Group Visit Starter Kit

Group Health Cooperative
February 2001

Used with permission. Improving Chronic Illness Care (ICIC) is a national program supported by The Robert Wood Johnson foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation

05/01/07

Group Visits: Introduction

This Group Visit Starter Kit is designed for health care teams who want to begin offering group visits for their patients. It contains information on:

- What are group visits
- Why they are useful
- How to plan and implement the visits
  - Task list and timeline
  - Who does what
  - Sample letter for patients
  - Sample agendas
- Information on a "Patient Workbook" for the participants
  - Group visit norms
  - Vitals record for patients
  - Clinic information sheet
- A list of resources to help you get started
  - Sources for patient education materials
  - Resources within the Cooperative
  - Tips on facilitating groups
- Comparison of group visit models
- References
- Business Operations:
  - Group Visit Business Process
  - Coding and Billing Group Visits

Information to prepare this notebook was received from Collene Hawes and the Olympic District, Kate Lorig of the Stanford Patient Education Research Center and John Scott of Kaiser-Colorado. Thanks to all the clinics and individuals who have shared materials and tools they have used.

What is a “Group Visit”?

The term is applied to a wide variety of visits designed for groups of patients, rather than individual patient-provider appointments. This Starter Kit describes the Cooperative Health Care Clinic (CHCC) model developed by the Kaiser Colorado staff. We will refer to it simply as a “group visit”. Group visits were pioneered with frail elderly patients who were high utilizers of primary care.

In this model, the health care team facilitates an interactive process of care delivery in a periodic group visit program. The team empowers the patient, who is supported by information and encouraged to make informed health care decisions. The group visit can be conceptualized as an extended doctor’s office visit where not only physical and medical needs are met, but educational, social and psychological concerns can be dealt with effectively.

Invitations are extended by the health care team to specific patients on the basis of chronic disease history and utilization patterns. The patients typically remain in the same group together. Members may be added to groups if the group size decreases.

Variations of this group visit format have been used for disease or condition specific populations, such as

- Diabetes
- Hypertension
- Orthopedic procedures
- Heart failure
- Cancer
- Asthma
- Depression
- Fibromyalgia
- Hormone replacement therapy
- Chronic pain
- Hearing impaired population

Some groups begin with monthly meetings and later adjust the interval to quarterly. Additional information on diabetes specific group programs was published in Diabetes Care. [Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, Watson R, Swain BE, Selby JV, Javorski WC SOURCE: Diabetes Care. 1999 Dec;22(12):2011-7.]

Additionally, some clinics find it is helpful to periodically provide a group meeting for new patients as an orientation to the clinic, or to initiate a new clinical guideline.

Another group visit model, Drop-In Group Medical Appointments (DIGMA) follows a distinctly different methodology and will not be discussed here.

Why Have Group Visits?

Evidence from a randomized trial of group outpatient visits for chronically ill older HMO members in the Colorado Kaiser program indicates that group visits had the following impacts:

- 30% decrease in emergency department use
- 20% decrease in hospital use / re-admissions
- Delayed entry into nursing facilities
- Decreased visits to sub-specialists
- Increased total visits to primary care
- Decreased same day visits to primary care
- Increased calls to nurses
- Fewer calls to physicians
- Increased patient overall satisfaction with care
- Increased physician satisfaction with care
- Decreased cost PMPM by $14.79

In focus groups, members have told us that they value

- trusting relationships with their provider
- hands-on care
- time with the provider.

Group visits are a way to address those needs.

Members who have participated in group visits report that

- they know each other better
- they know that they are not the only ones facing a particular disease or situation
- they learn new information
- they have an opportunity to ask questions, and
- they enjoy one another's company.

Summary

Group visits offer staff a new and more satisfying way to interact with patients that makes efficient use of resources, improves access, and uses group process to help motivate behavior change and improve outcomes.

Planning and Implementing Group Visits

Two Months Before the First Group Visit

Initiating a group visit requires some planning and coordination. Thankfully, many other providers have already tested the idea and materials are available to assist. The team may want to consider using the expertise of the Practice Improvement Consultants or Care Management Directors as they get their first group visit up and going. (for more resources, see page 26.)

It is important to begin planning at least two months before the first visit is scheduled to occur. Make sure that you have support from the leadership at your site. With the leadership, discuss what outcomes you want from your group visits. Some suggestions include patient and provider satisfaction, achievement on clinical standards of care and utilization. Determine a measurement plan.

At a team meeting, determine the population you would like to invite for group visits. Remember that between 30 and 50% of patients are amenable to participation in group appointments, so determine if the population you wish to include is at least 50 patients, or the group that results from your invitation may be too small to make the visit efficient for your team. Chronic illness registries and reports of patients with frequent visits can be used for this purpose. At this first team meeting, review the letters of invitation, standard agenda for the first meeting, and the roles of the team members. A task list and timeline is provided in the following section. Give top priority to scheduling the primary care provider, the nurse and an MA to assist with vitals during the "break" in the group visit. Don't forget to schedule the room.

One Month Before the First Group Visit

When a list of potential patients is obtained, the team should quickly review the list for patients who wouldn't be appropriate in a group. The typical exclusions are patients who are terminally ill, have memory problems, severe hearing problems, have difficulty with English or are out of the area for significant portions of the year. Create your mailing list and letters now. Plan to have letters reach patients about one month before the first session. The letter is viewed most positively if it is personally signed by the primary care provider, and followed up one or two weeks after the mailing with a personal phone call from the nurse who will be attending the group visits.

It is a good idea to have a second team meeting during this time. The materials for the patients to have at the first session should be reviewed. Each patient will be provided with a folder or three ring binder to bring with them to each visit. Review any assessments or documentation tools you wish to use. Discuss how the calling is going (or went) and who is expected to attend. Review the agenda and roles of the team. Some clinics like to provide coffee or a snack for the break in the visit. Arrange this as needed, as well as the materials for the folders, binders, a flip chart, BP cuffs and stethoscopes. It is a good idea to use nametags, especially for the first few visits.

One Week Before the First Group Visit

About one week before the first session, enlist someone to call the attendees and remind them of their appointment. These calls should describe the purpose of the visit, what is likely to occur at the visit and encourage the patient to attend. The caller should reinforce that this is an actual medical appointment, not a class or workshop, and people are expected to call and cancel if they cannot attend. Discuss the issues of co-pay and parking as necessary.
It is important to reinforce that this is a medical appointment, and that the standards for canceling appointments are expected. Many teams request the charts of those who will be attending and review them for preventive care needs or other concerns.

Supplies for a Group Visit

Charts
BP cuffs & stethoscopes
Specialty Tools (ex: monofilaments for diabetes foot exam)
Forms (sign-in sheets, order forms, etc.)
Pens
Nametags
Flip charts and markers

Day of the First Group Visit

The day of the first session, prepare the room well in advance, as some patients will arrive early. Tables should be set up in a horseshoe with the open end pointing toward the speaker. Start on time to set up the expectation that the visit has a beginning and an ending. At least one team member should be in the room to greet patients. Help patients to write the name they wish to be called in very large letters on their nametag.

Don't hog the airtime!

If the facilitator has been talking about him/herself for more than one minute, it's time to stop!

The primary care provider should open the meeting with a sincere welcome. All staff and team members are introduced. The patients are then given a format to follow for introductions. It is very important to include sharing in the introduction, as this will help to form the supportive relationships between the group members. For older patients, reminiscence can be very helpful. The primary care provider should **model** the introduction. The provider should introduce himself or herself again using the exact format they want the participants to use. For example, "My name is (use the name you wish to be addressed by). My favorite childhood toy was my bicycle. We used to ride all around our neighborhood in Des Moines, Iowa on our bikes." This modeling will help other participants to be brief. If participants begin to tell extended stories, the provider might need to gently interrupt by saying something like "Thank you, ___. We need to make sure we have time to hear from everyone." The introductions should take about 15 minutes.

After the introductions, the provider gives an overview of the group visit (30 minutes). Allow lots of time for interaction and questions. Review the group norms, which cover the expectation of confidentiality for the group.

We all like food

Consider offering simple refreshments.

In some groups, the members will take on the responsibility and offer to bring items to share.

Before the break, the provider and nurse should explain what will happen. The nurse will start at one end of the horseshoe and take vitals, and the physician will start on the other, and cover any individual issues. Some groups have found it helpful to have a medical assistant begin taking vitals in addition to the nurse. Vitals are recorded for the patients in their notebooks, and for the medical record. All team members should be assessing patients for those who may need an individual visit at the end of the group session.

After the break (15 minutes), the group should reconvene for an open question and answer period. The provider may need to prompt this session and encourage participation at first. Often asking what people have heard or seen on the news or in the newspaper will get the questions rolling. The provider should involve the team as much as possible and refer questions to the nurse, to demonstrate to the patients that the team works together.

Group Interaction is Powerful

Health care professionals are often tempted to use group visits as an opportunity to lecture patients – to tell patients everything they think patients should know about the disease process, treatment, etc. This can seriously undermine the success of the group visit.

Resist the temptation to take over and lecture! Trust the group to lead the way. The role of the health care team is to facilitate the group interaction.

After the question and answer period, the group discusses what topic they would like to discuss in the next group visit (typically one month in the future.) Writing down a list of all the ideas on a flip chart can be a very helpful technique. Providers find that patients typically bring up topics that the provider team also feels are important, and rarely suggest frivolous topics. If they do, other participants usually discourage the idea. Some provider teams may want to get a quick reaction from the participants about what they liked about the meeting. Thank the participants for coming.

Tips for Using Flipcharts

- Write in clear large letters
- Use Bullets for lists
- Use alternating colors to clearly separate items

Happy Endings

It's important to end each session with a strong, clear closing statement. Think about the difference between the following closures:

Example #1: "This was a great session. You all did a wonderful job discussing issues of medication management and thinking of creative solutions to the problems that some of you have experienced. I really appreciate your openness and your willingness to share. At the next meeting, we will be discussing ways to increase activity levels. Thanks for coming and we'll see you all on March 12th."

Example #2: "Well, I guess that's it. I can't think of anything else. OK, then. Bye."

Individual appointments then follow at 10 minute intervals. The nurse and provider may both have individual appointments. After 30 minutes of appointments, the provider is rewarded for the group visit by having 30 minutes of discretionary time.

After the first group visit, the team may want to have a short debriefing meeting. Discuss what went well and what didn't go so well. As you discuss things you might want to do differently, remember that the basic format of the group has been tested in clinical trials, and deviations from the outline may not have the same positive results.

Let the group answer questions

When questions arise, health care professionals tend to want to give the answers. Instead, learn to leverage the power of the group.

"Has anyone else experienced this problem? What worked for you?

This increases the participants' confidence in their own problem solving ability.

Providers have found that few materials should be prepared in advance of the group visit. Quickly reviewing the materials that patients have available (*Healthwise for Life* or the pamphlet service) is generally all that is required. What the patients want to hear about is the basic information they need to know and how others have dealt with the situation. Providers should strive for each session to be interactive. An appendix contains helpful information to deal with difficult people and situations that may arise in a group session.

Monthly Follow-Up

The team should hold a brief meeting each month to review the participants' requested topic and determine how to address it. Kaiser Colorado has found that it is best to have most of the presentations and discussion done by members of the primary care team. Review the roles of the team members and anything that the team would like to try differently for the upcoming session.

Task List and Timeline

Date	Action	Responsibility	Done	Comments
Two months before first session				
	Meet with leadership Determine goals and measurement			
	Team meeting (1 hour or less) Determine type of group visit (ex: frail elderly) Discuss plans and team member roles Review agenda and letters			
	Schedule room (2 ½ hour block)			
	Schedule provider (2 ½ hour block)			
	Schedule RN (2 ½ hour block)			
	Schedule MA for vitals during "break"			
	Obtain list of potential participants			
	Review list for inappropriate invitees	Provider		
One month before first session				
	Send out invitation letters to 40-50 people			
	Call all patients who received letter (2 weeks after mailing)	RN		
	Team meeting (45 minutes or less) Review agenda and roles, attendees, patient notebooks			
	Arrange refreshments, if desired			
	Create records for patients (folder/notebook for 25 per group)			
One week before				
	Create roster of attendees and sign-in sheet			
	Review charts for potential immediate needs			
	Call attendees to remind them of their appointment			
Day of Visit				
	Set up room (horseshoe)			
	Materials to room (patient folders, coffee, BP cuffs, stethoscopes, flip chart, nametags, tissues)			
	Be in room early to greet patients			
	Hold visit			
	Debrief after visit: What went well? What didn't go as well?			
Monthly	Plan next group visit			

Who Does What

Each team should review the tasks and roles and determine how best to use their team. The result might look something like this:

LPN/MA

1. Pull charts 3-5 days before the group visit.
2. Remind primary care provider about the upcoming group visit
3. As agreed upon by team, perform chart review
4. Give results of chart review to provider

Day of Group visit
1. Check room set-up
2. Take charts and supplies to room
3. Perform vitals, exams and immunizations as needed
4. Data entry into registry if appropriate

PCR

1. Reminder phone calls to patients
2. Check on room reservation
3. Make sure name tags are ready

Day of Group Visit
1. Print 4 labels for each patient, attach one to TRF, give others to LPN/MA
2. Print out registries for patients if appropriate
3. Complete Last Word functions as appropriate

MD

1. Participate in planning of the visit with the team, following suggestions of participants
2. Review charts, identify problems for review with individual patients

Day of Group Visit
1. Conduct discussion and group visit
2. During break, review individual needs and make 1:1 individual appointments for after the visit
3. Document visits

RN

1. Coordinate the planning of the visit with the team
2. Coordinate materials and information for the visit

Day of Group Visit
1. Circulate in room during break, performing vital signs and identifying patients who need individual attention.
2. After visit, follow up with patients via telephone as needed

Who Does What (continued)

Others: Pharmacist, Behavioral Health, Nutrition, Physical Therapy

It is sometimes helpful to provide access to other specialists during the group visits. It is important that the team adequately brief anyone brought into the group visit so they adhere to the high degree of interactivity encouraged in the group. Discourage these guest presenters from lecturing to the patients or providing them with excessive prepared materials.

A good model for these presentations is for the physician, nurse, or presenter to have the group list all the questions they have right before the presenter speaks. If these are listed on a flip chart, they can be checked off as they are discussed. The presenter can suggest topics that the patients may not be aware of if they are not included on the list.

Medical Center Letterhead

Date

Dear ,

I want to invite you to participate in a new way of delivering medical care. This program is designed specifically for (*describe group:* patients with _____, patients over 65). By choosing to participate you will be asked to

- Become a member of a small group of patients with ___. This group will meet every month with me to address medical and other issues of concern to you.
- Help us develop the program for your particular group.
- Help evaluate the success of the program in meeting your needs.

Most of the time when you come in to the clinic, you are ill or have a specific problem that we need to talk about. Discussions about managing or improving your health are often hard to fit into these short visits. The purpose of this group is improved health. In the group we will discuss ways you can maintain or improve your health and make sure you are up-to-date with care recommended for you.

The first group visit will be held _____ (day and date) from _____ am or pm. These group visits will be held at _____. We encourage you to bring a family member with you. Because this visit includes a medical evaluation, a co-pay will be collected if you usually pay for medical care.

If you are interested, please RSVP by _____ (date) to _____ (name) at _____ (phone number). If you are not interested, you will continue to receive usual health care.

PCP

Group Visit
Agenda for First Session

15 minutes **Introductions/Welcome**

Physician opens the session.
All team members present are introduced.
Introductions follow around the room, with sharing included. Example for older patients: Give your name as you would like to be called, and share your favorite childhood game (or where you were on Pearl Harbor Day, or favorite childhood holiday memory, etc.)

30 minutes **Group Visits**

What are they?
Why are we doing it?
What should you expect?
Questions from the group
Group Visit Norms
Review folder/notebook

15 minutes **Break**

Physician starts on one side, nurse on other.
Take blood pressures, ask about specific concerns for the day (look for patients who need 1:1 visits).
Refill meds.

15 minutes **Questions and Answers**

Ask for any questions the group has about their health, the visit, etc.

15 minutes **Planning**

Topic for next month
Announce time and date

30 minutes **1:1 visits with provider as needed**

30 minutes **Provider discretionary time**

Group Visit
Agenda Template

15 minutes **Introductions/Welcome**

Physician opens the session.
All team members present are introduced.
Introductions follow around the room, with sharing included.

30 minutes **Topic of the Day**

Physician and nurse provide information, interacting with the participants whenever possible.
Some suggestions to make the session interactive include asking:
"Has anyone here ever had this problem?"
"How has anyone dealt with this situation before?"
"What have you heard about _____ ?"
Always intersperse the presentation with questions from the group

15 minutes **Break**

Physician starts on one side, nurse on other.
Take blood pressures, ask about specific concerns for the day (look for patients who need 1:1 visits).
Refill meds.

15 minutes **Questions and Answers**

Ask for any questions the group has about their health, the visit, recent topics in the news, etc.

15 minutes **Planning and Closing**

Determine topic for next month
Thank everyone for coming, providers proceed to 1:1 visits

30 minutes **1:1 visits with provider**

30 minutes **Provider discretionary time**

Materials and Resources for Patient Folders/Notebooks

Assessments

For some types of group visits, the clinic may want to have the participants complete a questionnaire or health assessment before the group visit. It is highly recommended that when teams consider using assessments that they utilize instruments developed by Group Health Cooperative and in accordance with relevant roadmaps and guidelines. Contact Health Improvement Programs at 206-326-2803 or 8-330-2803 for assistance in locating GHC developed and/or approved health assessment tools.

Curricula

It is very tempting for the team to develop detailed lessons plans and curricula, but this is not recommended. Researchers have found that groups of patients will choose the topics that health professionals want to discuss, and by leaving the choice of discussion topic up to the participants, the group forms closer bonds and develop a sense of self-confidence. A great deal of the information that patients find helpful is hearing how other people have handled similar situations. The information that patients want from professionals tends to be basic information, and it is rarely necessary to research a topic or refer to books to work with patients. If this is necessary, it can be accomplished in the period between meetings, since the participants should be setting the topic for the upcoming meeting in the preceding one. Some groups have found it helpful to keep a checklist of topics they would like to cover and periodically review the checklist

Patient Education Materials

If you wish to choose and order patient education materials for your group visits, you can use the Health Information Services Patient Education Catalogue. The MMS in your clinic has a copy. You can also order the Catalogue and many of the materials on-line through the Copy Center at http://incontext.ghc.org/asd/forms/rdf_form.html. The order number for the Catalogue is DM1798.

If you'd like assistance choosing patient education materials or samples of materials, please call Health Information Services at 206-326-2807 or -2814 (8-330-2807 or -2814). The HIS staff is very experienced and would be happy to help you.

Remember to use materials prepared for use in GHC, because you will avoid the need to explain discrepancies in standards for care. Carefully review any materials supplied by outside organizations.

Clinic Brochures

You may wish to include brochures giving patients information about your clinic and hone numbers to call for appointments, prescriptions, and other needs. These brochures are printed twice a year in April and October; ordering takes place in March and August/September. Contact your Area Manager if you wish to order brochures for your groups. Clinic-specific information is also available on Group Health's external website at www.ghc.org.

Self Management Support Services

For information or assistance in promoting and utilizing GHC health improvement services within your group visits, contact Health Improvement Programs (HIP) at 206-326-2803 (8-330-2803). Examples of GHC program support your patients can receive include exercise classes, self-management support workshops, behavior change support phone calls, action plan follow-up phone calls, and Free & Clear. In addition, HIP can often find resources in the community to meet special individual or group needs.

Living Well with Chronic Conditions Workshops

The "Living Well with Chronic Conditions" workshop is a series of six weekly sessions that teach patients how to manage symptoms commonly associated with chronic conditions so that they can live a more full and active life. The six week workshop leads patients through hands-on skill building, specifically:

- setting goals
- making action plans
- managing emotions that are commonly present with chronic conditions
- increasing exercise
- improving nutrition
- making treatment decisions
- managing medications
- communicating and working as a partner with the healthcare team
- planning for the future.

A randomized controlled trial found that people who took the workshop had improved health status (decreased fatigue, less disability and improved role function) and improved health behaviors (increased exercise and improved communication with providers). The study also showed that people who took the workshop had fewer annual hospital days compared with those who didn't.[1]

The "Living Well with Chronic Conditions" workshops are offered at 9 Group Health sites statewide. For more information please contact Jamie Hunter-Mitchell, "Living Well with Chronic Conditions" Program Coordinator, by phone at 206-326-2905 (8-330-2905) or by e-mail at huntermitchell.j@ghc.org.

[1] Lorig K, Sobel D, Stewart AL, Brown BW, Bandura A, Ritter P, Gonzalez V, Laurent D, Holman H: Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: A randomized trial. Medical Care 37:5-14, 1999.

Group Visit Norms

We will…

- **Encourage everyone to participate.**
- **State our opinions openly and honestly.**
- **Ask questions if we don't understand.**
- **Treat one another with respect and kindness.**
- **Listen carefully to others.**
- **Respect information shared in confidence.**
- **Try to attend every meeting.**
- **Be prompt, so meetings can start and end on time.**

Group Visit
Vitals Record

Date	Blood Pressure	Pulse	Questions

Group Visit
Medication Record

Date	Medication	Dose	Reason

DEALING WITH THE DIFFERENT TYPES OF PEOPLE/SITUATIONS IN GROUP SETTINGS

This information is provided courtesy of the Stanford Patient Education Research Center that maintains the copyright. It has been adapted for use in group visits at Group Health Cooperative.

The following descriptions of different types of people and potentially difficult situations are presented here to stimulate your thinking about how **you** might handle these effectively during a group session that you are leading. Being prepared ahead of time may even help you prevent such problems. Each situation is different; therefore, use your best judgement to determine what suggestions might be effective in real situations.

If a difficult situation persists, discuss it with your co-workers. Together, you will get the support you need and can decide how best to handle the problem.

The Too-Talkative Person

This is a person who talks all the time and tends to monopolize the discussion.

The following suggestions may help:

- Remind the person that we want to provide an opportunity for everyone to participate equally.
- Refocus the discussion by summarizing the relevant point, then move on.
- Spend time listening to the person outside the group.
- Assign a buddy. Give the person someone else to talk to.
- Use body language. Don't look toward the person when you ask a question. You may even consider having your back toward the person.
- Talk with the person privately and praise him/her for contributions, and ask for help in getting others more involved.
- Thank the person for the good comment, and tell him/her that you want everyone to have a turn at answering the question.
- Say that you won't call on someone twice until everyone has had a chance to speak once first.

The Silent Person

This is a person who does not speak in discussions or does not become involved in activities.

The following suggestions may help:

- Watch carefully for any signs (e.g., body language) that the person wants to participate, especially during group activities like brainstorming and problem solving. Call on this person first, but only if he/she volunteers by raising a hand, nodding, etc.
- Talk to them at the break and find out how they feel about the group session.
- Respect the wishes of the person who really doesn't want to talk; this doesn't mean that they are not getting something from the group.

The "Yes, but . . . " Person

This is the person who agrees with ideas in principle but goes on to point out, repeatedly, how it will not work for him/her.

The following suggestions may help:

- Acknowledge participants' concerns or situation.
- Open up to the group.
- After three "Yes, but's" from the person, state the need to move on and offer to talk to the person later.
- It may be that the person's problem is too complicated to deal with in the group, or the real problem has not been identified. Therefore, offer to talk to the person after the session and move on with the activity.
- If the person is interrupting the discussion or problem-solving with "Yes, but's," remind the person that right now we are only trying to generate ideas, not critique them. Ask him/her to please listen and later we can discuss the ideas if there is time. If there is no time, again offer to talk to the person during the break or after the session.

The Non-participant

This is the person who does not participate in any way.

The following suggestions may help:

- Recognize that the people in the group are variable. Some may not be ready to do more than just listen. Others may already be doing a lot, or are overwhelmed. Some may be frightened to get "too involved." Still others may be learning from the sessions, but do not want to talk about it in the group. Whatever the reason, do not assume the person is not benefiting from the group in some way, especially if he/she is attending each session.
- Do not spend extra time trying to get this person to participate.
- Congratulate those participants who do participate.
- Realize that not everything will appeal to everyone in the same way or at the same time.
- Do not evaluate yourself as a leader based on one person who chooses not to participate in activities.

The Argumentative Person

This is the person who disagrees, is constantly negative and undermines the group. He/she may be normally good natured but upset about something.

The following suggestions may help:

- Keep your own temper firmly in check. Do not let the group get excited.
- If in doubt, clarify your intent.
- Call on someone else to contribute.

- Have a private conversation with the person; ask his/her opinion about how the group is going and whether or not he/she has any suggestions or comments.
- Ask for the source of information, or for the person to share a reference with the group.
- Tell the person that you'll discuss it further after the session if he/she is interested.

The Angry or Hostile Person

You will know one when you see one. The anger most likely has nothing to do with the leader, group or anyone in the group. However, the leader and groups members are usually adversely affected by this person, and can become the target for hostility.

The following suggestions may help:

- Do not get angry yourself. Fighting fire with fire will only escalate the situation.
- Get on the same physical level as the person, preferably sitting down.
- Use a low, quiet voice.
- Validate the participant's perceptions, interpretations, and/or emotions where you can.
- Encourage some ventilation to make sure you understand the person's position. Try to listen attentively and paraphrase the person's comments in these instances.
- If the angry person attacks another participant, stop the behavior immediately by saying something like, "There is no place for that kind of behavior in this group. We want to respect each other and provide mutual support in this group."
- When no solution seems acceptable ask, "At this time, what would you like us to do?" or "What would make you happy?" If this does not disarm the person, suggest that this group may not be appropriate for him/her.

The Questioner

This is the person who asks a lot of questions, some of which may be irrelevant and designed to stump the leader.

The following suggestions may help:

- Don't bluff if you don't know the answer. Say, "I don't know, but I'll find out."
- Redirect to the group: "That's an interesting question. Who in the group would like to respond?"
- Touch/move physically close and offer to discuss further later.
- When you have repeated questions, say, "You have lots of good questions that we don't have time to address during this session. Why don't you look up the answer and report back to us next week."
- Deflect back to topic.

The Know-It-All Person

This is the person who constantly interrupts to add an answer, comment, or opinion. Sometimes this person actually knows a lot about the topic, and has useful things to contribute. Others, however, like to share their pet theories, irrelevant personal experiences and alternative treatments, eating up group time.

The following suggestions may help:

- Restate the problem.
- Limit contributions by not calling on the person.
- Establish the guidelines at the start of the session and remind participants of the guidelines.
- Thank the person for positive comments.
- If the problem persists, invoke the rule of debate: Each member has a right to speak twice on an issue but cannot make the second comment as long as any other member of the group has not spoken and desires to speak.

The Chatterbox

This is a person who carries on side conversations, argues points with the person next to him/her or just talks all the time about personal topics. This type of person can be annoying and distracting.

The following suggestions may help:

- Stop all proceedings silently waiting for group to come to order.
- Stand beside the person while you go on with workshop activities.
- Arrange the seating so a leader is sitting on either side of the person.
- Restate the activity to bring the person back to the task at hand or say, "Let me repeat the question."
- Ask the person to please be quiet.

The Crying Person

Occasionally, a group discussion may stimulate someone in the group to express their feelings of depression, loss, sorrow or frustration by crying. People cry for many reasons. They may feel that someone finally understands what it's been like, which makes them feel safe to express emotions they have been suppressing for a while. Crying is usually a release that promotes emotional healing. To allow a person to cry is helpful; it may also help to bring the group closer together providing mutual support to one another. Your role is to convey that is okay to cry, so the person does not feel embarrassed in front of the group.

The following suggestions may help:

- Always have a box of tissues handy and pass it to the person.
- Acknowledge that it is all right to cry — having a health problem is difficult, then continue on with the class.

- If the person is crying a lot, one leader may want to accompany the person out of the class to see if anything needs to be done. The other leader should continue on with the rest of the group.
- Generally, if no one tries to stop the crying, within a short period of time, it will play itself out. Tension will be released and the person will feel better and the participants will feel closer to the person.
- At the break or after the session, ask if the person is okay now and if he/she needs help with anything. Reinforce to the person that crying is a perfectly normal, healthy behavior, and that he/she is not the first to cry in this class. In fact, it has happened quite often and probably will in the future.

The Suicidal Person

Rarely, you may encounter someone who is very depressed and is threatening to take his/her own life or expresses severe hopelessness or despair.

- Talk to the person privately. One professional can accompany the person out of the room, and perform a further assessment of suicide risk. Refer to the Group Health "Strategies for Managing Suicidal Patients" and the "High Risk Patient Flow Chart" from the Depression Registry, which can be located on the intranet.
- Engage Behavioral Health Services.

The Abusive Person

This is someone who verbally attacks or judges another group member.

The following suggestions may help:

- Remind the group that all are here to support one another.
- Establish a group rule and remind everyone that each person is entitled to an opinion. One may disagree with an idea someone has but under no circumstances will personal attack be appropriate. If the abuse continues ask the person to leave.

The Superior Observer

This is a person with a superior attitude who says he/she is present out of curiosity, and that he/she already knows everything about their health and is coping well.

The following suggestions may help:

- If the person knows a lot and is doing well, you may want to have them provide examples of what they do at selected times for the group.
- A person may also act superior if he/she feels uncomfortable and not a part of the group. If so, include him/her in some way.
- If the person wants to be ignored, then ignore them. They will get bored and leave or start to participate.

The Person in Crisis

The person in "crisis" is the one with the problems, who wants help and/or just needs to talk about these problems.

The following suggestions may help:

- Listen attentively, be empathetic, use open-ended questions, and use reflective listening.
- If after five minutes it is obvious that the person will need more time to "unload," talk to person during the break or afterwards, as you will have to go on with the group activities.
- Don't take up session time and energy with the very "needy" person because it takes time away from the other participants who can be helped. Refer them to appropriate services, such as social work or behavioral health.

Resources

The following resources are available to help you get started.

- Mary McGregor (206-326-3424, 8-330-3424), Dorothy Talbot (206-326-3806, 8-330-3806) and Barbara Fugleberg (253-383-6197, 8-490-6197) are Practice Improvement Consultants in the Puget Sound Regional Division. They are available to provide consultation and coaching for teams.

- June BlueSpruce (206-901-7366, 8-600-7366) is a Project Manager with the Internal Collaborative and the Practice Innovations Department. She works primarily with teams involved in the Learning Collaborative, but may also be available to consult with other teams.

- Connie Davis is Associate Director of the MacColl Institute (206-287-2554, 8-220-2554) and is involved in helping organizations across the country learn to utilize group visits. She is available for consultation as her other obligations permit.

- Linda Madsen (206-326-2803, 8-330-2803) is the Senior Manager for Health Improvement Programs and she or members of her staff are available to consult with teams regarding self-management support strategies and available resources.

- There are several different videos of the Colorado Kaiser Cooperative Health Care Clinics available. Copies of videos about the DIGMA-style group visits used by Kaiser Northern California are also available. **Contact the Kathleen Hill Library** to arrange to borrow the videos. **To order on InContext, go to InContext>Departments>libraries>Kathleen Hill Library>Library Collections>list of audio and videotapes.**

- The District Care Management Directors are also available for support.
  East King –Snohomish: Cara Robinson
  Seattle: Karen Wulff
  Tahoma Kitsap: Patty Reinkensmeyer
  Olympia: Collene Hawes

Subject: GROUP VISITS
Number: BPP: BP 0.50
Orig. Issue: 02/2001
Location to File: Business Process
Revision:

OVERVIEW:

Group Visits are conducted by one or more practitioners or a Practice care team from different specialties, or the same specialty, who together treat and/or assess a group of patients. The following is a general overview of Group Visits.

These are general instructions only. Because of system capabilities and billing requirements, it is the department's/clinic's responsibility to consult with Contracts and Coverage, Centralized Business Operations (CBO) and other departments as needed to ensure compliance and appropriate business processes are followed. Refer to department/clinic specific procedures.

OUTPATIENT NON-FACILITY BASED PROCEDURE:

1. **Appointing**

   All providers involved in the Group Visit may appoint the patient(s). Use appointment type "GV" for providers who can bill for their services. All others providers will use RSO.

   Example A: A Family Practice physician, a Family Practice RN and a Family Practice MA are seeing a group of patients. All three can appoint (if they have individual templates), the physician would be the only who would use appointment type GV. The RN and the MA would use RSO.

   Example B: A Family Practice physician, a Family Practice RN and Mental Health provider are seeing a group of patients. All three can appoint (if they have individual templates), the physician would use appointment type GV and the mental health provider would use appointment type MHG. The RN would use RSO.

2. **Check-in**

   All providers using appointment type "GV" or "MHG" can check the patient in. In the above example, only the physician and the mental health provider would check-in the patient.

3. **Service Capture**

   Only visits by providers who checked the patients in may be service captured. In the above example, services would only be captured for the Family Practice Physician in example A and the Family Practice Physician and mental health provider in example B.

4. **Copays**

   Copays will need to be waived when appropriate. The providers involved will need to determine which copay(s) need to be waived. See procedure BPP: CS 3.00, Service Recovery Adjustment (Waiving Copays). In the above examples, the Family Practice Physician in example A would not waive a copay, however in example B the Family Practice Physician and the mental health provider would need to decide who would not collect a copay.

5. **Individual Visit**

   During a group visit it may be decided that a patient needs to have a one on one with the provider following the group visit. If this happens the follow steps must occur:

   - Appoint patient with the appropriate provider
   - Check-in the patient on the providers schedule
   - The copay (if applicable) from the group visit can be used for the individual visit
   - After the copay (if applicable) is moved delete the encounter for the group visit
   - Complete service capture for the one on one visit as appropriate

NON-FACILITY BASED URGENT CARE/FACILITY BASED ED PROCEDURE:

N/A

FACILITY BASED INPATIENT/OUTPATIENT PROCEDURE:

N/A

Coding and Billing Group Visits

Background

This document gives coding and billing information for the Cooperative Health Care Clinic (CHCC) model for providing group visits at Group Health. In the CHCC model the health care team facilitates an interactive process of care delivery in a periodic group visit program. The health care team extends invitations to specific patients on the basis of chronic disease history and utilization patterns. The patients typically remain in the same group together and meet on a monthly basis.

CHCC model group visits at GHC follow a standard format:

1. Introductions / welcome
2. Topic of the Day – information and interaction
3. Break – physician and nurse meet briefly with each patient to take BP, elicit specific concerns of the day, refill medications, and assess for patients who need a one-on-one visit with the practitioner.
4. Questions and answers – this is a continuation of Topic of the Day
5. Planning and Closing – determine topic for next month

At the conclusion of the group visit the physician may meet with select patients for one-one-one appointments.

Coding Group Visits

The different models of group visits may require different coding approaches, and each model should be evaluated against CPT coding and documentation guidelines. **As with all office visits, industry-standard coding rules and standards for medical record documentation apply to group visits.**

The following instructions apply to the CHCC model described above.

E/M Coding – Group Visits

- Since CPT does not specifically provide codes for group visits, we must use E/M visit codes to describe the services provided. The CHCC model, as described above, meets the criteria for coding a level two office visit (99212) for an established GHC patient.
- **In order to code 99212 for a group visit the medical record documentation must include two of the three key components required for this E/M code:** 1) a problem focused history, 2) a problem focused exam, 3) straightforward medical decision making. We suggest the use of the SOAP format for documentation.
- If the documentation does not meet the CPT criteria for code 99212, the CPT guidelines should be reviewed for selection of a more appropriate code.
- E/M codes may only be used if the physician is present during the entire group visit and either documents the care or reviews and signs off on the documentation.

E/M Coding – One-on-one visits on the same day as a group visit

- A department can assign only one E/M code for a particular patient on the day of the group visit. If a patient is appointed to see the physician for a one-on-one visit at the conclusion of the group visit, do not code the group visit. Follow CPT guidelines to **code the one-on-one visit only.**

Diagnostic Coding

- Select the ICD-9 code that reflects the primary reason for the patient visit. This code should be designated as the primary diagnosis by placing a "1" or a "P" next to it on the TRF. If additional problems, symptoms or chronic diseases were addressed during the visit, add these conditions as secondary diagnoses. **All diagnoses must be documented in the medical record.**

Please contact your Coding Consultant if you have questions about how to code group visits.

Comparison of Group Visit Models

	Cooperative Health Care Clinic	**DIGMA**
Goal	Increase provider satisfaction caring for frail elderly	Improve access to care
Results	RCT: decr. ER visits decr. specialist visits decr. hospital admits incr nurse visits and nurse calls decr. calls to MD decr. cost $14.79 PMPM same or slight decr. primary care visits incr. preventive care incr. advanced directives incr provider satisfaction incr patient satisfaction	anecdotal data: decr. costs incr. access incr. patient satisfaction incr. provider satisfaction peer support
Patients	Elderly with one or more outpatient visits/month	Established patients of the DIGMA provider Could be homogenous (same diagnosis, for example), heterogenous (any issue)
Setting	HMO (Kaiser Colorado)	HMO (Kaiser specialty and primary practices, California)
Intervention: Interval	Monthly group meetings of cohort of 25 patients (ave. attendance is 10-15)	Varies: start with one a week or one a month, 10-16 patients/DIGMA
Intervention: Staffing	Primary Care Provider RN Occas. Ancillary staff (pharmacy, PT, dietician)	Primary Care Provider Behavioral Health (could be SW or RN with group skills) MA or LPN for vitals at check in
Intervention: Schedule	15 min. warm-up (social topics) 30 min presentation (very little prepared in advance) 15 min “break” (providers circulate and triage) 15 min. Q&A 15 min planning next session 30 min allotted for brief 1:1 with MD 30 min held for MD discretion	BH begins 90 minute session, asks for those who can’t stay full hour. MD works with them first. Work around room with provider doing most exams in the room, describing care and providing information for all. MD documents in the room while BH continues with group discussion.
Intervention: Topics	In the first year, six topics determined by provider (evidence-based clinical priorities, such as immunizations, advanced directives), six topics determined by group.	As determined by needs of those in group.

	Cooperative Health Care Clinic	DIGMA
Citation	Beck et al. A randomized controlled trial of group outpatient visits for chronically ill older HMO members: The cooperative health care clinic. *JAGS* 1997:45;543-549. Thompson E. The power of group visits. *Modern Healthcare* June 5, 2000;54, 56, 62. (Interview with John Scott, CHCC expert and Ed Noffsinger, DIGMA expert)	Noffsinger E. Establishing successful primary care and subspeciality drop-in group medical appointments (DIGMAs) in your group practice. *Group Practice Journal 1999*;48(4). Noffsinger E. Answering physician concerns about drop-in group medical appointments. *Group Practice Journal* 1999;48(2):14-21. Noffsinger E. Benefits of drop-in group medical appointments (DIGMAs) to physicians and patients. *Group Practice Journal* 1999;48(3):16-22 Noffsinger E. Increasing quality of care and access while reducing consts through drop-in group medical appointments. *Group Practice Journal* 1999:48(1);12-18. Noffsinger E. Will drop-in group medical appointments work in practice? *The Permanente Journal* 1999:3(3);58-67.
Materials available?	Yes contact John Scott, MD at Kaiser Colorado 303-657-6808 GHC has videos and GHC adapted manual	Yes Dr. Noffsinger is now a consultant, phone 831-427-1011 or 831-458-3388, email thedigmamodel@aol.com Kaiser Permanente has adapted the DIGMA model and made a video about how to do it; GHC has copies of the videos

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