patients are free to bring family members.

Date and time of the visit

Set date far enough in advance to avoid conflicts. Time of the visit can vary depending on the availability of space, staff and clinician schedules.

Frequency of Meetings – Usually range from every month to every three months with the same group of patients.

Length of Meeting – Inform the patients the entire session will take about 2.5 hours. The initial 15 to 30 minutes is used for vital signs and completing questionnaires. The first hour is with the staff person and the second is with both the staff person and the clinician. After the meeting an additional 10 to 15 minutes are needed to complete the paper work.

Invitations:

The most effective way to invite patients is through their own clinician. The clinician lets the patient know that they are using a new method to help patients achieve their goals. Let the patient know that the two of you have been working for some time on their diabetes and they are still not reaching goal. This new method may help. They can choose not to come but if you personally make the invite most will come. You can also use a combination of letters, phone calls, posters and invitations at the time of their regular diabetes visits. Let them know that the group visit will replace their routine diabetes visit but not their yearly physical and review of other aspects of their health.

SAMPLE INVITATION LETTER

Dear Patient

This new program is call group visits. We think this is a good way to help you better care for your diabetes.

These group visits will replace some of your routine visits for your diabetes. You will be charged for these visits like a regular visit to the Doctor.

Our first meeting will be held on (date) at (time) in (place). The visit will last 2.5 hours and go from x to y time. This gives you a lot of time with your Doctor and nurse. You will learn a lot about how to better care for your diabetes and prevent problems like blindness, kidney failure, stroke and heart attack.

Please call to confirm that you will be able to attend. Remember this is an appointment with the Doctor and Dr._____has set all this time aside for you.

If you have any questions, please call_____, coordinator, at _____.

Sincerely,

Other items

1. Prepare a handout that you have written explaining why you want to start these group visits
2. Put up a poster in the office informing patients
3. A week before the visit clinician and clinician associate sit down to plan agenda for the visit

Day before the visit (nurse/MA)

1. Phone call reminders-have ½ patients scheduled 15 mins earlier than others to facilitate more timely obtaining vital sign and questionnaire.
2. Pull charts-staff person to help
3. Review charts to be sure all labs etc entered
4. Print out patient report card and chart flow sheet and put both in the chart. If you see anything really out of line mention it to the clinician. Have an extra copy of the patient record flow sheet to give to the clinician before the groups visit starts.
5. Review the agenda that will be used for visit
6. Meet with the clinician for a few minutes the day before the visit to discuss agenda and any important items that you note in the charts you reviewed. Prepare a list of lab tests, immunizations and medication refills. Obtain clinician agreement on all of these items so he/she can sign the med refills and all other orders.

Day of the visit (staff)

1. Review charts to be sure all info is included

2. Look at room make sure it is set up correctly. Set up tables/chairs according to group size and discussion. Circle or horseshoe facilitates group discussion.
3. Make sure all teaching materials in the room.
4. First visit make sure all the permission slips are there
5. Prepare coffee/refreshments 20/30 minutes before meeting.
6. On flip Chart or Blackboard: Write information pertaining to meeting, future meeting dates, and names of staff members, etc.
7. Pay special attention to acoustics, signage, visibility, and climate for needs of disabled and elderly patients
8. Make notes about each session

The Visit

ROLES

Clinician

The clinician role is that of facilitator and leader of the discussion not the one with all the answers. Clinician encourages the patients to add to the discussion by describing their own experiences and ways of solving problems. Make sure patient knows their goals and takes the report card home. The clinician uses the meeting time to efficiently educate patients, briefly review problems, answer questions, make recommendations for treatments, order tests and renew prescriptions. Do not lecture

Nurse(s) or Medical Assistant(s)

The first hour of the meeting on patient education will be conducted by the nurse /MA. The nurse(s) or medical assistant(s) take vital signs provides triage and management of patient needs before and during the meeting. Establishing an environment that encourages open discussion and participation by all members is an important role. There is no formal curriculum but topics for discussion. Start with a short 15 to 20 minute discussion of the topic. Then ask patients questions about their understanding of the topic. Your questions will generate additional need for information and clarification about the topic. Topics discussion may include the following

1. Nutrition
2. Physical Activity
3. Reasons for Diabetes Quality Goals and review of diabetes report cards.
4. Foot Care
5. Hypertension
6. Lipids

General pointers

1. Explain the purpose of group visit emphasizing that the GROUP VISIT is an alternative to the way in which a member receives care that works.
2. Some will not like them and that is OK. Can request not to come in the future.

3. Clear definition of expectations of participants
4. A sharing of group norms and setting guidelines. Do not have to share any information if you do not want to do so.
5. Emphasize the value of helping each other care for diabetes. One patient may have suggestions that can help another diabetic
6. Discussion of roles of physician and nurse
7. Inform that this is like a regular office visits and there is a charge or co-pay

First hour

1. Staff person obtains B/P, Wt, on each patient and gives them their report card and questionnaire and sends them to the group visit room. May have a healthy snack in the room. May need help from another nurse/MA for the first part 30 mins for check in.
2. For first time visit- sign permission slip and HIPPA form.
3. See if meds need refilled and have prescriptions written for clinician to sign.
4. Make sure patients have completed questionnaires. May discover literacy problems if patients have difficulty completing questionnaires.
5. 30 to 40 minutes interactive educational session- -do not lecture more than 8 minutes at a time without asking for feedback and seeing what they are learning. Make sure they have their homework books and are using them at every visit
6. Stay on track with diabetes-**parking lot sheet** available for other issues. Some good questions about other health issues like mammograms and colon cancer screening may come up. Remind patient of purpose of session and place question on parking lot list for potential discussion and move on. Placing the question on the parking lot sheet permits continued focus on diabetes without discounting the patient's question. There may be time later for the question when it does not disrupt the focus on diabetes.
7. May want to show all of them how to examine their feet at least once for each group
8. Remember you are the note taker for not only your session but the session the next session with the clinician. It is a good idea to have a template for group visits for your paper or electronic record. Discuss with the clinician the length and content of the notes. A sample documentation sheet is included in the document.

Second hour

1. Clinician comes in and welcomes the group--looks at parking lot issues and decides when and what to address being sure to thank the patient for the questions.. If the questions are about other health related issues that are not acute remind patient they still have their yearly evaluation where these items are handled. May need to see a patient after the visit or schedule another visit. Remember primary goal of group visit is diabetes related.
2. Clinician asks if there are any questions about the discussion with the MA or nurse-nurse/MA may have a comment or question- may be a concern raised by a patient-if note ask them a question about what was discussed- e.g. importance of exercise or A1C. Your role is to reinforce what was said not give a lecture.

3. A nice way to get the group talking is to ask the participants to share something about their diabetes. Clinician strives to be a facilitator and not the answer to all questions. When someone asks you a question find out what the others think the answer might be before giving your opinion.
4. Create and atmosphere of trust and a feeling that "you can do it". Most patients don't feel they can control their diabetes and our job is to help them feel empowered to take control. You are the coach and they are the players

Sample consent form to attend a group visit

Signing this form indicates you have voluntarily consented to participate in a "Diabetes Group Medical Visit". During this visit you and other patients may share personal health information only if you agree to do so. This information will be used to help teach you and other members of the group about various health topics that help improve diabetes care.

The diabetes group visit will consist of discussions of the importance of exercise, diet and medications in the care of diabetes. The visit also may include your being examined in the group for blood pressure reading, and a foot exam.

The group visit is like a regular office visit and you will be charged for the visit.

The group visit may replace some of your routine visits for diabetes but you will still have some privately scheduled appointments with me.

There may be publications written describing the group visits and their ability to improve diabetes care but your name will not be mentioned.

You of course have the option not come to the group visits. If you have questions about this process please discuss with me.

Name of Physician/provider

If after reading the above and you wish to attend group visits please print and sign your name. Your signature indicates that you have read the above, understand what it says and agree to attend group visits.

Name (Printed) _____

Signature_____Date _____

Tips for survival

Make sure everyone in the office knows about the Group Visit schedule
Place sign on door
Name tags
Agenda posted with approximate time frames for each section
Charts ready
Sign-In sheet
Refreshments
Consider room arrangement
Handouts
Comfortable temperature
Greet everyone!
Pens, markers, flip chart, pencils, Kleenex, etc.
Start on time – end on time

AFTER THE MEETING

_____ Complete progress notes
_____ Take down meeting signs
_____ "Show or no show" attendance noted in chart
_____ Book appointments after meeting
_____ Review who needs labs or other tests and make reminder list.
_____ Book patients for next meeting (order charts, send reminders)
_____ Return completed charts
_____ Work on coordinating upcoming meeting topics and contacting speakers
_____ Try to plan meeting dates several months in advance. Book rooms, and consider early arrivals and late-ending meetings when planning times
_____ Maintain file of completed attendance rosters and speaker handouts, etc.

Documentation

Diabetes Group Visit Progress Note

Patient to complete this sheet

Name:_____ **Date**_____

1. How many times daily do you check your blood sugar? _____ What is the usual value?_____
2. What is your current activity level?
   ____ Not very Activity ___Moderate (2-4 times weekly) ___ Vigorous (5 or more times weekly)

3. If you are not very active what is the reason?
   ____ Arthritis ____Afraid I will hurt myself _____Do not like to exercise

4. How many times a week do you eat any of the following foods? (ham, pork, hamburgers, hot dogs, fried fish. fried chicken or other fried foods)
   _____ One time a week ____Three times a week ____Five or more times a week

5. How many times a week do you eat any of the following foods? (lean ground beef, chicken, fish or turkey that is broiled or baked)
   _____ One time a week ____Three times a week ____Five or more times a week

6. How many times a week do you eat vegetables? (for example green beans, cauliflower, other beans, broccoli, peas)
   _____ One time a week ____Three times a week ____Five or more times a week

7. How many times a week do you eat fruit? (for example bananas, apples, berries, peaches)
   _____ One time a week ____Three times a week ____Five or more times a week

8. Tobacco Use: _____Current _____Quit _____Never

9. When was the last time you saw an eye doctor (Ophthalmologist or Optometrist)? _____

10. Please list any questions you would like addressed today

Staff to complete

Date:_____Wt: _____ Ht._____ Pulse:_____BP:_____

Medications Name Dose Number of Refills
(write scripts for clinician to sign)

Lab tests ordered

Immunizations given today

Brief notes about todays visit to include discussion with the clinician-clinician to co-sign

MA/Nurse signature_____Clinician signature _____

Clinician to complete

Comments

Assessment: _____

ICD 10 codes

E11 Type 2 diabetes mellitus

E11.2 Type 2 diabetes mellitus with kidney complications
E11.21 Type 2 diabetes mellitus with diabetic nephropathy
E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.3 Type 2 diabetes mellitus with ophthalmic complications
E11.31 Type 2 diabetes mellitus with unspecified diabetic retinopathy
E11.36 Type 2 diabetes mellitus with diabetic cataract
E11.4 Type 2 diabetes mellitus with neurological complications
E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.5 Type 2 diabetes mellitus with circulatory complications
E11.61 Type 2 diabetes mellitus with diabetic arthropathy
E11.64 Type 2 diabetes mellitus with hypoglycemia
E11.8 Type 2 diabetes mellitus with unspecified complications
E11.9 Type 2 diabetes mellitus without complications

Plan:
□ Discussed targets and management of HbA1c.
□ Discussed targets and management of lipids
□ Discussed targets and management of Blood pressure
□ Recommended ASA daily.
□ Discussed and encouraged activity.
□ Discussed and encouraged diet.
□ Reviewed Medication options; risks, benefits and side effects
□ Reviewed Foot Care
□ Spent more than 50 percent of visit counseling re: therapy options and management of diabetes.

Charge Code □ 99213 □ 99214 □ 99215

Signed:_____
Date:_____

Charging and coding

Diabetes Codes
Without coding the symptom or the diagnosis to show why the treatment was necessary, third parties may not reimburse you for the service. So link the CPT with the ICD-10. For example diabetes

Documentation is the key and most established patients qualify for a 99214 if they are properly documented.

99213 documentation

A 99213 requires a CC, 1 to 3 questions about their diabetes (frequency and values of self monitored blood sugars, vision, feet, exercise, diet etc), 1 ROS question, and low complexity care of diabetes, an assessment of **controlled diabetes**, and a plan that deals with the diabetes. (See CPT summary) Use a controlled diabetes ICD 9 code like 250.00 for type 2 controlled or 250.01 for type 1 controlled. The fifth digit indicates control and the fourth digit indicates complications. (See summary end of page 2) If they are controlled but the complication like renal disease is not controlled you should be able to code a 99214. You do not need to do any exam but you need to ask some questions directly to the patient that allow you to document the above items like the CC, usual diabetes questions, etc.

99214 documentation

Most of your patients in a group visit should be the ones that are the most difficult to control and have HBA1C's of >6.5, LDL >100, or B/P greater than 130/80. The ICD 9 fifth digit would be 2 or 3 if one of these values is not controlled. Remember to document all of these values. The fourth digit indicates complications. An example would be severe diabetic neuropathy (fourth digit of 6) in a type 2 in control would be 250.60. If the patient is not controlled (HBA1C is >6.5) the ICD 9 code would be 250.62.

A 99214 requires four questions related to their diabetes, 2 ROS questions, and one question about either past med history and or social history. Include in the documentation evidence that the patient is an **uncontrolled diabetic** not at target and how you will be attempting to bring the patient into control. Documenting the attempt to bring the patient into control satisfies the **moderate complexity** requirement. (See CPT summary) Other documentation that indicates uncontrolled and moderate complexity includes some of the following:

1. Numbers that are out of control i.e. A1C, LDL B/P
2. Patient not obtaining eye consult or other consults
3. Complications are present like retinopathy (dilated eye exam positive), neuropathy (monofilament or vibratory sense decreased), nephropathy (creatinine increased), angina, TIA, stroke, chest pain, MI, hypertension
4. Modifications in their care like more exercise, diet, eye exam, urine testing etc.

5. Increasing a medication dosage or starting a new med, or suggestions for increased adherence to medications
6. Discussion of side effects of medications like statins, review of drug interactions (note where you found the information i.e. Epocrates)
7. Advise and discussion of how to adhere to lifestyle changes

For group visits you do not need to do any exam other than vital signs to code a 99213 or 99214 for established patients as long as you have satisfied the history and level of complexity requirements as indicated above.

Be sure your ICD 9 code reflects the level of control, type of diabetes and any complications.

Summary of choosing the right ICD- 10 code in diabetes

ICD 10 codes

E11 Type 2 diabetes mellitus

E11.2 Type 2 diabetes mellitus with kidney complications
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E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.3 Type 2 diabetes mellitus with ophthalmic complications
E11.31 Type 2 diabetes mellitus with unspecified diabetic retinopathy
E11.36 Type 2 diabetes mellitus with diabetic cataract
E11.4 Type 2 diabetes mellitus with neurological complications
E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.5 Type 2 diabetes mellitus with circulatory complications
E11.61 Type 2 diabetes mellitus with diabetic arthropathy
E11.64 Type 2 diabetes mellitus with hypoglycemia
E11.8 Type 2 diabetes mellitus with unspecified complications
E11.9 Type 2 diabetes mellitus without complications

CPT code summary

Documentation requirements for established patient visits at group visits

	History: CC	**History: HPI**	**History: ROS**	**History: PFSH**	**Medical decision making**
99213	Required	1-3 elements	Pertinent	Not required	Low complexity
99214	Required	4+ elements (or 3+ chronic diseases)	2-9 systems	1 element	Moderate complexity

Group visit Articles

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