

Putting Group Visits into Practice in the Patient Centered Medical Home



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Disclosures

- We have no relevant financial disclosures

Overview

- Discuss evidence on power of group visits
- Review the model and structure for conducting groups
- Understand the behavioral reasons why groups work and
- Learn group facilitation skills for increasing effectiveness of groups in the medical setting through a demonstration

Definition and Evidence on Groups

Definition of Medical Group Visit

- Multiple patients meet together as a group
- Group facilitated by a team consisting of clinicians
- Meets for 1.5 to 2.5 hours at periodic intervals
- Often uses an interdisciplinary approach
- Each group session includes:
 - Medical management by a licensed practitioner
 - Interactive patient education
 - Coaching and counseling through a facilitated discussion
- Simultaneously, patients share experiences and advice with one another and with the facilitators

(Eisenstat et al 2012)

Groups Have Been Used for Many Medical Conditions

- **Joseph Pratt was the first to use groups for tuberculosis patients in 1907 at MGH** (Pratt 1908)
- **Diabetes** (Naik 2011; Sanchez, 2011; Riley 2010; Tavieria 2010; Kirsh 2008; Deakin 2005; Culhane-Pera 2005; Clancy 2003; Trento 2001, 2002, 2004, 2005, 2010; Sadur 1999)
- **Metabolic syndrome** (Greer 2011), **hypertension, cardiac disease** (Bartley 2010; Yehle 2009; Masley 2001)
- **Asthma** (Wall-Hass 2012), **arthritis** (Shojania 2010), **chronic pain** (Gaynor, 2007)
- **Menopause** (Thacker 2005), **sleep disorders** (Ulman 2003), **stress** (Ulman 2000)
- **Chronic headaches** (Blumenfeld 2003) **and Parkinsons** (Dorsey 2011)
- **Geriatric patients** (Levine 2010; Scott 2004; Coleman 1999, 2001; Beck and Scott 1997)
- **Obstetric patients** (Ickovics 2003)

Impact of Groups:

- Health benefits of groups for medically ill:
 - Increased compliance and adaptation to illness
(Clancy 2007; Ulman 1993)
 - Decrease in symptoms (Sadur 1999; Trento 2001, 2002, 2004)
 - Decrease in office and emergency room visits and inpatient admissions (Sadur 1999; Coleman 2001; Beck 1997;)
 - Improved blood pressure, blood glucose levels and other health targets (Edelman et al, 2012; Burke 2011; Jaber 2006; Trento 2001, 2002, 2004; Wolf 2004)
- Improved access to care (Thompson 2000; Bronson 2004; Gutman 2004; Bowers 2009)
- Behavioral change (Burlingham, 2013; Wagner 2007)

What is the Evidence for Effectiveness of Group Visits?

Cochrane Collaboration Systematic Review 2005

Group based training for self-management strategies in people with type 2 diabetes mellitus

- Decreased HbA1c at 6m, 1yr, 2yr
- Lower fasting glucose at 1 yr
- Weight loss at 1 yr
- Lower systolic blood pressure at 6m
- Decreased diabetes Rx
- Increased diabetes knowledge at 1 yr

(Deakin 2008)

Effectiveness of Group Visits:

US systematic review 2012 (Edelman 2012)

Shared medical appointments for chronic medical conditions: a systematic review

- Examined 15 trials
 - 13 in diabetes
 - 2 for older adults with high utilization

Systematic Review of Trials in Diabetes

(Edelman 2012)

- HbA1c
- Cholesterol
- Blood pressure

- Emergency department visits*
- Hospitalizations

- Health-related quality of life



* Not significant

Systematic Review of Trials in Older Adults with High Utilization (Edelman 2012)

- Patient experience of care 
- Emergency department visits 
- Hospitalizations 
- Costs * 

* Not significant

Which Components of Group Visits Affect Outcome?

- Evidence too limited to permit analysis of effects based on components or intensity of group visits
- Limited evidence suggests that groups incorporating a behavioral component are more effective than those focused solely on information

Effects of Behavioral Component of Group Visit on Outcome

- RCT of modular behavioral-focus groups vs usual care groups (information-focus) for patients with rheumatoid arthritis
- Behavioral-focus group had better outcomes at 6 months
 - Pain, fatigue, functional ability, self-efficacy, exercise, perceived control
- and at 12 months
 - Pain, self-efficacy, perceived control

(Hammond A. Rheumatology 2008;47:1712)

How Long do Effects of Group Visits Last?

A 5-year randomized controlled study of learning, problem solving ability, and quality of life modifications in people with type 2 diabetes managed by group care. (Trento Diabetes Care 2004)

- RCT of group vs individual diabetes care in Italian hospital-based diabetes unit
- Results:
 - Diabetes knowledge and problem-solving improved from year 1 with group (worsened with individual care)
 - Quality of life improved from year 2 with group (not individual) care
 - Group: BMI decreased, HDL cholesterol increased over 5 yrs
HBA1c did not significantly increase (worsened with individual care)

Why Groups Work: The Physician's Perspective

- Increased face-to-face time with patients
- Can do more efficient patient education than one-on-one office visit
- Provides an integrated process to support behavioral change and identify psychosocial stressors
- Opportunity to learning from other disciplines
- Change in pace from typical office visits is refreshing

Medical Group Design

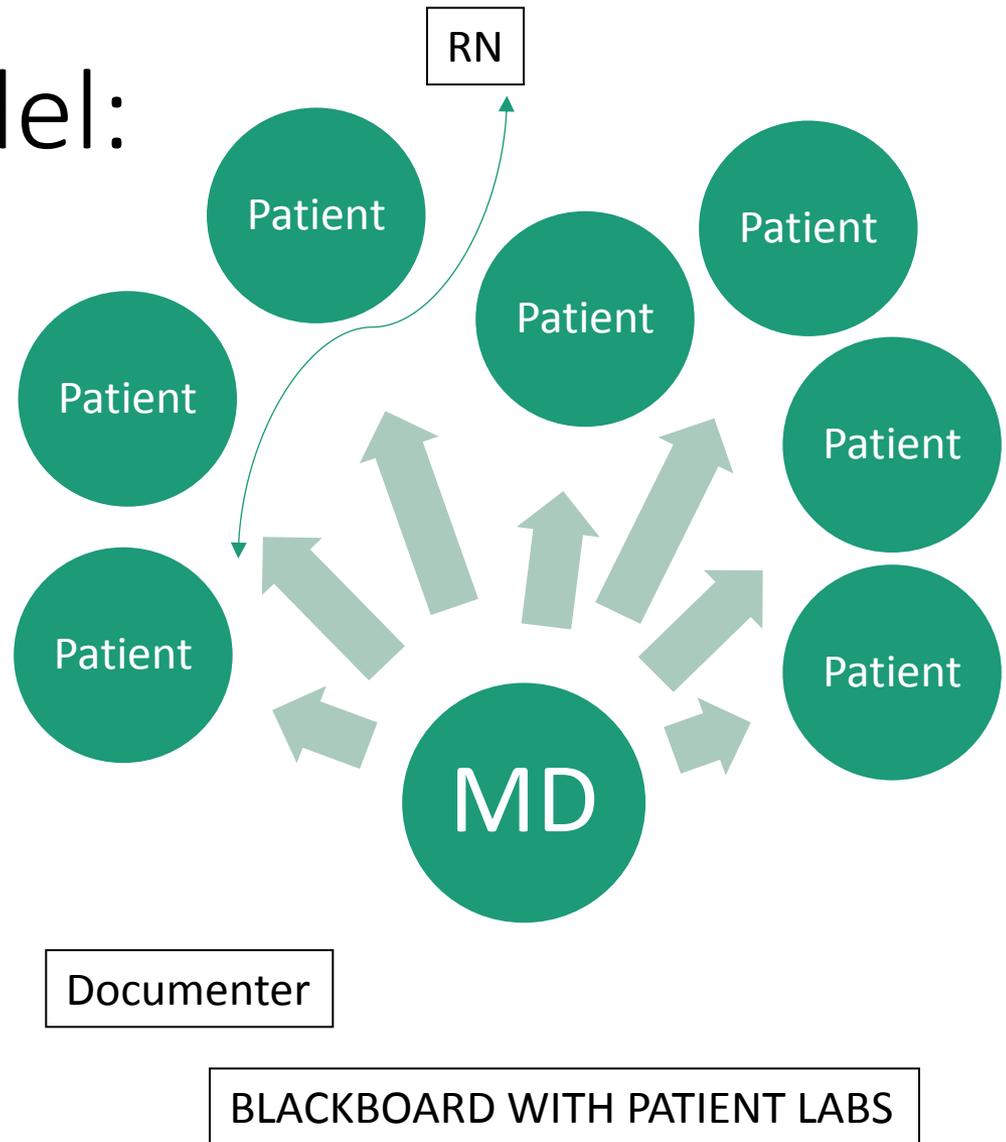
Mr. Smith Goes to Group

Mr Smith is s/p aortic valve replacement, with history of diabetes, coronary artery disease and atrial fibrillation. He is on coumadin, metformin, glypizide, lopressor and losartan and has not seen you for awhile. His wife reports that he “eats what he wants” and does not exercise. He recently retired and needs medical follow-up. Your front desk staff books him for the next group medical visit.

Noffsinger Model:

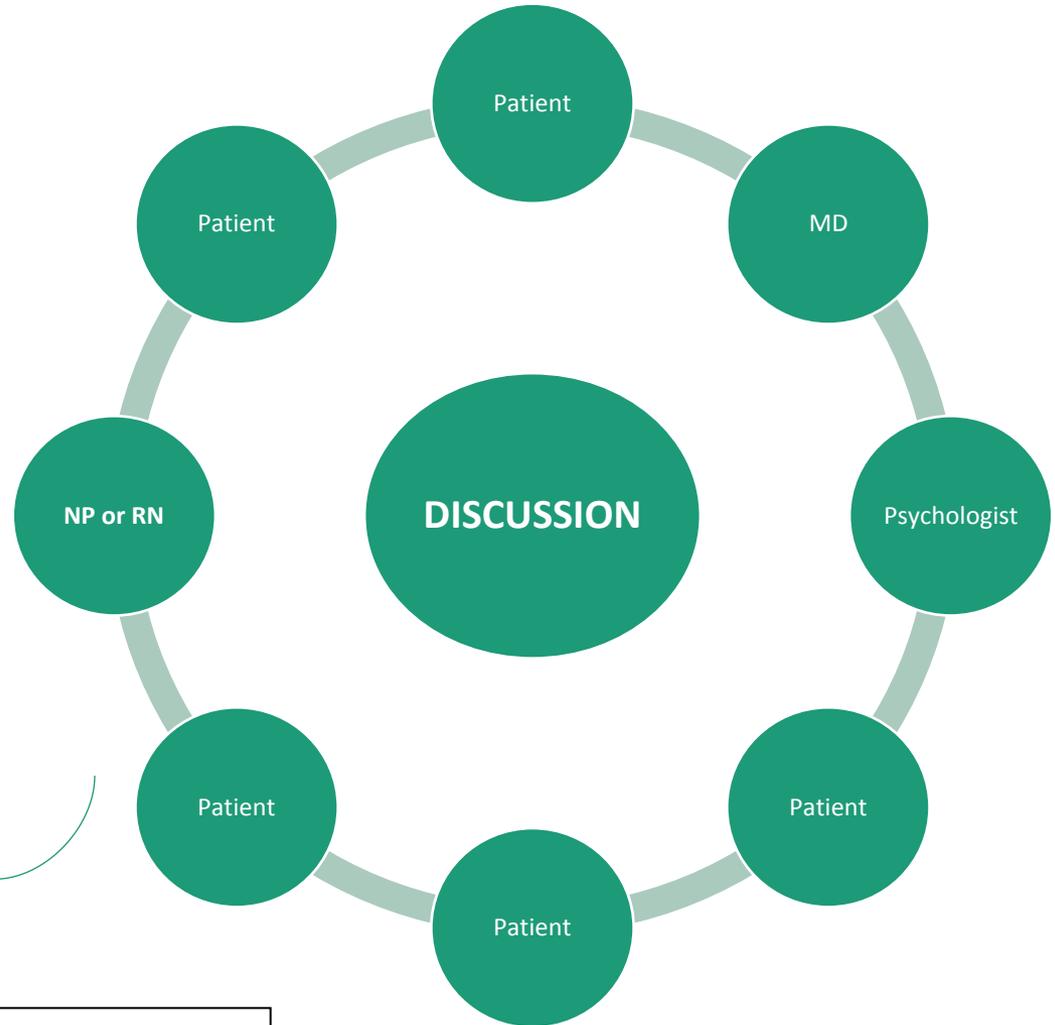
- RN or LPN (called a behaviorist or facilitator) coordinates the group for or with MD
- Administrative assistant is present for documentation
- MD addresses patient one by one, examining in the room and uses patient responses to start group discussion
- Usually MD or RN gives short educational presentation
- Recent labs are posted for all patients to see and are reviewed as part of the visit
- 16- 20 patients, over 90 minutes

(Noffsinger 2000, 2002, 2008, 2009)



Scott Model:

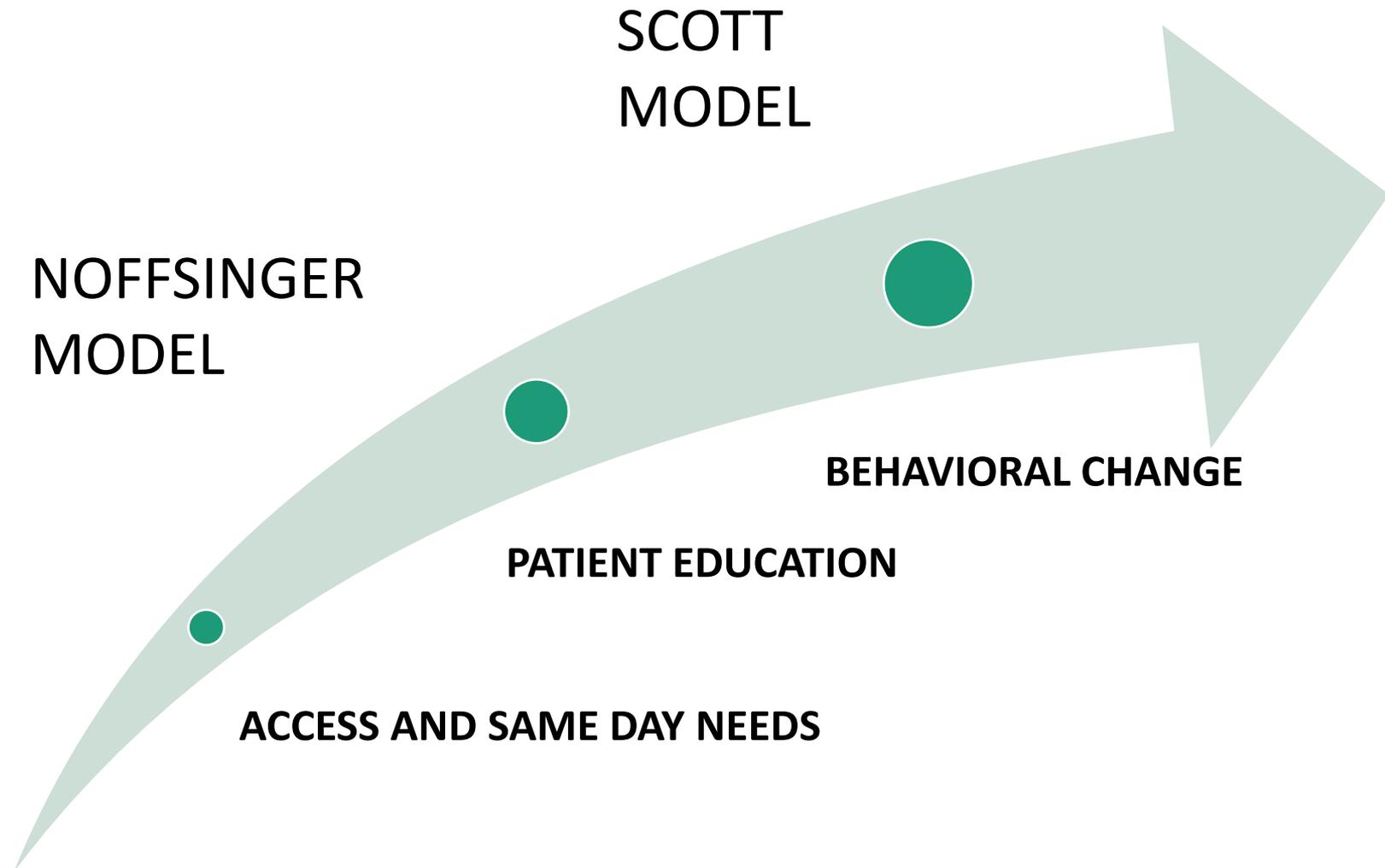
- Interdisciplinary team coordinates group together
- No documenter present
- Group discussion starts the session, and MD builds off of that
- Educational presentation by RN, NP or invited guest speaker
- Labs, medications and exam are done individually during session, but data is not displayed on blackboard
- Psychologist (or other behaviorist) facilitates interactive group discussion focused on behavioral change
- 6-10 patients, over 2-2.5 hours



(Scott 1996, 1998, 2004)

MD evaluation in or out of room

Most Medical Groups are a hybrid.
The focus depends on your goal:



Group Models differ:

- The components of groups vary by :
 - Goal of the group:
 - To increase *access*
 - To improve *patient education*
 - To promote *active behavioral change*
 - Nature of interaction with clinical team:
 - More directed
 - Open ended
 - Homogeneity of group members:
 - Type of medical condition(s) and burden of disease
 - Degree of life stress and support needed
 - The complexity of behavioral change

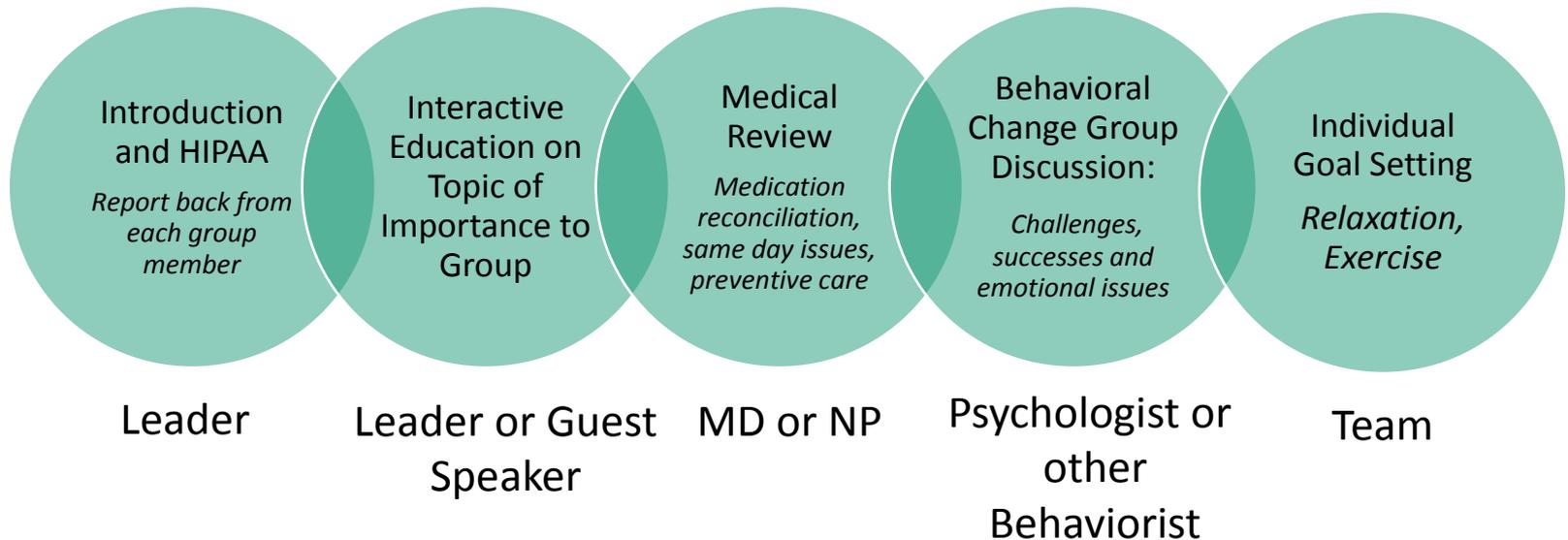
Other Differences Among Groups:

- Orientation and training of the leader or facilitator:
 - Active leader versus a facilitator
 - Behaviorist versus medical
 - Consistent versus variable leaders
- Mode of delivery of education material:
 - Didactic, open ended
 - Teaching behavioral techniques
- Attendance:
 - Open ended or time limited
 - Fixed membership or drop- in
 - Your panel or patients from the practice (or outside the practice)
 - Inclusion of family members

Sample Medical Group Design



8-16 patients for 90 minutes to 2.5 hours



Preparation for the Group

- Marketing of group
 - Engagement of referring physicians
 - Engagement of patients
- Review of record in advance
- Patients arrive:
 - Sign form re: confidentiality requirements
 - Pre-visit survey specific to condition
 - Assessment using standard screening instruments
 - Vital signs
- The target attendance is usually 8 to 16 patients per group session, depending on model

During the Group

- Introduction and explanation of format
- Education and interactive discussion on topic specific to medical condition, or of interest to the group
- Individual medical visits done in or out of the room as needed, with facilitated group discussion
 - Medical management may include review of symptoms, labs, preventive health screening, medical decision making, titration of medications
- Psychologist or behaviorist focus often includes mindfulness or relaxation training
- Goal setting for individual patients

Post Group

- Debrief by group leaders with one another
- Documentation and billing of visit
- Email follow-up to PCP as needed—report back to your PCPs because they are key source of referral
- Outreach to patients for next group

Sample Groups in Women's Health Associates, MGH

- Diabetes, metabolic syndrome, hypertension
 - Structure: 2.5 hours; Psychologist, MD and guest speakers (dietitian, exercise specialist) and includes teaching relaxation exercise
- Arthritis and joint pain, with Physical Therapy
 - Structure: 2 hours; MD, physical therapist, psychologist and includes movement and teaching relaxation exercise
- Sleep group
 - Structure: 2 hours; psychologist alone, includes teaching relaxation exercise

Observed Outcomes

- Improvement over 1 year of standard health targets (i.e., HbA1c and weight for those with diabetes)
- Increase patient engagement with self management of their medical condition, attributed to group support by participants and leaders (i.e, improved medication compliance for those with diabetes)
- Positive wellness coaching
- More time with clinicians
- No problems with confidentiality

Billing:

- **There is no nationally accepted standard for medical group visits**
- Medicare has disseminated general policy statements in support of reimbursement of group medical visits, but there is regional variation.
- Some insurers have policies for reimbursement of group visits

Common Billing Practice:

- Document clearly:
 - Emphasize the medical management component
 - Use medical E/M code 99213 (rarely 99214)
- If more than one clinician billing (i.e, a physician and psychologist) differentiate services provided to avoid duplicate billing
- Patient education is not directly reimbursed under current system, except in specific cases such as diabetes self management education (DSME) by a certified diabetes educator (CDE)

Billing Options for Group Visits

Visit Type	Billing Recommendation
Individual medical visit is included:	MEDICAL (MD/NP): Level 3 or 4 E/M visit depending on individual patient complexity (CPT Codes 99212-99215)
If psychologist, psychiatrist, Social worker or psychiatric nurse present:	CPT Code 96153- Health and Behavior Assessment/ Intervention group
If medical nutritional specialist (RD):	Some payers allow additional direct billing, CPT Code 97804
If diabetes self management education:	Medicare and some private payers pay for self management training in group; must be CDE accredited educator or practice (HCPCS code G0109): Diabetes self management training services (2 or more), per 30 minutes

- For Medicare and most private insurers, billing is based on extension of the individual medical visit (checking data collected, diagnosis, and answering individual patient questions)
- Do not bill based on time. Rely on complexity of diagnosis and your documentation
- Medicare states that "face to face E/M visit can be observed by other patients"
- Billed under a medical diagnosis. Most payers do not pay for obesity or overweight alone
- For Medicaid in some states: can bill for additional group education (CPT code 99078) in relation to certain chronic conditions such as diabetes, asthma
- Smoking and tobacco use cessation programs (99406 if 3-10 minutes; 99407 if > 10 minutes)

Why Groups Work From the Behavioral Perspective

Learning Group Facilitation Skills

Why Groups Work:

- People in groups are more suggestible and feel more effective than outside the group
- They experience contagion and intensification of affect that helps them make changes
- Groups decrease shame and isolation associated with having a medical condition
- Groups provide a healing community and validation

(Kleinberg, 2007)

Enhances the Clinician-Patient Relationship:

- Provides increased face-to-face time with patients
- Allows for more focused medical care and efficient patient education
- Provides an integrated process to support behavioral change and identify psychosocial stressors

Curative Factors in Groups for Medical Patients

- Instillation of hope
- Universality
- Imparting of information
- Altruism
- Imitative behavior

(Yalom, 2005)

Other Curative Factors:

- Insight
- Group cohesiveness
- Catharsis
- Existential factors
- Reduction of shame
- Reduction of social isolation

(Yalom, 2005)

Setting up the Group

- This is the most important part of offering a group
- The structure (framework) of the group including the goals, the target population, the planned interventions must be decided on and reflected in the advertisement of the group
- They must all hang together to make a coherent whole
- When the structure and expectations are not clear the group members become anxious, disappointed and angry

Present a Clear Framework for the Group

- Outline goals, describe how these goals will be met, set a clear description of a consistent time and place and length of group
- Predictability and continuity are key for creating a sense of safety and cohesion in a group. Safety is necessary for group members to participate. Cohesion is the glue of the group and has been found to be the best predictor of group satisfaction.

Present Clear Expectations

- Must outline what is expected of group participants and group leaders.
- Are the participants expected to come to each session?
- How will the time be spent?
- What will be the roles of the leader and group members?

Set Expectations for Behavior Change

- Set the stage for the expectation that the group participant will be actively involved in the process.
- Reinforce the concept that it is the patient's responsibility for making changes
- You can ask “What do you want to get out of this?”
“What will you do differently when you go home?”
“What may interfere with your making the changes that you want to make?”

Group Cohesion

- Create a sense of group cohesion by giving life and value to the group
- Talk about the group in positive terms as if it were a living entity
- Help members to feel that participation in the group is valued.
- This can be done even for a one-time group
- This is the glue that holds together the bones or structure of the group

First Phase of the Group Development

- At first, point out similarities and play down differences. This enhances group cohesion, a sense of belonging and safety
- Create a culture of tolerance and respect
- After the initial stage when cohesion is developed, the leader then can acknowledge and welcome differences.

Group Dynamics to Watch For

- Pay attention to those members who do not talk or who are different from the others in group
- Make efforts to bring them into the group
- Watch for interactions that might lead to scapegoating and stop the process by bringing the potential scapegoat into the group
- Mention similarities among group members and express respect for differences in the group members

Group Dynamics to Watch For

- Prevention of scapegoating or lack of inclusion of outliers is very important to the protection of all group members and to the success of the group.
- The leader needs to be vigilant in executing interventions that decrease these destructive group dynamics.

Countertransference

- Countertransference is the feelings engendered in the group leader by the participant.
- These can be feelings that all group leaders would feel or can be ideosyncratic reactions of a particular leader
- Both types are normal and to be expected, welcomed and used as information
- The leader needs to be aware of the feelings that are stirred up and find a way to work with them

In Summary

- Goal is to create a group situation in which members feel bonded together as valued members of the group, safe, and clear on goals and expectations for themselves and others so they can relax and concentrate on the agenda and profit from the curative forces taking place in the group

Challenges to Groups:

- Lack of physical space
- RECRUITMENT: The more disease-specific the groups, the more challenging to keep the groups filled
- Time commitment for patients
- Scheduling complexity for multiple group leaders
- Variation in needs of the group members
- Providers need to adapt to a different way of relating to patients, and to other providers
- Leaders benefit from training in managing the group process

Other Challenges to Group

- Patient inertia or discomfort with group
- Patients dropping out, and then back in
- Physician personal discomfort with group, “I can’t imagine sharing my feelings in a group setting”
- Co-management by multiple providers
- Coaching to retain interaction among patients

Facilitation Skills

- Boundaries and cohesion
- General techniques for stress reduction
- Psychosocial context
- Leaders tasks
- Norms of group process
- Management techniques during the group process

Summary

- Groups work, and complement the individual medical visit in the patient centered medical home
- You can increase the effectiveness of group:
 - Have clear goals and purpose in mind when designing a group
 - Engage leaders who are comfortable with group process and team care and are good facilitators
 - Develop a marketing strategy to sustain attendance
 - Identify space and provide complementary snacks, meals or parking
 - Organize the group around education, medical review and behavior change
 - Improve facilitation skills that promote positive patient interaction and discussion in group
 - Track your billing
 - Have system in place for evaluating effectiveness of group

Reference

- Eisenstat S, Siegel AL, Carlson K, Ulman K. *Putting Group Visits into Practice. A Practical Overview to Preparation, Implementation, and Maintenance of Group Visits at Massachusetts General Hospital*. Boston, MA: The John D. Stoeckle Center for Primary Care Innovation, Jan 2012.