

Diabetic Group Visits How & Why to get Started

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Advantage Health Physician Network

- Physician Hospital Organization
- Kent/Ottawa Counties
 - 117 Employed Physicians
 - 49 Affiliated Independent Physicians
 - 47 Specialists
- 22 sites Designated by BCBSM for PCMH

Northwest Family Medicine Total Diabetics - 631

**Reyelts,
Fredric A**
130 Patients
21%

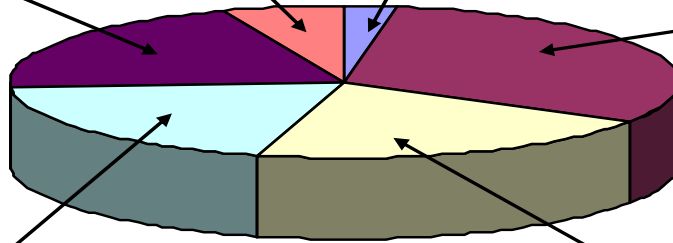
Rolinski, Jill
37 Patients
6%

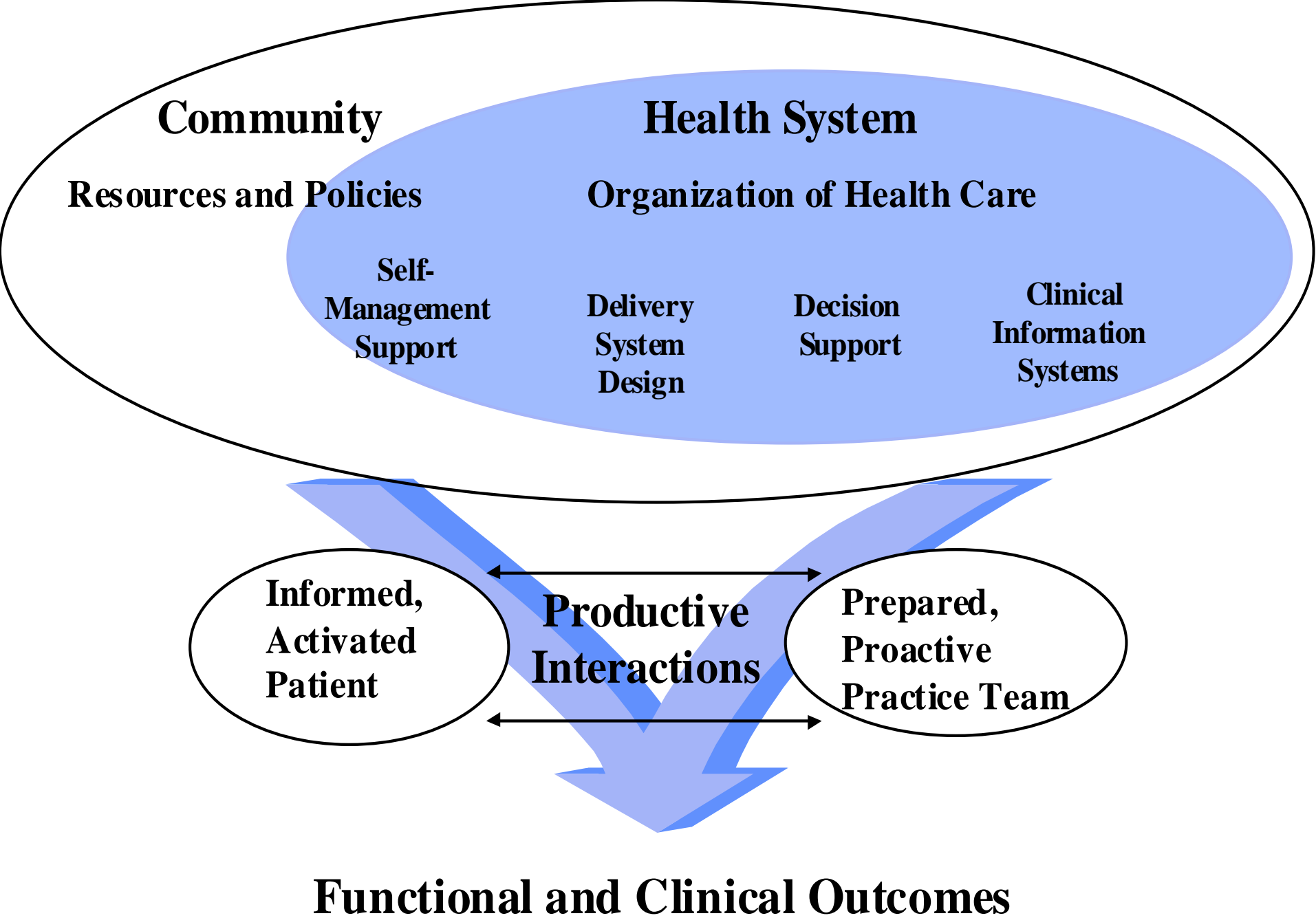
Cesario, Mario
15 Patients
2%

Elsen, Paul C
198 Patients
32%

Nguyen, An G
123 Patients
19%

Kliphuis, Sally L
128 Patients
20%





Delivery System Design

- Pro-active Planned Care Visits arranged for patients
- Roles and tasks of office members are designed to ensure coordinated care
 - Pre-visit work
 - Post-visit follow-up care
- Group Diabetes Visits initiated 2007

Health System & Community Linkages

- Saint Mary's Diabetes & Endocrinology Center
 - Certified Diabetes Educators
 - Registered Dieticians
- Advent Physical Therapy – Physical Therapists/exercise physiologists
- Pharmacists – Saint Mary's and community
- Podiatry
- Ophthalmology/Optomety

Why Group Visit?

- Improved access for patients
- Increased productivity
- Improved utilization of office and ancillary team
- Interactive
- Efficient

Team

Office:

- Physician
- Patient Coordinator
- Medical Assistant
- RN

Ancillary

- Registered Dietician
- RN CDE
- PharmD
- Exercise Physiologist

Concept

- 4 provider visits per year
 - 3 group sessions
 - 1 comprehensive individual exam

Group Session

- 6-12 patients per session
- Length – 2 hours
- Morning or afternoon sessions – NO evenings

Patient Recruitment

- **Initially** – the next 12 diabetic patients on the schedule received a phone call invitation from physician
- **Currently** – patients are invited at a visit by the physician to participate

Pre-visit

- 2 weeks prior to group visit – chart assessment
 - Identify diabetic labs and health maintenance tests the patient is due for
 - Patient mailing:
 - **Letter from physician**
 - **Lab orders**
 - **Diabetic form patient completes prior to visit**
 - Review of systems
 - Reason for visit
 - PHQ-2
 - Current medications
 - BP/Blood sugar monitoring forms

Visit Curriculum

- Introduction to group visit
- Diabetes pathophysiology
- Common Vascular problems
- Renal implications
- Hypertension
- Diet
- Medication
- Exercise
- Pharmacy

Visit

RN/MA

- Vital signs completed
- A1c drawn if patient did not complete prior to visit
- Review completed diabetic form with patient

Visit - Provider

- 20-30 minute introduction on one of the following topics:
 - Introduction to group visit
 - Diabetes pathophysiology
 - Common vascular problems
 - Renal implications
 - Hypertension
 - Immunizations

Presentation by Speaker

90 Minutes

Rotate every 3 months

- RN CDE
- Dietician
- Pharmacists
- Exercise Physiologist

Future - Podiatrist and Ophthalmologist

Face to Face

- Each patient received a 5-10 minute face-to-face visit with physician
 - Focused on diabetes related concern
 - Limited physical exam
- MA scribes visit
- RN – completes diabetes treatment plan
 - E-Rx refills
 - Reviews treatment plan
 - Assists patient in setting Self-management goals

Name: _____

DOB: _____

Date: _____

Diabetes Type 1 / 2

With neuropathy/nophropathy/retinopathy

A.C. Goal <7

Recommended Blood Sugar Testing Frequency

x daily

Goal: At least 1/2 of readings

Fasting 80-140 Other _____

2 hrs after meal 120-180 Other _____

Medications:

Blood Pressure:

Today's Blood Pressure _____ Goal < 130/80

Medications:

Cholesterol Total _____
LDL _____ Goal <100

Medications:

Lifestyle Goals

Exercise 30 Minutes daily at least 3-4x per week

Other

Tobacco: _____

Alcohol: _____

Diet: _____

Weight goal by next visit: _____

Overall: _____

LABS

A.C.

Cholesterol

Metabolic Profile

Other: _____

Referral

Ophthalmology last visit: _____

Other: _____

Health Maintenance Due

Mammogram Pap PSA

Bone Density Colonoscopy

Next Visit: _____

Other Medications:

Health System & Community Linkages

- Saint Mary's Diabetes & Endocrinology Center
 - Certified Diabetes Educators
 - Registered Dieticians
- Rehab Pros – Physical therapists/exercise physiologists
- Pharmacists – Saint Mary's & community
- Podiatry
- Ophthalmology/Optomety

Post Visit

- Patient leaves group visit with a scheduled group visit appointment in 3 months or a 1:1 comprehensive visit
- RN – makes follow-up phone call in 1-2 weeks to discuss self management goals or any changes made to treatment plan

Barriers

- Office staff education and buy-in of proposed process
- Time factor - additional pre-work to the planned care visit
- Required development of patient assessment tools
- The registry required enhancement – customized to track depression screening & Self-management and trend results

Staff Perspective

- “This is a multi-disciplinary approach to diabetes care that provides an “at a glance” worksheet for the provider and a written outline for the patient”