



Diabetes Group Visit Project Replication Manual

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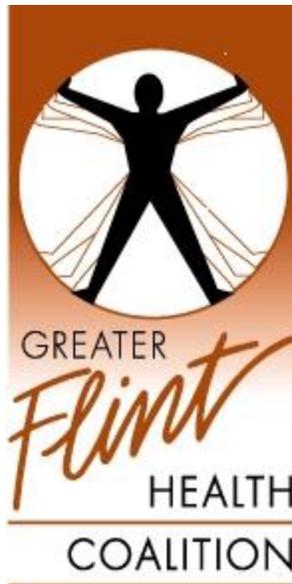
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This document provides a comprehensive overview of Diabetes Group Visits, how to implement them into the clinical setting, and resources available to clinicians who are beginning to administer diabetes group visits in practices.

For more information on the Greater Flint Health Coalition, diabetes group visits, or on how to acquire additional copies of this manual, please contact:

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Greater Flint Health Coalition Diabetes Group Visit Project Replication Manual

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Chapter 1

Diabetes Group Visits: A Conceptual Overview

OVERVIEW OF DIABETES GROUP VISITS

What is a Diabetes Group Visit?

A Diabetes Group Visit (DGV) is a customized, extended, medical appointment with a patient's own doctor and sometimes, a behavioral health professional. These physician-specific appointments are held in a group setting that is composed of other patients with similar medical issues (in this case diabetes) from his/her own roster of patients.

Patients best served by DGVs are those who have diabetes and require regular follow-up visits. The monitoring and support components of DGVs also make an excellent vehicle for patients with a new diagnosis or recently prescribed medication. In addition, patients wanting to know their physician better or to speak with their physician about non-emergency issues are good candidates. The optimal group size is approximately 8-12 patients.

DGVs provide a supportive, interactive environment for both patients and physicians, enabling a flow of information to occur over an extended period of time and in a much more open setting than what typically occurs during the conventional, brief medical appointment. DGVs typically last approximately 2 hours and exams (e.g. eye, foot, etc.) can occur during the visit or in private depending on the comfort level of the patient. This is a medical appointment and patients should schedule the visit as such so charts and labs may be retrieved for use during the appointment.

Given the length of time allotted to conduct group visits, there is ample time to discuss general education topics that could lead to improvements in the patients' understanding of diabetes and potentially improve self-management. These topics include:

- General information about diabetes;
- Goals and targets;
- Diabetes health maintenance;
- Medications and how they work;
- Foot care; and
- General nutrition/reading labels.

What is the rationale for establishing Diabetes Group Visits?

It is widely acknowledged that the current medical environment has placed tremendous pressure on physicians and institutions to reduce the cost of care while improving patient outcomes. Because of the demand for decreased utilization, many patients, particularly those with chronic illnesses (like diabetes) and/or challenging psychosocial issues, find it increasingly difficult to gain access to their physicians and to spend

adequate time with them when they do get access. This limitation leads to an inability to effectively manage their diabetes in some cases.

Diabetes Group Visits alleviate this issue by giving patients more time with their physicians and by giving physicians more insight into the challenges their patients face in managing their diabetes. Greater access provided by the group setting results in a better use of time in the treatment of this chronic condition. In fact, studies conducted on this model of care (i.e. group medical appointments) have indicated increased satisfaction for both the patient and physician while simultaneously improving clinical outcomes and reducing the cost of care.

The format of the group visits also allows for a significant amount of patient interaction, allowing them to share not only their own challenges with each other, but also what they have found helpful in dealing with those challenges. The setting promotes best-practice sharing among patients, encouragement by others living with the same condition, and in some cases, friendly competition between patients over diabetes monitoring test values, such as HbA1c levels. This interaction also provides more opportunity for patients to ask questions that may not have occurred to them during a conventional appointment.

Who benefits from Diabetes Group Visits?

Diabetes Group Visits offer substantial benefits to virtually everyone involved in the delivery and receipt of care. For example:

- Patients get more time with their physician along with extended access to a broad range of medical services in a supportive group setting.
- Patients get more guidance with lifestyle changes because they are able to meet with their physician more frequently. This can lead to better outcomes relative to diabetes management.
- Physicians are better able to manage multiple patients through extended, in-depth interaction which provides a more satisfying level of medical care for patient and physician.
- Physician hospital organizations and medical groups will see increases in physician productivity, patient access, efficiency, and quality of care, all while utilizing existing resources.

What is the physician's role in Diabetes Group Visits?

The physician's role in group visits is vital to the adoption, implementation, and ultimate success of Diabetes Group Visits. The physician's responsibilities include:

- Marketing and promoting the concept of DGVs to both patients and staff;
- Encouraging patients to make their next appointment a group visit;
- Physicians and office staff will be responsible to keep group visits full;
- Physicians need to develop a relationship with a Behaviorist as they will, at times, co-facilitate a group. The Behaviorist should be allowed to observe the office practice prior to participating in a DGV;
- Arrive on time;
- Be open, flexible, and most importantly, willing to learn new ways of doing things in treating patients.

GR-8D21 DGV.overview.long.080609cn

KEY PRINCIPLES OF DIABETES GROUP VISITS

Census/Production

BENEFITS

- Gives the patient the opportunity to be seen earlier than if they scheduled an individual appointment;
- Gives the physician an opportunity to talk about things once and reach a number of people;
- Physician can see more patients per unit of time without working harder;
- Patients can be seen more often if needed in order to respond to treatment;
- Patients learn more from other patients.

GROUP VISITS ARE SUCCESSFUL IF:

1. There is active recruitment of patient participants by the physician.
 - The physician encourages patients to make his or her next appointment in a group.
 - The physician uses statements such as:
 - "I want you to attend one of my diabetes group visits for your next appointment."
 - "I am excited about this opportunity and would appreciate your feedback."
 - "I would like my patients to try a group visit once to see if this may work for them."
 - "Many patients enjoy the group visits and benefit from them too."
 - Physicians and staff remain open to new ideas and concepts.
2. There is purposeful scheduling:
 - Schedulers offer group visits first to patients who may benefit from them in lieu of the standard appointment.
 - Letters inviting patients to participate in group visits are provided when a patient checks in.
 - Physicians, medical assistants, and schedulers ensure that certain patients leave with a flyer about group visits.
 - The physician escorts willing patients to the scheduler and asks that the patient's next appointment be a group visit.

Enhanced Patient and Physician Experience

Patients' experience is enhanced:

- "They don't feel so alone." This is heard numerous times, both, during the group visits and after.
- They learn from other patient's health problems and experience, even though the situations appear to be very different.
- They feel like they have had 90 minutes with their physician even though their medical issues may have only been specifically addressed for 5-10 minutes.
- They are able to both give and receive help.
- There is both laughter and tears, both of which are more therapeutic in a group.
- They experience hope.
- They don't have to worry about getting a timely appointment, as this is regularly available.
- They go away with hope for living a higher quality of life.

Physicians' experience is enhanced:

- Provides the opportunity to incorporate creativity, care and compassion into the group visit.
- The workload is reduced as physician and staff learn to use the other patients in the group to teach patients.
- It's an opportunity to sit for 90 minutes with very few, if any interruptions.
- Opens up schedule and reduces access problems.
- Is wonderful for problem or time-consuming patients.
- Is fun!
- Patients who have attended group visits are often easier to deal with, in comparison to those that have not, as both the physician and patient are more relaxed.
- Physicians can use other patients as models of good adherence to treatment protocol which reinforces good behavior and serves as an excellent education tool for other patients.

THERAPEUTIC FACTORS OF DIABETES GROUP VISITS

As discerned from The Theory and Practice of Group Psychotherapy by Yalom

Instillation of Hope

- Hope is enhanced/increased as patients see other patients in the group cope effectively with similar problems.
- Research shows that having hope correlates with positive therapeutic outcomes.

Universality

- Many patients believe that their problem is unique, which is often heightened by social isolation. They tend to have less hope for the possibility of positive outcomes. When they hear other patients discuss similar problems, patients feel less isolated, more understood, and have a general feeling of everyone being “all on the same boat.”
- Despite the complexity of human problems, there is no human deed or thought that is fully outside the experience of other people. Understanding that there are others out there that also have problems often reduces the level of anxiety and urgency patients may feel about their health problems.

Imparting Information

- In groups patients receive education from a variety of sources. Often the experience of another patient provides the best source of education for the patient.
- Excellent opportunity to teach patients about the disease process and lifestyle management without restrictions on time.
- Able to provide information to many at once instead of repeating the same information multiple times a day.
- People are uncomfortable with uncertainty. Groups are an excellent opportunity for patients to ask questions, and through education they often perceive that they have gained a measure of control in their lives.
- As we know, anxiety stemming from uncertainty often creates more havoc than the primary disease.

Altruism

- Patients receive through giving.
- Often persons with chronic conditions feel a deep sense of having nothing to offer others. Finding out that they were able to help another person in the group with information, support, etc. is refreshing and boosts their sense of self-worth.
- Patients will often listen and absorb observations from another patient more readily than from the physician or behaviorist.

The Corrective Recapitulation of the Primarily Family Group

- Observing and getting the opportunity to participate in healthy interactions can often serve as a corrective healing experience for the patient.

Development of Socializing Techniques

- The groups offer the opportunity for accurate feedback for the patient and also gives the direction in helping that patient make changes to better function in the world.
- Groups are a powerful modeling force for healthy behaviors. Examples of this are for patients to learn to resolve conflict, to experience giving and receiving accurate empathy, to be less judgmental, and to be able to better understand areas in which they could benefit from changes.

Imitative Behavior

- In groups patients get the opportunity to observe behaviors that receive positive reinforcement and other behavior that are discouraged. Groups are an opportunity to practice new behaviors and responses to situations that occur in their lives.

Interpersonal Learning

- Change can be an emotional and corrective experience. Group members responding spontaneously and with honesty help "hold up the mirror" for other group members.
- Groups help keep patients focused on the here and now, reducing time spent in lamenting over lost ability and moving them toward active problem solving.

Group Cohesiveness

- Patients quickly develop group cohesiveness or a sense of solidarity to varying degrees in each group visit.
- Cohesiveness helps patients be more accepting, and more understanding of each other.
- Patients feel safe being vulnerable.

Catharsis

- Purging of feelings often opens up the patients to be willing to look at their current unhealthy behavior and make changes to healthier behavior. In the group visit, patients are more likely to tell the truth and take responsibility to be accountable to the other group members.

Existential Factors

The following factors are often illustrated in group visits:

- Recognizing that life is at times unfair and unjust.
- Recognizing that ultimately there is no escape from some of life's pain and from death.
- Recognizing that no matter how close I get to other people, I must still face life alone.
- Facing the basic issues of my life and death and as a result living life more honestly, being less caught up in trivialities.
- Learning that I must take the ultimate responsibility for the way I live my life no matter how much guidance and support I get from others.

Chapter 2

Literature Review on the Effectiveness of Group Visits

LITERATURE REVIEW

Wagner EH, Grothaus LC, Sandhu N, Galvin MS, Artz K, Coleman, EA

Chronic care clinics for diabetes in primary care: a system-wide randomized trial.

Diabetes Care April 2001 vol. 24 no. 4 695-700

OBJECTIVE—To evaluate the impact of primary care group visits (chronic care clinics) on the process and outcome of care for diabetic patients.

RESEARCH DESIGN AND METHODS—We evaluated the intervention in primary care practices randomized to intervention and control groups in a large-staff model health maintenance organization (HMO). Patients included diabetic patients > or = 30 years of age in each participating primary care practice, selected at random from an automated diabetes registry. Primary care practices were randomized within clinics to either a chronic care clinic (intervention) group or a usual care (control) group. The intervention group conducted periodic one-half day chronic care clinics for groups of approximately 8 diabetic patients in their respective doctor's practice. Chronic care clinics consisted of standardized assessments; visits with the primary care physician, nurse and clinical pharmacists; and a group education/peer support meeting. We collected self-report questionnaires from patients and data from administrative systems. The questionnaires were mailed, and telephoned interviews were conducted for nonrespondents, at baseline and at 12 and 24 months; we queried the process of care received, the satisfaction with care, and the health status of each patient. Serum cholesterol and HbA1c levels and health care use and cost data was collected from HMO administrative systems.

RESULTS—In an intention-to-treat analysis at 24 months, the intervention group had received significantly more recommended preventive procedures and helpful patient education. Of five primary health status indicators examine, two (SF-36 general health and bed disability days) were significantly better in the intervention group. Compared with control patients, intervention patients had slightly more primary care visits, but significantly fewer specialty and emergency room visits. Among intervention participants, we found consistently positive associations between the number of chronic care clinics attended and a number of outcomes, including patient satisfaction and HbA1c levels.

CONCLUSIONS—Periodic primary care sessions organized to meet the complex needs of diabetic patients improved the process of diabetics care and were associated with better outcomes.

Paul Bray, MA, Melissa Roupe, MSN, RN, Sandra Young, MSN, RN, Jolynn Harrell, BSN, Doyle M. Cummings, PharmD, FCP, FCCP, Lauren M. Whetstone, PhD

Feasibility and Effectiveness of System Redesign for Diabetes Care Management in Rural Areas

The Diabetes Educator 2005 vol. 31 no. 5 712-718

PURPOSE—Redesigning the system of care for the management of patients with type 2 diabetes mellitus has not been well studied in rural communities with a significant minority population and limited healthcare resources. This study assesses the feasibility and potential for cost-effectiveness of restructuring care in rural fee-for-services practices for predominantly minority patients with diabetes mellitus.

METHODS—This was a feasibility study of implementing case management, group visits, and electronic registry in 5 solo or small group primary care practices in rural North Carolina. The subjects were 314 patients with type 2 diabetes mellitus (mean age = 61 years; 72% African American; 54% female). An advanced practice nurse visited each practice weekly for 12 months, provided intensive diabetes case management, and facilitated a 4-session group visit educational program. An electronic diabetes registry and visit reminder systems were implemented.

RESULTS—There was an improvement in the percentage of patients achieving diabetes management goals and an improvement in productivity and billable encounters. The percentage of patients with a documented self-management goal increased from 0% to 42%, a currently documented lipid panel from 55% to 76%, currently documented aspirin use from 25% to 37%, and currently documented foot examination from 12% to 54%. The average daily encounter rate improved from 20.17 to 31.55 on intervention days.

CONCLUSIONS—A redesigned care delivery system that uses case management with structured group visits and an electronic registry can be successfully incorporated into rural primary care practices and appears to significantly improve both care processes and practice productivity.

John C. Scott, MD, Douglas A. Conner, PhD, Ingrid Venohr, RN, PhD, Glenn Gade, MD, Marlene McKenzie, RN, Andrew M. Kramer, MD, Lucinda Bryant, PhD, Arne Beck, PhD

Effectiveness of a Group Outpatient Visit Model for Chronically Ill Older Health Maintenance Organization Members: A 2-Year Randomized Trial of the Cooperative Health Care Clinic

Journal of the American Geriatric Society September 2004 vol. 52 no. 9 1463-1470

OBJECTIVE—To compare the effectiveness of Cooperative Health Care Clinic ((CHCC) group outpatient model for chronically ill, older health maintenance organization (HMO) patients) with usual care.

DESIGN—Two-year, randomized, controlled trial conducted with recruitment from February 1995 through July of 1996.

SETTING—Nonprofit group model HMO.

PARTICIPANTS—Two hundred ninety-four adults (145 intervention and 149 usual care), aged 60 and older (mean age 74.1) with 11 or more outpatient visits in the prior 18 months, one or more self-reported chronic conditions, and expressed interest in participating in a group clinic.

INTERVENTION—Monthly group meetings held by patients' primary care physicians.

MEASUREMENT—Differences in clinic visits, inpatient admissions, emergency room visits, hospital outpatient services, professional services, home health, and skilled nursing facility admissions; measures of patient satisfaction, quality of life, self-efficacy, and activities of daily living (ADLs).

RESULTS—Outpatient, pharmacy services, home health, and skilled nursing facility use did not differ between groups, but CHCC patients had fewer hospital admissions ($p=.002$), emergency visits ($P=.008$), and professional services ($P=.005$). CHCC patients' costs were \$41.80 per member per month less than those of control patients. CHCC patients reported higher satisfaction with their primary care physician ($P=.022$), better quality of life ($P=.002$), and greater self-efficacy ($P=.03$). Health status and ADLs did not differ between groups.

CONCLUSION—The CHCC model resulted in fewer hospitalizations and emergency visits, increased patient satisfaction, and self-efficacy, but no effect on outpatient use, health, or functional status.

Edward H. Wagner, MD, MPH, Nirmala Sandhu, MPH, Katherine M. Newton, PhD, David K. McCulloch, MD, Scott D. Ramsey, MD, PhD, Louis C. Grothaus, MS

Effect of Improved Glycemic Control on Health Care Costs and Utilization

Journal of the American Medical Association January 10, 2001 vol. 285 no. 2 182-189

CONTEXT—Because of the additional costs associated with improve diabetes management, there is interest in whether improved glycemic control leads to reductions in health care costs, and, if so, when such cost savings occur.

OBJECTIVE—To determine whether sustained improvements in hemoglobin A1c (HbA1c) levels among diabetic patients are followed by reductions in health care utilization and costs.

DESIGN AND SETTING—Historical cohort study conducted in 1995-1997 in a staff-model health maintenance organization (HMO) in western Washington State.

PARTICIPANTS—All diabetic patients aged 18 years or older who were continuously enrolled between January 1992 and March 1996 and had HbA1c measured at least once per year in 1992-1994 (n=4744). Patients whose HbA1c decreased 1% or more between 1992 and 1993 and sustained the decline through 1994 were considered to be improved (n=732). All others were classified as unimproved (n=4012).

MAIN OUTCOME MEASURES—Total health care costs, percentage hospitalized, and number of primary care and specialty visits among the improved vs unimproved cohorts in 1992-1997

RESULTS—Diabetic patients whose HbA1c measurements improved were similar demographically to those whose levels did not improve but had higher baseline HbA1c measurements (10.0% vs 7.7%; P<.001). Mean total health care costs were \$685 to \$950 less each year in the improved cohort for 1994 (P=.09), 1995 (P=.003), 1996 (P=.002), AND 1997 (p=.01). Cost savings in the improved cohort were statistically significant only among those with the highest baseline HbA1c levels (≥10%) for these years but appeared to be unaffected by presence of complications at baseline. Beginning in the year following improvement (1994), utilization was consistently lower in the improved cohort, reaching statistical significance for primary care visits in 1994 (P=.001), 1995 (P<.001), 1996 (P=.005), and 1997 (P=.004) and for specialty visits in 1997 (P=.02). Differences in hospitalization rates were not statistically significant in any year.

CONCLUSION—Our data suggest that a sustained reduction in HbA1c level among adult diabetic patients is associated with significant cost savings within 1 to 2 years of improvement.

Raja Jaber, MD, Amy Braksmajer, MPH, Jeffrey S. Trilling, MD

Group Visits: A Qualitative Review of Current Research

Journal of the American Board of Family Medicine May-June 2006 vol. 19 no. 3

PURPOSE—The group visit model has emerged as one possible solution to problems posed by the limitations of current structures of care and the demands of a growing chronic illness load. In this article, we summarize current group visit research and develop suggestions for furthering this care model.

METHODS—An electronic review of all group visit articles published from the years 1974 to 2004 was conducted via the PubMed and the MedLine databases. Reference sections of articles thus obtained were mined for additional citations. Articles were excluded if: (1) they were not research studies (ie, purely descriptive, with no evaluative component); or (2) the group visit intervention was subsumed under larger primary or hospital-based interventions.

RESULTS—Although the heterogeneity of the studies presented renders the assessment of this care model problematic, there is sufficient data to support the effectiveness of group visits in improving patient and physician satisfaction, quality of care, quality of life, and in decreasing emergency department and specialist visits.

CONCLUSIONS—Group visits are a promising approach to chronic care management for the motivated patient. Future research may benefit, however, from abandoning old nomenclatures and clearly defining the structure, processes of care, content of visits, and appropriate outcome measure.

Arne Beck, PhD, John Scott, MD, Patrick Williams, MD, Barbara Robertson, PhD, Deborah Jackson, RN, Glenn Gade, MD, Pamela Cowan

A Randomized Trial of Group Outpatient Visits for Chronically Ill Older HMO Members: The Cooperative Health Care Clinic

Journal of the American Geriatric Society May 1997 vol. 45 no. 5

OBJECTIVE—To compare the impact of group outpatient visits to traditional “physician-patient dyad” care among older chronically ill HMO members on health services utilization and cost, self-reported health status, and patient and physician satisfaction.

DESIGN—A 1-year randomized trial.

SETTING—A group model HMO in the Denver Metropolitan area.

PARTICIPANTS—Three hundred twenty-one members aged 65 and older, randomized to a group visit intervention (n=160) or to usual care (n=161).

INTERVENTION—Patients with high health services utilization and one or more chronic conditions had monthly group visits with their primary care physician and nurse. Visits included health education, prevention measure, opportunities for socialization, mutual support, and for one-to-one consultations with their physician, where necessary.

MEASUREMENTS—Health services utilization and associated cost, health status, and patient and physician satisfaction.

RESULTS—Outcome measures obtained after a 1-year follow-up period showed that group participants had fewer emergency room visits (P=.009), visits to subspecialists (P=.028), and repeat hospital admissions per patient (P=.051). Group participants made more visits (P=.021) and calls (P=.0380 to nurses than control group patients and fewer calls to physicians (P=.019). In addition, a greater percentage of group participants received influenza and pneumonia vaccinations (P<.001). Group participants had greater overall satisfaction with care (P=.019), and participating physicians reported higher levels of satisfaction with the groups than with individual care. No differences were observed between groups on self-reported health and functional status. Cost of care per member per month was \$14.79 less for the group participants.

CONCLUSION—Group visits for chronically ill patients reduce repeat hospital admissions and emergency care use, reduce cost of care, deliver certain preventive services more effectively, and increase patient and physician satisfaction.

Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, Watson R, Swain BE, Selby JV, Javorski WC.

Diabetes management in a health maintenance organization.

Department of Medicine, Kaiser Permanente Medical Care Program, Northern California, Pleasanton 94588, USA.

OBJECTIVE: To evaluate the effectiveness of a cluster visit model led by a diabetes nurse educator for delivering outpatient care management to adult patients with poorly controlled diabetes. RESEARCH

DESIGN AND METHODS: This study involved a randomized controlled trial among patients of Kaiser Permanente's Pleasanton, CA, center who were aged 16-75 years and had either poor glycemic control (HbA1c > 8.5%) or no HbA1c test performed during the previous year. Intervention subjects received multidisciplinary outpatient diabetes care management delivered by a diabetes nurse educator, a psychologist, a nutritionist, and a pharmacist in cluster visit settings of 10-18 patients/month for 6 months. Outcomes included change (from baseline) in HbA1c levels; self-reported changes in self-care practices, self-efficacy, and satisfaction; and utilization of inpatient and outpatient health care.

RESULTS: After the intervention, HbA1c levels declined by 1.3% in the intervention subjects versus 0.2% in the control subjects (P < 0.0001). Several self-care practices and several measures of self-efficacy improved significantly in the intervention group. Satisfaction with the program was high. Both hospital (P = 0.04) and outpatient (P < 0.01) utilization were significantly lower for intervention subjects after the program.

CONCLUSIONS: A 6-month cluster visit group model of care for adults with diabetes improved glycemic control, self-efficacy, and patient satisfaction and resulted in a reduction in health care utilization after the program.

AL Peters, MB Davidson

Application of a diabetes managed care program. The feasibility of using nurses and a computer system to provide effective care.

Diabetes care, Vol. 21, No. 7. (July 1998), pp. 1037-1043.

OBJECTIVE: Treatment of patients with diabetes often falls short of recommended process and outcome guidelines. To improve the quality of the provided diabetes care, a program (the Comprehensive Diabetes Care Service [CDCS]) using a computerizing tracking and recall system in conjunction with nurses following protocols was implemented in a managed care setting. The impact of this program was studied and compared to the care provided to patients in another managed care setting. **RESEARCH DESIGN AND**

METHODS: Patients followed in the CDCS who completed a diabetes education course were compared with patients followed in a group model health maintenance organization (GMH) who also completed a diabetes education course. CDCS patients received routine care in the program. GMH patients came to the CDCS yearly to have a diabetes evaluation. A chart review was also performed on their GMH outpatient records.

RESULTS: Initial HbA1c levels were higher in the CDCS group than in the GMH group (median of 11.9 vs. 10.0%). In the CDCS patients, HbA1c levels not only fell significantly but were also significantly lower ($P < 0.05$) than in the GMH patients during the 2nd and 3rd year of follow-up care. There were no significant changes in HbA1c levels in the GMH patients. When CDCS patients were divided into compliant and noncompliant patients, the median HbA1c levels in compliant patients was 8.2%, compared with 11.5% in the noncompliant group. The CDCS patients who needed treatment for hypercholesterolemia were more likely to have a lowering of their cholesterol levels than the GMH patients. All process measures, such as yearly measurement of HbA1c levels, lipid levels, and foot and retinal exams, occurred much more frequently in the CDCS patients.

CONCLUSIONS: The system developed and implemented for managing diabetes improved both outcome and process measures. The comparison group, followed at another managed care setting, received the care consistent with the average (suboptimal) quality of care provided to patients with diabetes in the U.S. Therefore, by using innovative systems of management, the treatment of patients with diabetes can be greatly improved.

Renders CM, Valk GD, Griffin S, Wagner EH, Eijk JT, Assendelft WJ.

Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings.

Cochrane Database Syst Rev. 2001;(1):CD001481

BACKGROUND: Diabetes is a common chronic disease that is increasingly managed in primary care. Different systems have been proposed to manage diabetes care.

OBJECTIVES: To assess the effects of different interventions, targeted at health professionals or the structure in which they deliver care, on the management of patients with diabetes in primary care, outpatient and community settings.

SEARCH STRATEGY: We searched the Cochrane Effective Practice and Organisation of Care Group specialised register, the Cochrane Controlled Trials Register (Issue 4 1999), MEDLINE (1966-1999), EMBASE (1980-1999), Cinahl (1982-1999), and reference lists of articles.

SELECTION CRITERIA: Randomised trials (RCTs), controlled clinical trials (CCTs), controlled before and after studies (CBAs) and interrupted time series (ITS) analyses of professional, financial and organisational strategies aimed at improving care for people with Type 1 or Type 2 diabetes. The participants were health care professionals, including physicians, nurses and pharmacists. The outcomes included objectively measured health professional performance or patient outcomes, and self-report measures with known validity and reliability.

DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed study quality.

MAIN RESULTS: Forty-one studies were included involving more than 200 practices and 48,000 patients. Twenty-seven studies were RCTs, 12 were CBAs, and two were ITS. The studies were heterogeneous in terms of interventions, participants, settings and outcomes. The methodological quality of the studies was often poor. In all studies the intervention strategy was multifaceted. In 12 studies the interventions were targeted at health professionals, in nine they were targeted at the organization of care, and 20 studies targeted both. In 15 studies patient education was added to the professional and organizational interventions. A combination of professional interventions improved process outcomes. The effect on patient outcomes remained less clear as these were rarely assessed. Arrangements for follow-up (organizational intervention) also showed a favorable effect on process outcomes. Multiple interventions in which patient education was added or in which the role of the nurse was enhanced also reported favorable effects on patients' health outcomes.

REVIEWER'S CONCLUSIONS: Multifaceted professional interventions can enhance the performance of health professionals in managing patients with diabetes. Organizational interventions that improve regular prompted recall and review of patients (central computerized tracking systems or nurses who regularly contact the patient) can also improve diabetes management. The addition of patient-oriented interventions can lead to improved patient health outcomes. Nurses can play an important role in patient-oriented interventions, through patient education or facilitating adherence to treatment.

Aubert RE, Herman WH, Waters J, Moore W, Sutton D, Peterson BL, Bailey CM, Koplan JP.

Nurse case management to improve glycemic control in diabetic patients in a health maintenance organization. A randomized, controlled trial.

Prudential Center for Health Care Research, Atlanta, Georgia 30339, USA.

BACKGROUND: Control of hyperglycemia delays or prevents complications of diabetes, but many persons with diabetes do not achieve optimal control. **OBJECTIVE:** To compare diabetes control in patients receiving nurse case management and patients receiving usual care. **DESIGN:** Randomized, controlled trial.

SETTING: Primary care clinics in a group-model health maintenance organization (HMO).

PATIENTS: 17 patients with type 1 diabetes mellitus and 121 patients with type 2 diabetes mellitus.

INTERVENTION: The nurse case manager followed written management algorithms under the direction of a family physician and an endocrinologist. Changes in therapy were communicated to primary care physicians. All patients received ongoing care through their primary care physicians.

MEASUREMENTS: The primary outcome, hemoglobin A1c (HbA1c) value, was measured at baseline and at 12 months. Fasting blood glucose levels, medication type and dose, body weight, blood pressure, lipid levels, patient-perceived health status, episodes of severe hypoglycemia, and emergency department and hospital admissions were also assessed.

RESULTS: 72% of patients completed follow-up. Patients in the nurse case management group had mean decreases of 1.7 percentage points in HbA1c values and 43 mg/dL (2.38 mmol/L) in fasting glucose levels; patients in the usual care group had decreases of 0.6 percentage points in HbA1c values and 15 mg/dL (0.83 mmol/L) in fasting glucose levels ($P < 0.01$). Self-reported health status improved in the nurse case management group ($P = 0.02$). The nurse case management intervention was not associated with statistically significant changes in medication type or dose, body weight, blood pressure, or lipids or with adverse events.

CONCLUSIONS: A nurse case manager with considerable management responsibility can, in association with primary care physicians and an endocrinologist, help improve glycemic control in diabetic patients in a group-model HMO.

Alice P.S. Kong, FRCP, Xilin Yang, PHD, Gary T.C. Ko, MD , Wing-Yee So, FRCP, Wing-Bun Chan, FRCP, Ronald C.W. Ma, MRCP, Vanessa W.S. Ng, MRCP, Chun-Chung Chow, FRCP, Clive S. Cockram, MD, Peter C.Y. Tong, PHD, Vivian Wong, MD and Juliana C.N. Chan, MD

Effects of Treatment Targets on Subsequent Cardiovascular Events in Chinese Patients With Type 2 Diabetes

Diabetes Care April 2007 vol. 30 no. 4 953-959

OBJECTIVE—International guidelines recommend optimal control of risk factors in diabetes to prevent cardiovascular events. We examined risk associations between achieving treatment targets for glycemia, blood pressure and lipid control, and other risk factors on subsequent cardiovascular events in Chinese patients with type 2 diabetes.

RESEARCH DESIGN AND METHODS—Between 1995 and 2005, 6,386 Chinese type 2 diabetic patients without a history of coronary heart disease (CHD) or stroke were recruited. They were classified according to the number of treatment targets attained at baseline, and their cardiovascular outcomes were compared. Treatment targets were defined as A1C <7.0%, blood pressure <130/80 mmHg, and LDL cholesterol <2.6 mmol/l.

RESULTS—After a median follow-up of 5.7 years, cumulative incidence of CHD or stroke ($n = 749$) increased with decreasing numbers of treatment targets attained at baseline. Attainment of two or more targets at baseline was associated with reduced risk of CHD compared with those with no target achieved (hazard ratio 0.69 [95% CI 0.50–0.94], $P = 0.020$). However, the association lost its significance after adjustment for urinary albumin-to-creatinine ratio, estimated glomerular filtration rate, and hemoglobin.

CONCLUSIONS—Reaching more treatment targets was associated with reduced risk of new onset of CHD in Chinese patients with type 2 diabetes.

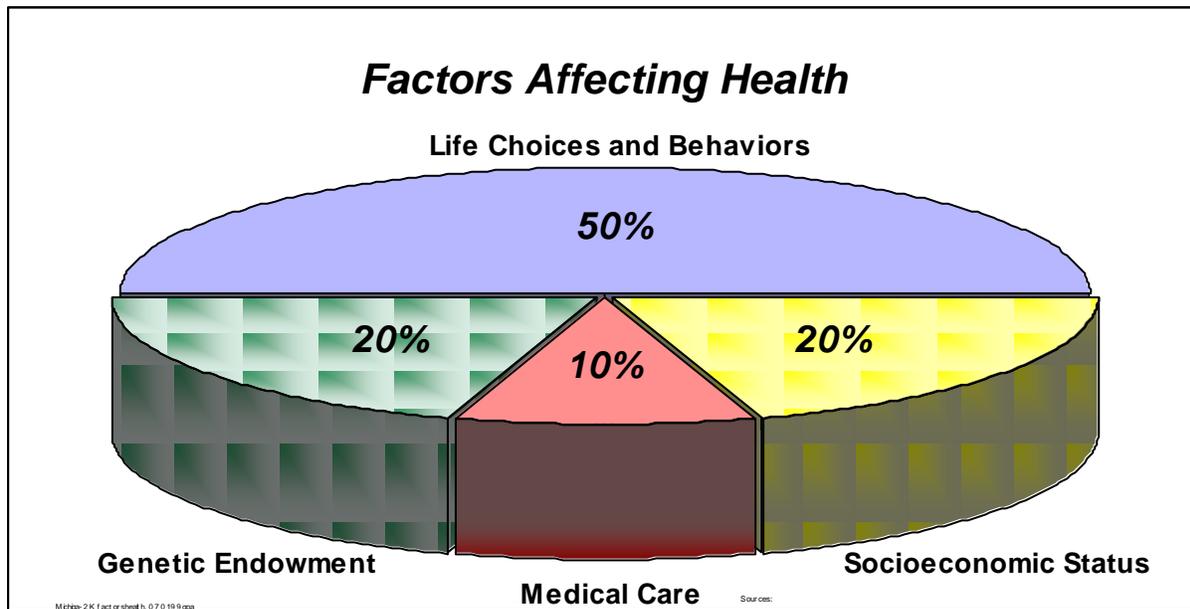
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Chapter 3

Anticipated Results & Care Improvements

ANTICIPATED RESULTS & CARE IMPROVEMENTS

Trento, et al. showed that group visits improved metabolic control by inducing more appropriate health behaviors in a randomized controlled clinical trial of 112 patients (56 patients were allocated to groups of 9 or 10 individuals) who participated in group consultations and 56 patients (considered control subjects) who underwent individual visits plus support education.¹



Clancy, et al. demonstrated that for patients with Type 2 diabetes, who are uninsured or inadequately insured, participating in group visits showed an improved sense of trust in their physician, reported better coordination of their care, better community orientation, and more culturally competent care.² Using group visits as a method for diabetes care helps patients improve their behaviors relative to their diabetes treatment. Recognizing the proven successfulness of the diabetes group visits, the McLaren Family Medicine Residency Program in Genesee County has conducted diabetes group visits since January 2007. Thus far, these group visits have demonstrated that not only do patients respond positively to the basic concept, but they also become advisors and champions for each other, resulting in previously unseen levels of motivation to actively engage in self-management of their disease and its root causes. Participants ability to share individual experiences around unique challenges and the tactics they've developed to overcome them has been an unexpected benefit to the participants of the program.

¹ Trento M, Passera P, Marco T, et al. Group Visits Improve Metabolic Control in Type 2 Diabetes. *Diabetes Care*. 24(6) 2001: 995-1000.

² Clancy D., Cope D; Magruder K, et al. Evaluating group visits in an uninsured or inadequately insured patient population with uncontrolled Type 2 diabetes. *The Diabetes Educator*. 29(2) 2003: 292-302.

Chapter 4

Group Visit Meeting Structure/Format/Agenda

GROUP VISIT MEETING STRUCTURE / FORMAT / AGENDA

A component of the success of the group visit model is that it does not adhere to a strict structure which allows for greater patient to doctor and patient to patient interaction. Some topics should be covered at each group visit however. These topics include:

- General information about diabetes
- Goals and targets
- Diabetes health maintenance
- Medications and how they work
- Foot care
- General nutrition/reading labels

Two hypothetical scripts follow this page to demonstrate how to begin a group visit and how a diabetes group visit may progress during the session. A list of issues related to lifestyle is also included which provides a list of questions which the physician should seek to have answered during the course of the Diabetes Group Visit.

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Facilitator Introduction Script

Hello, my name is _____ and welcome to the Diabetes Group Visit.

A group visit is just like an individual medical appointment except in here you will have the others in the group present while you speak with your physician. Another difference is that instead of waiting and having a only a few minutes for your appointment, you will have 90 minutes to 2 hours of time. How many of you have thought of another question right after the physician leaves the room? Some advantages of these groups are that you have more time to get answers to your questions and learn from others who have had similar experiences and can share information that may be helpful to you. This is an open forum and we encourage you to share your personal experience with each other. Another advantage of group visits is that they take place every _____ and you can use this as a tool to see your physician more often if needed.

We ask that you look over your list of questions and select your two biggest concerns to discuss today. Often times, other patients will ask questions that may provide you with some of the answers you needed, but if you still have questions, we will schedule you for another group until all of your concerns are addressed. If I interrupt you, please know that it has nothing to do with the quality of your statement but reflects my desire to keep things moving along.

Now we will address confidentiality. You are going to hear stories during the group visit that could be helpful for you to pass on to your friends and relatives. We ask that you only share the story and not the name or any identifying information about the person who shared their experience with the group.

If anyone needs to leave early, please let me know now so we may field your questions first. If anyone needs to have a private discussion, there will be time allotted at the end of the group visit for private exams or questions.

The restrooms are located in _____.
Coffee, tea, and water are available at _____.

Diabetes Group Visit Script – March 31, 2008

Physician: Good afternoon, everyone; welcome to today's Diabetes Group Visit; Tom, it's good to see you again – are you still working the night shift at the pharmacy?

Tom: Yes, but I was able to sleep about 5 hours since my shift ended, so I'm feeling fairly good right now, and I'll catch a few more hours before I go back in tonight. Last time we met, Elaine and John had mentioned a few tips for increasing exercise without interfering with a busy schedule and those have really helped; since that meeting, I've been usually getting in a total of 25-30 minutes of walking every day, in 3-5 minute segments; I feel less stiff and more energetic, and I'm even sleeping better, when I do get to bed.

Physician: That's great to hear. Elaine, how are you today?

Elaine: I'm OK, I guess, but I'm worried about Jean. She hasn't been able to walk with me for the last week or so because she's having a problem with her foot. She stubbed her toe walking barefoot to the bathroom in the night and didn't realize it was bleeding until the next morning. She remembered that we had talked several meetings ago about always turning the light on when you get up at night, but she said George had had a very busy day and she didn't want to wake him up. She had an appointment yesterday with her Podiatrist and it looks like the nail will fall off soon. He said it's not looking infected, but he wanted her to stay off her feet for another few days. She asked me to let everyone know she wouldn't be able to make it today, but she expects to be here next time.

Physician: I'll watch for a note from her Podiatrist.

Joe: Let her know we're thinking of her and we're looking forward to seeing her next month. I always like her cooking tips. She comes up with great ideas to help spice up plain old chicken and fish. The other day, my wife made one of the recipes she brought to the last meeting. I didn't know a diabetic chicken dish could taste so good!

Physician: Catherine, I particularly want to welcome you to our group today, since it's your first meeting. Can you tell us a little about yourself and what sort of problems you've been having with your diabetes.

Catherine: Hi everybody. I'm Catherine Jones and I've known about my diabetes for about two years, but my doctor told me I probably had it for at least a few years before that. I've been having a terrible time getting motivated to stick with the right foods and to exercise and he said coming to this group type of visit might really help me. I don't like the medicine I have to take, because it seems to make me gain weight.

Physician: I'm sure you'll find everyone eager to help you out in any way they can. They're not at all bashful about letting folks know what has worked for them with these kinds of issues. Well, it looks as if everyone we're expecting is here now, so does anyone have any burning issues they would like to talk about today.

Joe: I would like to get some idea of what it's like to be on insulin. My sugar checks at home have been way too high and I've been told I'll have to start it as soon as I take the class on self-injection at the hospital. I don't much like needles and I'm worried that it might be too complicated for me to understand.

Elaine: I remember feeling that way about a year ago when my doctor told me the same thing. But I was feeling lousy, tired all the time because I was running to the bathroom 4 and 5 times a night, and my A1c was over 10. I tried to get her to just up the dose of some of the pills I was already taking, but she said I was already on the maximum doses. She told me that once my blood sugar started coming down where it belonged, I would probably be able to stop some of the pills I was taking. Now I take one type of insulin shot each evening and a different type just before each meal and I'm only on one pill twice a day; it's actually a lot simpler than what I was taking before the insulin. I feel a lot better, my last A1c was 6.9, the insulin needles don't hurt nearly as much as when I check my blood sugar, and I'm sleeping straight through the night.

Joe: Thanks a lot. That makes me feel better about it already.

Catherine: I'd like to know more about what sorts of eye problems to watch out for. I'm going for my first exam next week and I'd like to be able to understand what the doctor is talking about when he tells me what he found.

Physician: Excellent suggestion, Catherine! In fact, Dr. Joseph, one of our residents, will be joining us shortly, and she is going to give a talk on that very topic a little later in the meeting. After that, she will have some time to answer any other questions you might have about it.

Well, let's get started with the usual questions; we'll start here and go around the room getting each person's answer. First, have you been having any unusually frequent urination or any insulin reaction symptoms?

From this point, we usually work our way through the Subjective portion of the progress note template. The discussion typically wanders occasionally into answering a particular question posed by someone and, at those times, the greatest challenge for the physician is to keep quiet and let the group teach itself as much as possible. I usually join the conversation only to offer a piece of information the group needs to continue its problem-solving or to correct any misconceptions.

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What To Look For During A Diabetes Group Visit

1. Are they addicted to or using any substances that would negatively affect their health?
2. Social Support:
 - a. Are they married or living with someone? If alone, is there someone who checks up on them regularly?
 - b. Do they have people they can confide in or are they the type that shoulder other people's burdens?
 - c. Do they attend a church or belong to some other community group?
3. Coping Ability:
 - a. Have they been through difficult times before?
 - b. How have they coped?
 - c. How resourceful are they? Knowledge and ability to seek help from: friends, family, or community.
4. Lifestyle Changes:
 - a. Exercise:
 - i. Do they currently exercise?
 - ii. What do they do for exercise?
 - iii. Are they able to develop a plan and stick with it?
 - b. Diet:
 - i. Are they aware of dietary restrictions?
 - ii. Do they need to see a nutritionist?
 - iii. Do they do their own cooking?
 - iv. Do they eat regular meals?
 - v. Can they do their own grocery shopping?
 - vi. Can they afford healthy food?
 - c. Stress:
 - i. Do they experience an amount of stress that is negatively impacting their life?
 - ii. What is their level of coping skills?
 - iii. How do they cope with stress?
 - iv. Are they able to look for support?
 - v. Do they report feeling overwhelmed, no options to change a bad situation? LOOK FOR SIGNS OF DEPRESSION
5. Sleep: It's a habit
 - a. Do they have trouble sleeping?
 - b. What is their sleep hygiene?

- i. Do they go to bed at the same time every night?
- ii. Do they take in caffeine products during the day?
- iii. Do they exercise close to bedtime or work until bedtime?
- iv. Do they have a TV in the bedroom.

6. Depression:

- a. Food – Too much? Too little?
- b. Sleep – Too much? Too little? Do they wake up after several hours and are unable to go back to sleep?
- c. Don't enjoy activities like they used to?
- d. Frequent accidents?
- e. Suicidal thoughts or plans?
- f. Family history of depression?
- g. Ever been on antidepressants before?
- h. Psychotherapy?
- i. BRING BACK TO THE GROUP OFTEN TO MONITOR

Chapter 5

Miscellaneous Tools for Diabetes Group Visit Start Up

MISCELLANEOUS TOOLS FOR DIABETES GROUP VISIT START UP

In recognition that Diabetes Group Visits are quite a departure from the traditional treatment model, a number of miscellaneous tools to facilitate the launch of group visits have been included in this manual. Utilization of these tools can ensure that group visits are implemented with minimal interruption to office workflow and staff burden.

The following items are included:

- Diabetes Group Visit Start Up Tasks in Chronological Order
- Group Design Guide
- Group Visit Checklist
- Sample Recruitment Letter
- Sample Welcome Correspondence
- Plan for Communication of Diabetes Group Visits

Diabetes Group Visit Start-Up Tasks in Chronological Order

1. Understand the idea that group visits may be a helpful tool for practice.
2. Become educated on the basic aspects of the group visits and begin to get a general idea of how they could be effective.
3. Present the ideas to both the operational and medical administration.
4. Give a presentation to the total administrative team and possible interested physicians.
 - Look at resources currently available within the system to set this up.
 - Data: financial, access, & disease outcomes.
 - Design a group/groups that address the goals to be achieved in the practice – use all levels of employees to gather input.
5. Assign a project manager (where applicable) to work with the project start-up.
6. Obtain a consolidated business plan of resources – both staff and monetary, needed and create a timeline with tasks that include:
 - Start date of group
 - Marketing materials
 - Charting and scheduling mechanisms
 - Space to conduct the group visits
 - Training for the team and physicians
 - Outcome studies planned and ready to implement
7. Start the group
8. After every group have some time to debrief to fine tune and discuss the experience, which is also an excellent training tool for all involved.

Group Design Guide

1. What are the most pressing problems in your practice? (i.e. access, not enough quality time with patients, a type of patient taking too much time, no enjoyment in practicing medicine...)
2. In what ways could groups help manage these issues?
3. What resources are currently available?
 - Space
 - Staff – Facilitator?
 - Coverage for the physician so that interruptions are minimal
 - Marketing
 - Other?
4. Implementation
 - Set date for first group (generally 4-6 weeks after design of group)
 - Use group visit checklist.
5. Decide outcomes and how they will be measured.
6. Plan team review strategies. For example you may want the facilitator and physician to debrief for 5 minutes after every group and the team to meet monthly to problem solve.

Group Visit Checklist

Task	Responsible Person	Due Date	Task Completed
Marketing (Posters, Letters, Flyers)			
Scheduling (Change schedule to accommodate group participants)			
Review scheduling scripts with schedulers			
Develop strategies for enrolling patients in group visits			
Locate space which can accommodate 8-12 patients plus staff			
Identify staff to do vitals			
Locate any equipment needed			
Put supplies (name tags, paper, etc.) in identified room			
Design flow and structure of the group			
Review flow and structure with staff which will assist			
Review roles of physician and staff prior to visit			
OTHER			

Sample Recruitment Letter

Dear Valued Patient,

I would like to invite you attend a new diabetes group visit program I am starting for patients from my practice. My diabetes group visits give you an extended 90 minute to 2-hour medical appointment. This group includes other patients from my practice, other professionals, and me.

I am very excited about this new program. It will give us time to get to know each other better and discuss your questions and concerns. This group will also give you support and information from other patients with diabetes. This can help you cope with your situation and live a better life. During each group visit, I will be able to answer questions, prescribe and refill medications, order tests, discuss test results, talk about side effects and treatment options, and provide brief exams. These group visits are very useful, interesting, and more relaxed than a regular, private office visit. Group visits are another option and do not take the place of individual medical visits. There will be times when you will need to see me one on one.

My group visits take place every _____ from _____ to _____. Please register 15 minutes before the start of the group. You will pay your regular co-pay and we will then meet in the group room.

Pre-register for the group by calling (____) _____-_____ to make an appointment for the group you would like to attend. Please feel free to bring your spouse or another support person. They will likely find the discussions helpful as well.

It is a pleasure to be able to recommend this new program to you. It will be a warm, supportive, and rewarding experience. I look forward to participating in this group visit with you. For questions about this program, please call _____ at (____) _____-_____.

Sincerely,

[NAME]

Sample Welcome Correspondence

Hello _____,

We are excited about the diabetes group visits at the _____ and are looking forward to your participation. For your information, diabetes group visits are scheduled for the following times:

DAY, DATE, YEAR, TIME

Please make sure to arrive on time for group visits as with any appointment. For any questions, please contact _____ at (____) ____ - ____.

We look forward to seeing you!

Sincerely,

Plan For Communication of Diabetes Group Visits

Here is a summary of the plan for communication to the primary care physicians when you have a patient attending the diabetes group visits.

Patients will be informed that they may not be seeing their primary care physician during these sessions (if applicable). They will be told that all of the physicians in this building are part of the same practice and this is like a referral to a diabetes care team for managing diabetes. The patients will also be told that their primary care physician will be kept informed and made aware of any changes to their treatment and/or issues which may arise.

Documentation of each diabetes group visit will be done using the included forms. The diabetes group visit progress note will be used for the appointments. We will also be completing the diabetes self-management tool ("My Action Plan") at each visit. Between visits, _____ may contact the patient to review their self-management goals and to assess their medication adherence. All contacts will be documented and reviewed by the appropriate physician before entering the information in the patient chart.

All medication changes, specialty referrals, or changes to therapy will be discussed with the primary care physician before implementation. The patient will be informed that they are able to consult with their own doctor at any time while participating in the group visit program.

If a patient is scheduled for a group visit and does not show up, they will be contacted by phone by appropriate office staff and the reason for their absence will be documented. If transportation is an issue, we will work to find alternative transportation for the individual using local resources.

Chapter 6

Diabetes Group Visit Documentation Tool: Patient Questionnaire Template

DIABETES GROUP VISIT PATIENT QUESTIONNAIRE OVERVIEW AND USE

The Diabetes Group Visit Patient Questionnaire following this page should be completed by all group visit participants at the beginning of each group visit. For your reference, two examples are included for consideration. A patient questionnaire is a useful tool which gives the physician a good overview of how well the patient is managing their condition. It also can provide the physician with a general understanding of the barriers patients are experiencing in managing their diabetes.

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DIABETES GROUP VISIT PATIENT QUESTIONNAIRE

Welcome to today's Diabetes Group Visit! Please answer the following questions by circling the appropriate choice. If your chosen answer is followed by an arrow, please fill in the blank that follows.

1. Have you had any unusually frequent urination?

No										
Yes	→	When?								

2. Have you had any insulin reaction symptoms since your last office visit?

No										
Yes	→	When?								

3. Have you been staying with your diabetic diet?

Yes										
No	→	Why Not?								

4. Are you a smoker? If **NO** then skip to question # 5. If **YES** then go to the next line.

Are you trying to quit?										
No	→	Why Not?								
Yes	→	Are you interested in some help with this?					→	Yes	No	

5. In the past month, have you been bothered by...

	→	feeling down, depressed or hopeless?					→	Yes	No	
	→	little interest or pleasure in doing things?					→	Yes	No	

6. Are you exercising regularly?

Yes										
No	→	Why Not?								

7. Are you taking good care of your feet?

Yes										
No	→	Why Not?								

8. Are you taking your medications as directed by your doctor?

Yes										
No	→	Why Not?								

9. What are your blood sugar levels? A.M.'s P.M.'s

--	--	--	--	--	--	--	--	--	--	--

10. Are you satisfied with the treatment of your diabetes so far?

Yes										
No	→	Why Not?								

11. Is there anything you would like to be sure we discuss during today's visit?

No										
Yes	→	What?								

12. Is there any other information you would like the doctor to know today?

No										
Yes	→	What?								

REVIEWED BY: (DR'S SIGNATURE) _____

PATIENT NAME _____ DOB: / / _____

VISIT DATE: / / _____ GR-8D21 dg.v.questionnaire.070709cn

Diabetes Planned Care Visit Form-Patient Questionnaire-please respond to the questions below

Name _____ Date of Birth _____ Date of Appointment _____

I have: **Diabetes type 2** **Diabetes type 1**. I've had diabetes since _____.

I check my sugars _____ times a day.

My fasting blood sugar usually ranges (check) 70–110, 111–140, 141–170, 171–200, or above 200.

My sugar levels are highest in the morning After eating evening.

I do have low blood sugars. When? _____; I do not have low blood sugars I'm not sure.

I control my sugars with exercise, watching my diet, medication changes.

I also have high bloodpressure, high/abnormal cholesterol, heart disease, obesity, kidney problems, eye problems,

nerve/numbness problems, other _____.

Allergies: _____

Medications:

(Please write name and dose, for example: GLUCOPHAGE 500 mg, 2 tabs twice a day)

DIABETES MEDICATIONS	OTHER PRESCRIPTION MEDICATIONS

Family History: Diabetes high blood pressure high cholesterol heart disease other

Social History: Tobacco Alcohol: number of drinks per day _____ Exercise

Review of Symptoms: Please check the current symptoms you are experiencing:

Constitutional:

- ____ fever or chills
- ____ fatigue
- ____ weight change

- ____ nausea
- ____ vomiting
- ____ change in bowel habits
(what? _____)

Endocrine:

- ____ menstrual problems
- ____ increased thirst

Vision:

- ____ glasses or contacts (circle)
- ____ vision changes
- My last dilated eye exam occurred on _____

Genitourinary:

- ____ urinary problems
- ____ loss of urine
- ____ sexual problems

Other: _____

Ears, Nose, Mouth and Throat:

- ____ hearing problems
- ____ dental problems

Musculoskeletal:

- ____ back pain
- ____ muscle pains
- ____ joint pains

Cardio/Pulmonary:

- ____ cough
- ____ shortness of breath
- ____ chest pain
- ____ irregular heart beat
- ____ ankle swelling

Skin:

- ____ rashes/skin concerns

Neuro/Psych:

- ____ headache
- ____ numbness or tingling of hands or feet
- ____ sleep problems

Gastrointestinal:

Over the past two weeks, have you been bothered by:

- 1) Little interest or pleasure in doing things Yes No
- 2) Feeling down, depressed or hopeless Yes No

I have, have not been hit, slapped, kicked, physically hurt, or forced to have sex by someone in the last year.

I need the following medications, referrals, and supplies today to help manage my diabetes:

Chapter 7

Diabetes Group Visit Documentation Tool: Progress Note Template

DIABETES GROUP VISIT PATIENT PROGRESS NOTE

Following this page are three sample Patient Progress Notes (SAMPLE A, SAMPLE B, and SAMPLE C) which capture all vital clinical information for a diabetic patient. Use of these tools (or ones that are similar) allows the physician to monitor patient progress over time, and capture the necessary information for reimbursement and pay for performance incentives.

Relative to the Progress Note labeled "SAMPLE A," the second page, which is labeled "SAMPLE A (cont.)," should be copied directly on the back of the of the first page and upside down so the two-sided document can be used in "tumble fashion." This document is completed by the physician and captures the level care which will be provided to the patient.

Medication lists are invaluable reference tools when treating patients for diabetes. A sample medication list is included which will log all medications, dosages, pharmacy information, and any allergies.

Also included are two tools for measuring depression in patients, which occurs at higher rates in individuals who suffer from chronic conditions such as diabetes. Included for your use are the PHQ-2 and PHQ-9 depression assessment tools. The PHQ-2 should be administered first and if the results are positive, the PHQ-9 should be utilized. Interpretation guidelines are included.

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SAMPLE A

McLAREN FAMILY PRACTICE CENTER DIABETES GROUP VISIT PROGRESS NOTE (Draft 2-9-09)

S: ___ y/o ___ M F returns → ___ as requested; OR _____ late → for diabetes followup. See Summary of Care, Medication List, and Diabetic Plan of Care, all of which are reviewed with the pt today. History (in addition to the Group Visit Questionnaire): _____

O: Ht: ___" Wt: ___# Change ___# BMI: ___ BP: ___/___; ___ deg, P ___, R ___ MA Initials → ___
___ No distress OR → Distress as follows _____

Fundus exam ___ deferred OR _____ **Oral Lesions?** No OR _____

Neck: ___ Carotid pulses ___ +/4, no bruit, mass or tend OR → _____

Lungs ___ Clear or → Crackles Rhonchi Wheezes → (where) _____

Heart Rhythm? Reg OR _____ **Murmur?** None Or → Grade ___/VI → Murmur _____

Peripheral Pulses → Radial - R ___ +/4, L ___ +/4; *Pedal - DP → R ___ +/4, L ___ +/4; PT → R ___ +/4, L ___ +/4 Type/Location

Abd ___ No mass, organomegaly, or tenderness (in sitting position) OR → _____

Feet Exam – (* = required for Diabetic Foot Exam billing)

***Lesions?** No Yes → What/Where? _____

***Monofilament** ___ Deferred

Test Abnormal? No Yes → Where? _____ **Edema?** None OR → ___ +/4 Right Left

Other Findings: _____

A: Diabetes Mellitus, Type → ___ 1 Uncontrolled; ___ 1 Controlled; ___ 2 Uncontrolled; ___ 2 Controlled
BP _____ Lipid Control ___ Good ___ Poor; Control ___ Good ___ Poor; also → _____

P: See Medication List for changes.
Topics discussed at today's visit: _____

Next Studies Due: ___ Call c results; ___ Discuss/RTO
Micro-
A1c → ___/___; albuminuria → ___/___;

GFR → ___/___; FLP → ___/___;
Retinal Exam → ___/___; Return in ___ wks ___ mos. Sig: _____ Provider

Pt Name: _____ Pt DOB: ___/___/___ Visit Date: ___/___/___

SAMPLE A (continued)

Diabetes & DM-Related Diagnoses		Standards for Monitoring/Treatment		
(4th digit is for complications; 5th digit is for type/control; e.g. 250.42 = Uncontrolled DM 2 c renal manifestations)		Measure	At target/Nml	Not at target/Abn
Diagnosis	ICD-9 Code			
Angiopathy, Peripheral, Diabetic	443.81	HgA1c	Q 6 mos	Q 3 mos
Diabetic Coma	250.3	LDL	Q 6 mos	Q 3 mos
Diabetic Nephropathy NOS	583.81	GFR	Q 1 year	Q 6 mos
DM 1, Controlled	250.x1	Microalbuminuria	Q 1 year	Q 6 mos
DM 1, Uncontrolled	250.x3	Retinal exam	Q 1 year	PRN
DM 2, Controlled	250.x0	Monofilament (foot)	Q 1 year	Q 6 mos
DM 2, Uncontrolled	250.x2	Foot Inspection	Each visit	Each visit
DM c complications not o/w specified	250.9	BP	Each visit	Each visit
DM c Ketoacidosis	250.1x	Measure	Target	
DM c Neurological Manifestations	250.6x	HgA1c	<7.0	
DM c Ophthalmic Manifestations	250.5x	LDL	<100	
DM c Peripheral Circulatory Disorders	250.7x	GFR	>60	
DM c Renal Manifestations	250.4x	Microalbuminuria	<18	
Gangrene, Diabetic	785.4	Systolic BP	<130	
Gastroparesis Diabeticorum	536.3	Diastolic BP	<80	
Gestational Diabetes	648.8	Other Recommendations		
Hyperglycemia	790.6	Flu Vaccine	Annually	
Hyperosmolar Nonketotic Coma	250.2x	Pneumonia Vaccine	Initially; then Q 8-10 years	
Neonatal DM	775.1	Smoking Cessation Advice	Each visit	
Neuropathy, Peripheral Autonomic	337.1	Depression Screening	At least annually	

*** TO BE COPIED ONTO THE BACK OF THE DIABETES GROUP VISIT PROGRESS NOTE UPSIDE DOWN TO BE USED IN "TUMBLE" FASHION BY THE PHYSICIAN**

SAMPLE B

Progress Note for Group Medical Appointment

Patient Name _____ DOB _____ MR# _____

Allergies to Drugs _____

CC: _____

Hx of Illness _____

Medications

Name Dose Frequency

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vital Signs: MA _____ (Initials)

BP _____ P _____ T _____ W _____

COUNSELING: (Time Spent) Etoh _____ Diet _____ Cholesterol _____ Exercise _____ Diabetes _____
Smoking _____ Other _____

Assessment:

A _____

B _____

C _____

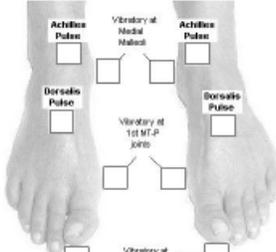
Plan: _____

Pt to return; as needed
In _____ Days Weeks Months Group Individual

Physician Signature _____ Date _____

Facilitator Signature _____ Date _____

SAMPLE C

Diabetes Planned Care Visit Progress Note	
Name: _____	Weight _____ Pulse _____
MR #: _____	Height _____ Temp _____
DOS: _____	BMI _____ RR _____
DOB: _____	BP _____ Pain _____
PHQ9 score _____ (PHQ9 <= 4 no depression, 5-14 mild/mod depression, >= 15 severe depression)	
PE: Appearance: <input type="checkbox"/> Alert and Oriented <input type="checkbox"/> other _____ EYES _____ ENMT _____ NECK/THYROID _____ HEMATOLOGIC/LYMPHATIC _____ RESPIRATORY _____ CARDIAC _____ GI _____ MUSCULOSKELETAL _____ NEUROLOGICAL _____ SKIN _____	FOOT EXAM Pulses as indicated: 0 = absent, 1/2 = barely felt, 1 = reduced, 2= normal  Monofilament Testing:  <p>10 gm monofilament sensation at points shown. 0 = not felt +1/2 = barely felt + = normal</p>
A/P:	
Goals:	
Med changes:	
Management tools given:	
Referrals:	
Immunizations:	
Lab data:	
Instructions:	
Diet instructions:	
Exercise instructions:	
Refills and supplies:	
Tobacco Packet:	
Self management goals (confidence >= 7):	
RTC:	
Signature:	

PRIME-MD PHQ (2 Question Screen)

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- | | Yes | No |
|--------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the past month, have you often been bothered by little interest or pleasure in doing things? | <input type="checkbox"/> | <input type="checkbox"/> |

PRIME-MD PHQ (2 Question Screen) Scoring Instructions

If the response is "yes" to either question, consider administering the PHQ-9 questionnaire or asking the patient more questions about possible depression.

If the response to both questions is "no", the screen is negative.

Whooley et al. (1997) compared the 2-question screen to the Quick Diagnostic Interview Schedule (QDIS-III) and reported a sensitivity and specificity of 96% and 57% respectively.
Whooley MA, Avins AL, Miranda J, Browner WS. Case finding instruments for depression. Two questions are as good as many. *Gen Intern Med.* 1997;12:439-45. From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams,

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder**
—if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)
Consider Other Depressive Disorder
—if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Chapter 8

Presentation Topics/Curriculum

PRESENTATION TOPICS / CURRICULUM

Following are some suggestions for topics to be discussed during diabetes group visits. These topics represent the general components of diabetes self-management:

- **General information about diabetes**
- **Goals and targets**
- **Diabetes health maintenance**
- **Medications and how they work**
- **Foot care**
- **General nutrition/reading labels**

Part of the success of the group visit model however, is the “Circular” curriculum which allows the participants to set the agenda.

A Circular Curriculum

A circular curriculum means that the discussion and lessons emanate from the attendees of the group visit.

As questions or topics are raised by attendees, the physician facilitating the group visit will promote discussion about that topic. For example, if a participant asks a question about nutrition, the facilitator may ask other attendees to share tips about nutrition. The peer to peer interaction is part of the reason why group visits are successful.

As participants incorporate more information, their knowledge grows. Topics will inevitably be revisited by the group as participants request further information.

Disease Topics for Behaviorist Orientation

TOPICS:

- Hypertension
 - Essential Hypertension
- Congestive Heart Failure (CHF)
- Diabetes:
 - Type 1
 - Type 2
- High Cholesterol: HDL, LDL, and Triglycerides
- Arthritis/Fibromyalgia/Chronic Pain
- Rheumatoid Arthritis
- Asthma
- Depression – “Know the meds and their side effects.”
- Anxiety – “Know the meds and their side effects.”
- Acid Reflux
- Irritable Bowel
- Cancer – Common types, i.e. breast, colon, lymphomas
- Lupus/Undifferentiated Connective Tissue Disease
- Osteoporosis

GENERAL TOPICS/FAQ'S

1. Find out generally what physically happens.
2. Discover psycho-social implications:
 - How does this diagnosis change relationships with family/friends?
 - What lifestyle changes are needed for optimal control?
 - What would some of the losses be for this person with this disease?
3. What are some of the ways for treating this?
4. What are some of your thoughts as you learn about this disease?
5. How does the environment affect those with this disease?

OTHER TOPICS - SHORT (2-3 MINUTES) LECTURES ON THE FOLLOWING:

Exercise

Stress Management

Nutrition

Memory Disorders

Sleep Disorders

* Patient education materials are provided at the end of this section to help facilitate some group discussion.

Any Food Can Fit! It is not what you eat; but how much and how often you eat it. Read this whole sheet to make some good choices. This is not your meal plan, but ways to eat until you come to our program.

IDEAS	HOME COOKED MEALS	MEALS ON THE GO-once a week
Breakfast	½ cup grits or oatmeal 1 slice whole wheat toast 1 tsp. margarine ½ banana ½ cup 100% fruit juice	(Dunkin Donuts) ½ blueberry muffin (2.5 ounces) 1 tbsp. light cream cheese
Lunch 	½ cup cream of broccoli soup ½ sandwich (lean meat) 1 tsp. mayonnaise 17 small grapes 2 small low-fat cookies 1 cup skim, ½ % or 1 % milk	(McDonalds) 1 cheeseburger 1 garden salad 1 packet fat-free dressing 1 vanilla ice cream cone (low fat)
Dinner	3 ounces baked fish, chicken, or other lean meat 1 cup broccoli 1 cup baked sweet potato 1 small piece corn bread 2 tsp. margarine ½ cup ice cream (low fat)	(KFC) 3 Colonel's crispy strips 1 serving corn on the cob 1 serving green beans 1 biscuit with 1 tsp. honey

EATING TIPS FOR PEOPLE WITH DIABETES *

What can I eat?	How much can I eat?	When should I eat?
<ul style="list-style-type: none"> ■ It's okay to eat carbohydrates like: ■ Fruits ■ Starchy vegetables ■ Skim, ½ % or 1% milk and yogurt ■ Whole grain breads, cereal, pasta and rice 	<ul style="list-style-type: none"> ■ Here are some ideas for <u>one</u> serving: (have 3-4 servings at a meal) <ul style="list-style-type: none"> ■ 1 medium piece of fruit ■ ½ cup canned (light) fruit ■ 1 small potato (3 oz) ■ ½ cup corn or peas ■ 1 cup milk, soy milk, or yogurt ■ 1 slice bread ■ ½ cup grits or oatmeal ■ ¾ cup dry unsweetened cereal ■ 1/3 cup rice or pasta ■ 3 cups popcorn or 6 crackers 	 <ul style="list-style-type: none"> ○ Do not skip meals ○ Eat every 4 to 5 hours ○ Try to eat at the same time each day ○ Have small snacks, if needed ○ Snack on: Raw veggies, sugar free jello, vegetable salads.
<ul style="list-style-type: none"> ■ Lean protein: Bake, broil, grill, microwave 	<ul style="list-style-type: none"> ■ Chicken, turkey, (no skin), fish, roast beef, pork (size of your palm) 	
<ul style="list-style-type: none"> ■ Good fats: Olive/canola oil, peanuts, walnuts 	<ul style="list-style-type: none"> ■ 1 tsp. oil, margarine, or mayonnaise, 2 tbsp. salad dressing, 1 oz. nuts 	
<ul style="list-style-type: none"> ■ High sugar foods: Candy, cake, pie, doughnuts, fruit drinks, and regular pop 	<ul style="list-style-type: none"> ■ One small serving once a week 	
<ul style="list-style-type: none"> ■ Drink water or <u>sugar free</u> drinks 	<ul style="list-style-type: none"> ■ As much as you want of diet pop, <u>sugar free</u> lemonade, <u>sugar free</u> Kool-Aid, or Crystal Light 	<p>Questions ? Call: 810-239-0485</p>

*Not for people with diabetes whose doctor has told them to limit their protein

Be Smart About Your Heart: Control the ABCs of Diabetes

If you're one of the more than 18 million Americans with diabetes, you are at high risk for heart attack and stroke. Heart disease is more likely to strike you – and at an earlier age – than it is to strike your friends and family without diabetes. In fact, 2 out of every 3 people with diabetes will die of a heart attack or stroke. But you can fight back. You have the power to prevent heart attack and stroke by controlling the ABCs of diabetes.

A is for A1C. The A1C test (sometimes known as the HbA1c or hemoglobin A1c test) measures your average blood glucose (sugar) over the last 3 months.

B is for blood pressure. High blood pressure makes your heart work too hard.

C is for cholesterol. Bad cholesterol, or LDL, builds up and clogs your arteries.

Work with Your Health Care Provider

Ask your health care provider these questions:

What *are* my ABC numbers? Your A1C level should be tested at least twice a year. Blood pressure should be checked at each visit and cholesterol should be tested at least once a year.

What *should* my ABC target numbers be? For most people with diabetes, the goals are A1C below 7, blood pressure below 130/80, and LDL cholesterol below 100.

What *actions* should I take to reach my ABC target numbers? You and your health care provider will put together an action plan of lifestyle changes and medications, if needed, to help you reach and maintain your goals for the ABCs of diabetes.

Take Action Now.

You can take action now to lower your risk for heart attack and stroke and other diabetes problems. Work with your health care provider, and get started now:

- Get at least 30 minutes of physical activity, such as brisk walking, on most days of the week.
- Eat less fat and salt.
- Eat more fiber – choose whole grains, fruits, vegetables, and beans.
- Stay at a healthy weight.
- Stop smoking – ask your provider for help.
- Take medicines as prescribed.
- Ask your doctor about taking aspirin.
- Ask others to help you manage your diabetes.

Chapter 9

Confidentiality and HIPAA Compliance in the Group Visit Setting

CONFIDENTIALITY AND HIPAA COMPLIANCE IN THE GROUP VISIT SETTING

Diabetes group visits are shared medical appointments. Given that personal and confidential medical information is discussed, it is important that participants understand that they may be sharing such information about themselves. In addition, participants must understand that information they hear about their fellow group visit participants is confidential and cannot be disclosed. For reference, two sample HIPAA Notices and Confidentiality Agreements which patients sign prior to participation are provided.

HIPAA Notice

During a Group Medical Appointment, it is possible that some of my personal health information will be disclosed. For example, at a Group Visit for Diabetes, it might be assumed that everyone attending has diabetes. Discussion may occur regarding personal health information during a group visit. I have been notified of this potential disclosure and I wish to participate in a group medical visit. I realize I have the option of being seen individually.

Name [PRINT] _____

Signed _____

DOB: _____

Date _____

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Confidentiality Agreement

As group medical visits involve patients disclosing private medical and social information, all participants during a group medical visit, whether the direct patient or accompanying family, must agree to respect the privacy of all information and keep such information confidential. By signing this confidentiality agreement, I assume the responsibility for keeping all information confidential.

Name _____

Signature _____

Date _____

GR-8D21 DGV.confidentiality.agreement.071009cn

GROUP MEDICAL APPOINTMENT CONFIDENTIALITY AGREEMENT

Privacy is something everyone is concerned about when they come for group medical appointments. You have the right to expect that what is said here is private and confidential. Along with our commitment to maintain your privacy, you will also have a responsibility to respect and protect each other's privacy.

Please share useful information outside of the group, but what you hear and learn about individual group members should stay here.

Printed name _____

Signature _____

Date _____

Authorization for Disclosure of Medical Information

One of the biggest benefits of group medical appointments is the opportunity to learn from other patients. This means you also have the opportunity to positively impact someone else's life. Knowing this:

I authorize _____ to share medical information pertaining to my current medical issues with participants of a group medical appointment of which I am in attendance.

This authorization shall become effective immediately and shall remain in effect for 1 full calendar year from the date of signature.

I further understand that I have a right to receive a copy of this authorization upon my request.

Signature _____

Date _____

Chapter 10

Referring the “Right” Patient to Diabetes Group Visits

REFERRING THE "RIGHT" PATIENT TO A DIABETES GROUP VISIT

Diabetes group visits are not for every patient. Those patients who are effectively adhering to their treatment regimen and managing their condition would not benefit (but may still contribute to the group dynamic) to the degree of patients whose diabetes is not appropriately managed, particularly when lifestyle issues are the main obstacle to good diabetes control.

Who is the "right" patient for diabetes group visit?

Group visits are generally most appropriate for:

- Patients needing routine follow-up care
- Stable, chronically ill patients requiring total mind/body care
- Patients who typically require more time with their physician
- Patients who come for frequent return visits
- Patients with extensive emotional, informational, or psychosocial needs
- The "worried well"

Following is a table which illustrates who may benefit the most from participating in group visits. While the table may be a useful reference tool, it should not be used as explicit guide to selecting patients. Use your discretion as you know your patients best.

Also included in this section, is a sample vignette that office staff may reference when contacting patients regarding group visit participation once it is determined which patients may benefit.

GR-8D21 DGV.rightpatient.052109cn

Diabetes Group Visit "Right Patient" Tiers

<p><u>TIER 1</u> – WILL LIKELY DERIVE THE MOST BENEFIT FROM DIABETES GROUP VISITS</p>	<ul style="list-style-type: none"> • Diabetes mellitus type 2 uncontrolled (HbA1c > 9 in last 6 months, and/or 2 or more hospitalizations or ED visits within the last year) • Transportation capabilities • Support system • Obese • Some form of insurance coverage • Non - substance abuser • No underlying mental health disorder • Patients needing routine follow-up care • Stable, chronically ill patients requiring total mind/body care • Patients who come for frequent return visits • The "worried well"
<p><u>TIER 2</u> – MAY DERIVE SOME BENEFIT FROM DIABETES GROUP VISITS</p>	<ul style="list-style-type: none"> • Diabetes mellitus type 2 uncontrolled or poorly controlled (HbA1c > 9 in last 6 months, and/or 2 or more hospitalizations or ED visits within the last year) • Transportation difficulties • Obese or overweight • Uninsured • Non-substance abuser • No Underlying mental health disorder • Patients needing routine follow-up visits that do not return as needed
<p><u>TIER 3</u> – WILL NOT BENEFIT OR MAY REDUCE THE EFFICACY OF GROUP VISITS FOR OTHERS</p>	<ul style="list-style-type: none"> • Diabetes mellitus type 1 • Mental health disorder or some other barrier which may impede constructive group discussion • Substance abuser

GR-8D21 right.patient.tiers.070909cn

Patient Recruiting Vignette

Hello, my name is _____ and I am calling you on behalf of your doctor, Dr. _____. How are you doing today? Your doctor thought that you could benefit from a clinic that we are offering here at _____ for people with diabetes. I would like to go over this clinic with you, is now a good time?

This is a medical appointment where the doctor meets with a group of people with diabetes for about 1 ½ to 2 hours. It is a great opportunity for patients to gain a lot of helpful information from the doctor and from other patients. Often other patients have similar experiences to what you are going through and have helpful ideas. Also, YOU probably have something of value from your experience that would be very helpful to others. We know that diabetes is a complicated condition to live with. These groups will offer you plenty of time to find solutions that work specifically with your life.

Dr. _____ is very excited about this and would like you to try it once and see if it is helpful to you. We have offered this clinic in the past and the patients like it a lot and found it to be very helpful.

- The next group visit will be held on DAY/DATE/TIME.
- The first visit may take longer than other visits so please allow for some extra time.
- We will check your blood pressure, feet, weight, and blood sugar.
- You are welcome to bring a spouse or support person with you.
- If needed, you can ask for individual time with your doctor at the end of the group.

Can I answer any questions?

- Please bring a list of your medications to the first visit.

We are very excited about this program and are looking forward to having you come!

Scripts for talking about the Group Visits

USE ANY OF THE FOLLOWING STATEMENTS TO DESCRIBE GROUP VISITS TO PATIENTS. OBSERVING A GROUP VISIT MAY HELP YOU TO DESCRIBE THEM IN THE FUTURE.

What is a group visit? I've never heard of such a thing!

It's a medical appointment where Dr. _____ meets with a group of patients for 1 ½ to 2 hours. It's a great opportunity for patients to spend more time with Dr. _____ and also gain a wealth of helpful information from the doctor and from other patients that may pertain to your care. It is relaxed and interactive. All your medical concerns can be addressed such as treatment options, prescriptions, labs ordered, referrals, etc. Often patients are reluctant at first to attend but the majority like them very much and find much benefit in them.

Dr. _____ is excited about this and would like you to try it once and see if it is beneficial and interesting.

Often other patients have similar experiences to what you are going through and have helpful ideas. Also, you probably have something of value from your experience that will be very helpful to someone else.

Generally other patients will ask questions that pertain to you, but you have never thought of asking. You may learn about health issues relevant to a family member, if not yourself.

These groups have become popular. Our patients tell us how much it helped them.

If needed, you can ask for individual time with the doctor at the end of the group visit.

If time is a problem, let Dr. _____ know and your issues will be dealt with first. If you need to leave and return to work, that's fine.

During this group, Dr. _____ prescribes, changes, and refills medications, goes over lab or test results, can follow-up from another appointment, answer questions, reevaluate treatment choices, etc.

Dr. _____ can spend more time talking in-depth about relevant health issues and do more education.

You are very welcome to bring a spouse or support person at no charge.

Chapter 11

Motivational Interviewing

MOTIVATIONAL INTERVIEWING

Motivational interviewing techniques are used during diabetes group visits. This allows for more participant interaction and also enables the facilitators to reach the participants in ways that are more likely to positively impact their specific life situation. These techniques have repeatedly proven their effectiveness in changing behaviors. Motivational interviewing relies on open-ended questions to better engage the patient and glean additional information regarding patient's behavior which may not be realized through close-ended questions. Affirmation also is used to reinforce positive behaviors.

There are four main principles in Motivational Interviewing:

- **Roll with resistance**
 - Use an understanding demeanor.
 - Seek clarification from the patient of any perceived resistance.
 - Invite new perspectives from the patient; carefully avoid imposing them upon the patient.
 - It is important to ignore any apparently antagonistic elements in patient's comments and instead to focus on the more important issues underlying the resistance, the 'root causes.'

- **Express empathy**
 - Active listening is crucial to conveying your empathy to the patient and, indeed, to anyone with whom you interact.
 - Identify and seek to understand resistance and reasons for unhealthy behaviors without judgment.
 - Identify with the patient's feelings about the disease or the experience, not with the disease or the experience itself.
 - Attempt to understand the patient's challenges, both with the disease and with any proposed treatment, as non-judgmentally as possible.

- **Develop discrepancy**
 - Between important personal goals or values and present behavior...
 - Generally very motivating, when applied to health behavior change
 - Method:
 - First, have the patient identify his/her goals for treatment...
 - Then, ask the patient to help you understand any apparent discrepancies between his/her stated goals and the current behaviors that appear to contradict those goals.

- **Support self-efficacy**
 - Patient's belief in possibility of change is a crucial motivator.
 - Patient is responsible for choosing & carrying out change.
 - Praise patient's changed attitude/behavior.
 - Encourage the patient at every opportunity.

A useful tool in motivational interviewing is to promote the use of an action plan. A sample of an action plan is included for reference.

To see these principles in practice, please refer to the two vignettes at the end of this section.

GR-8D21 DGV.motivational.interviewing.052109cn

MY ACTION PLAN

DATE: _____

I _____ and _____
(name) (name of clinician)

have agreed that to improve my health I will:

1. Choose one of the activities below:



____ Work on something that's bothering me:



____ Stay more physically active!



____ Take my medications.



____ Improve my food choices.



____ Reduce my stress.



____ Cut down on smoking.

2. Choose your confidence level:

This is how sure I am that I will be able to do my action plan:



10 VERY SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Complete this box for the chosen activity:

What: _____

How much: _____

When: _____

How often: _____

(Signature)

(Signature of clinician)

Vignette #1

Mr. James Johnson is a long-term patient of yours who is well-enough acquainted with you that, at his request, you refer to him as Jim. He is a 62 y/o, Caucasian male Vietnam veteran with a medical history of severe COPD, hypertension, sleep apnea, and PTSD, who continues to smoke 2 packs of cigarettes a day. You have known Mr. Johnson for the past 6 months and have thus far had little success convincing him to change his lifestyle and improve adherence to his medical regimen.

Dr: Good morning Jim. It's nice to see you again. How can I help you today?

Patient: Hi doc, I think I've got bronchitis again. I need you to take care of it and I'm almost out of my blood pressure medicine.

Dr: We'll definitely check out your bronchitis today, and take care of your blood pressure prescription. But Jim, I'd also like to spend a little time today getting a better understanding of your point of view and attitudes regarding your health. Then I'd like to share with you some of my concerns. Does that sound all right to you?

Point out interviewing principles: Reassurance; patient's agenda matters and will be addressed; physician cares and expresses his/her concerns; physician's agenda matters too (physician is pro-active); physician invites and gently asks patient's permission.

Patient: If this is going to be about smoking doc, I'm still not interested in quitting. We can talk about smoking as long as you don't push me to change.

What stage of change is the patient in at this time?

Dr: It sounds like you're clear about not wanting to quit smoking right now, and that you're worried I'll try to push my agenda. I promise not to be pushy; I just want to have a better understanding of some of the reasons you continue to smoke.

Interviewing principles: reflective listening; roll with resistance; respecting the patient; assessing resistance to change

Dr: Often, the easiest way to do this is for you to walk me through a typical day in your life and along the way, I'll be asking you a few questions. Can we do that? **[questions will include: describe how much, when, with whom, and where you typically smoke; what do you feel before and after smoking; what does smoking mean to you; what do you gain from smoking; how does smoking interfere with your life?]**

Patient: It seems to help my anxiety and boredom. My wife died 4 years ago and it gets pretty lonely around the house during the day and evenings.

Dr: I hadn't realized that, Jim; I'm sorry you lost her; thanks for letting me know. My next question is about how important you feel it is to give up smoking at this time; if 1 is not important at all, and 10 is very important, where do you think you might fall on that scale right now?

Patient: I would say about a 3.

Interviewing principle demonstrated: assessing motivation for change

Dr: And if you were to decide to quit smoking today, how confident are you that you could do it, if 1 means not at all confident and 10 means very confident? What score seems right for you at this moment?

Patient: That would probably be about a 5.

Interviewing principle demonstrated: assessing self-efficacy

Dr: You gave yourself a 3 on your motivation to change. Why not a 1?

Interviewing principles demonstrated: let patient advocate for change; create dissonance; develop discrepancy; assess reasons for not smoking and the negative aspects of smoking, which will be later used as leverage for change

Dr: You rated your level of confidence at a 5. What changes might raise that to 6 or 7?

Interviewing principles demonstrated: Assess ways to increase self-efficacy and self-confidence

Dr: Tell me Jim, what would you say is most important to you in life?

Patient: Well, I want to be a good father and grandfather; I want to spend time with my family. I think of myself as a family man.

Dr: And what do you do in order to live according to those values?

Interviewing principles demonstrated: getting to know the patient better; information will be used later to develop discrepancy

END OF VIGNETTE #1

Vignette #2

Mr. Ford is a 45 y/o, Caucasian male with a history of hypertension and type-2 diabetes. You recently started working with him. The main struggle with Mr. Ford is his non-adherence to his blood pressure medication. Consequently, his blood pressure is not well controlled.

Dr. Hello Mr. Ford. It is nice to see you again. How are you doing?

Patient: Not very well. I recently lost my job and I feel very anxious almost all the time. I am sure that's the reason my blood pressure is high again.

Dr: It sounds like you're going through a difficult time right now. It must be scary to lose a job in this frail economy?

Interviewing principles: reflective listening and expressing empathy

Dr: I am glad that you came. It tells me that you care about your health and that you're interested in doing something about it. It sounds like you feel there is a close connection between your blood pressure and the stress you're feeling. We can talk about this a little more before you leave today. If you don't mind, I would also like to take a few minutes to discuss certain aspects of your blood pressure medications.

Interviewing principles: affirmation; patient's opinion matters; physician gently pushes his/her agenda;

Dr: How important do you feel it is for you to take your blood pressure medications regularly? In order for me to get a sense of how you feel, I'd like you to give me a rating, in which 1 is not at all important, and 10 is very important; where would you rate yourself?

Patient: Probably about a 3.

Interviewing principles: Exploring motivation to change

Dr: Why did you choose that number?

Interviewing principles: exploring pros and cons for taking the medications; understanding patient's ambivalence

Patient: I have serious sexual side effects that really embarrass me. Besides that, I don't think this medication works. My blood pressure is directly connected to my anxiety. I would consider taking it if you could prove me that it's working and that it won't affect my sex life.

What stage of change the patient is in?

Dr: This sounds like a very difficult issue for you. Your concerns are certainly serious. Tell me more about these side effects. OR I am glad you told me this; sexual side effects are typically an uncomfortable topic to bring up. Fortunately, there are many different types of blood pressure medication, and as long as I know that this is a problem with this one, I'm sure we can find one that won't have that side effect in you.

Interviewing principles: empathy; validation

The physician may choose to discuss sexual side effects in further detail, along with possible ways to resolve them, possibly followed by some education about the side effects of NOT taking blood pressure medication. If time permits, his anxiety could be addressed as well.

END OF VIGNETTE #2

Chapter 12

Tracking Patient Progress: Elements of a Diabetes Patient Registry

TRACKING PATIENT PROGRESS: ELEMENTS OF A DIABETES PATIENT REGISTRY

In order to track the progress of diabetic patients, a diabetes patient registry should be utilized in order to monitor how the disease is being managed. An effective registry will be composed of the following data elements:

- Patient Demographic Data
 - First and Last Name
 - Sex
 - Birth date
 - Patient's preferred contact phone number
 - Type of diabetes (1 or 2) - Year diabetes was diagnosed
 - Location of current diabetes care
 - Whether the patient has previously attended diabetes group visits

- Lab results and vital signs, to be collected quarterly (at most), including:
 - HbA1c
 - LDL
 - Systolic blood pressure
 - Diastolic blood pressure
 - Patient's BMI

- Lab results to be collected every 6 months (at most), including:
 - Microalbuminuria

- Examination results, including:
 - Diabetic Foot exam
 - Diabetic retinal exam

- Diabetic Medication Categories:
 - Oral
 - Injectable
 - Date Started

Following, please find a sample of a report from a diabetes registry created on Microsoft Access.

GR-8D21 DGV.diabetes.registry.052109cn

Diabetes Monitoring Profile for A Particular Patient

Measure	2008 Q1 Date	2008 Q1 Value	2008 Q2 Date	2008 Q2 Value	2008 Q3 Date	2008 Q3 Value	2008 Q4 Date	2008 Q4 Value
HbA1C	2/13	7.50	6/13	6.7			12/16	6.4
Microalbuminuria					8/14	3.0		
LDL	2/13	79			8/14	88		
GFR					8/14	78		
Foot Exams	5/13	NML						
Retinal Exams								
BMI	2/13	29.70	5/13	30.00	7/23	28.60	12/16	29.10
Systolic BP	3/6	130	6/3	126	7/23	130	11/6	116
Diastolic BP	2/13	74	5/13	74	7/23	80	11/6	78

Primary Care Physician Specific HgA1c Quarter 1 – Quarter 4 (2008)

Primary Care Physician	Patient Name	2008 Q1 Date	2008 Q1 Value	2008 Q2 Date	2008 Q2 Value	2008 Q3 Date	2008 Q3 Value	2008 Q4 Date	2008 Q4 Value
Doctor X	Bob					9/25	11.7		
Doctor X	Tom	2/22	7.5			8/12	8.3		
Doctor X	Joe	1/23	11.2	6/12	9.2	9/17	8.2		
Doctor X	Estelle	2/13	7.5	6/3	6.7			12/16	6.4
Doctor X	Bill	1/8	6.9			8/14	8.7		
Doctor X	Alice			4/2	7.8			10/8	6.5

While it is important to document all clinical data gathered during group visits, it is also important to document why individuals miss group visit appointments. Tracking this information could show that perhaps group visits are being hosted at inconvenient times or patients are facing other challenges which may hinder their ability to attend. Following are two formats for tables that could assist in this type of data tracking:

Diabetes Group Visit Attendance (Example #1)

Patient Name/Contact #	Session 1 (Y/N)	Session 2 (Y/N)	Session 3 (Y/N)	Session 4 (Y/N)	Session 5 (Y/N)	Session 6 (Y/N)	Reason Not Attending

Diabetes Group Visit Attendance (Example #2)

Name	Phone #	Physician	Attending (Y/N)	If no, why?

Chapter 13

Billing & Reimbursement

BILLING AND REIMBURSEMENT: BILLING CODE REVIEW REGARDING THE REIMBURSEMENT OF DIABETES GROUP VISITS

The most commonly accepted billing code of diabetes group visits (or “shared medical appointments”) is Evaluation and Management (E&M) code 99214 for a level 4 medical appointment. Page 80 clearly outlines the appropriate documentation for this billing code.

This documentation and coding is supported by the information provided below from the Centers for Medicare and Medicaid Services, the American Academy of Family Physicians, State of Michigan insurers, and multiple peer-reviewed journal articles. To date the GFHC has been unable to locate any information which contradicts the acceptability of this billing procedure. Full documents elaborating on the information below are available upon request.

Group Visit Billing and Coding Position of Medicare/CMS

Centers for Medicare and Medicaid Services (CMS) support the billing of group visits and shared medical appointments using traditional E&M codes depending on the complexity of the patient visit. The following is a statement outlining CMS’ position:

“Under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E&M visit (CPT code 99213 or similar code depending on the level of complexity) to a particular patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary.”

Thus, if appropriately documented this supports billing for a level 4 medical appointment for each patient treated in the diabetes group visit.

Suggested Group Visit Billing and Coding by the American Academy of Family Physicians (AAFP)

The American Academy of Family Physicians, supporting the position of CMS, suggests billing group visits with office visit codes 99201-99215 based on the services rendered in the entire group visit.

Group Visit Billing and Coding Supported by Blue Cross Blue Shield of Michigan

As of March, 2010, Blue Cross Blue Shield of Michigan, supporting the position of CMS, accepts billing group visits with office visit codes 99201-99215 based on the services rendered and documented for each patient at the group visit. Please contact your local Blue Cross Blue Shield of Michigan Provider Consultant to obtain current billing information for diabetes group visits.

Group Visit Billing and Coding Supported by HealthPlus of Michigan

As of March, 2010, HealthPlus of Michigan, supporting the position of CMS, accepts billing group visits with office visit codes 99201-99215 based on the services rendered and documented for each patient at the group visit. Please contact your local HealthPlus of Michigan billing representative to confirm current billing information for diabetes group visits.

Suggested Group Visit Billing and Coding by American Journal of Health-System Pharmacy Article, "Development and Implementation of Group Medical Visits at a Family Medicine Center"

A peer-reviewed article by Barud et.al. entitled "Development and Implementation of Group Medical Visits at a Family Medicine Center" suggests that each patient in the group visit be billed using the standard E&M codes 99212-99215. It further notes that E&M code 99214 is the most commonly used because of the physical examination and complexity of medical decision-making.

Suggested Group Visit Billing and Coding by Clinical Diabetes Article, "The Potential of Group Visits in Diabetes Care"

A peer-reviewed article by Davis et.al. entitled "The Potential of Group Visits in Diabetes Care" suggests that each patient in the group visit be billed using the office visit E&M codes employed in standard one-on-one office visits. It is noted that the code depends on the extent of history, physical exam, decision making, and complexity and that billing cod Level 3 or Level 4 (99213 or 99214) may be appropriate in a typical visit.

Suggested Group Visit Billing and Coding by Family Practice Management Article, "Planning Group Visits for High-Risk Patients"

A peer-reviewed article by Masley et.al. entitled "Planning Group Visits for High-Risk Patients" suggests that E&M codes 99213 and 99214 are acceptable for group visit services. It is noted that the level service billed should correspond to the services documented.

BILLING & REIMBURSEMENT: DOCUMENTING A LEVEL 4 PATIENT VISIT

In order to bill for a Level 4 medical appointment, **THREE** general components must be addressed with the patient:

HISTORY-Documentation of the chief complaint is needed along with **four or more** descriptive elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated symptoms

EXAM: As part of the group visit, patients are examined for various symptoms and conditions associated with diabetes. These include examinations of the feet and eyes in addition to HbA1C and LDL screenings.

MEDICAL DECISION MAKING: For this component, **2 of 3** of the following three areas must be satisfied:

- Diagnosis – In diabetes, this involves the management options for the patient.
- Data – This refers to the data required to make a clinical recommendation for condition management.
- Risk – This refers to the overall risk associated with the presenting condition, management options, or recommended diagnostic procedures.

NOTE: HELPFUL TOOL FOR LEVEL 4 CODING

The *Patient Progress Note* which was provided Chapter 7 ensures that all components necessary for Level 4 coding are met provided each item is completed.

Chapter 14

Pay for Performance and the Diabetes Group Visit

PAY FOR PERFORMANCE AND THE DIABETES GROUP VISIT

Conducting diabetes group visits can help physicians meet performance requirements as they relate to diabetes management. While if a physician is affiliated with a physician hospital organization there is likely a negotiated bonus level for care improvements, a general overview of pay for performance incentives by major local insurers follows:

HealthPlus of Michigan ***(as of September 2009)***

2009 Quality Performance Plus

- *Clinical Quality (HEDIS) for Diabetes HbA1c Test (family practice and internal medicine physicians).*
 - *WEIGHT = 7.5%*
- *Clinical Quality (HEDIS) Diabetes LDL Screening (family practice and internal medicine physicians)*
 - *WEIGHT = 5.0%*

Blue Cross Blue Shield of Michigan ***(as of September 2009)***

Physician Group Incentive Program (PGIP)

Blue Cross Blue Shield of Michigan's (BCBSM) Evidence-Based Care Report (EBCR) component of the Physician Group Incentive Program (PGIP) recognizes physician organizations who effectively deliver evidence based care to their patient population. EBCR goals are to reduce gaps in care, improve health outcomes through adhering more closely to evidence-based guidelines and reduce health care costs. The following EBCR metrics are currently utilized to evaluate the care rendered to diabetic patients:

- HbA1C testing
- LDL-C Screening
- Monitoring for Nephropathy
- Lipid Lowering Drug Rate
- Statin Use
- ACE/ARB Use with Comorbidity of Congestive Heart Failure
- ACE/ARB Use with Comorbidity of Nephropathy
- ACE/ARB Use with Comorbidity of Hypertension

Additional information regarding BCBSM's PGIP pay for performance program and EBCR may be accessed online at www.bcbsm.com/provider/value_partnerships/pgip/care_tracking.shtml.

Chapter 15

Improving Physician Satisfaction

IMPROVING PHYSICIAN SATISFACTION

Reports have shown increased levels of physician satisfaction by physicians conducting group visit for patients with chronic diseases. The group visits allow for more time for patient education and also allow for reinforcement of the physician's message by the group. Group visits have also proved to be an effective method to providing evidence based care in addition to enabling the provider to increase efficiency and ultimately increase access.³

Studies have also shown that physicians are highly satisfied with their ability to treat patients in the group visit setting. Since group visits improve physician productivity by allowing physicians to treat more patients in a more efficient manner, improvements in physician satisfaction are to be expected.⁴

Please assist us as we begin to assess local physician satisfaction with the Diabetes Group Visit Model. At the end of this section you will find a physician satisfaction survey. Please complete the survey and send it to:

**Greater Flint Health Coalition
c/o Diabetes Group Visit Project
Commerce Center
519 South Saginaw Street, Suite 306
Flint, Michigan 48502**

Or via email at:
gfhc@flint.org

Or via fax at:
(810) 232-3332

³ Agency for Healthcare Research and Quality: Innovations Exchange;
<http://www.innovations.ahrq.gov/content.aspx?id=1890>

⁴ Raja Jaber, MD, Amy Braksmajer, MPH and Jeffrey S. Trilling, MD. Group Visits: A Qualitative Review of Current Research. The Journal of the American Board of Family Medicine. 19:276-290 (2006)

Physician Satisfaction Survey: Group Medical Appointments

Thinking about Group Medical Appointments, how would you rate the following:

(Circle one number on each line.)

		Very			
	Excellent	Good	Good	Fair	Poor
1. The quality of care	5	4	3	2	1
2. Support from administration (space, co-facilitator...)	5	4	3	2	1
3. As a disease management tool	5	4	3	2	1
4. As a tool to assist with access problems	5	4	3	2	1
5. The ability to utilize your own creativity for treating patients	5	4	3	2	1
6. The effectiveness of GMA's in achieving your goals	5	4	3	2	1
7. The overall usefulness GMA's in your practice.	5	4	3	2	1

For any answer scoring less than "3", what can be changed or what resources would you need to improved your experience with group visits?

Do you know any other physicians who would benefit from implementing group visits in their practice and would like to receive additional information?

NAME: _____

CONTACT INFORMATION: _____

Thank You! We appreciate your feedback!

Chapter 16

Improving Patient Satisfaction

IMPROVING PATIENT SATISFACTION

Patients who have participated in group visits report high rates of satisfaction with participation in group visits. Patients reported increased knowledge of physical and stress management exercises, nutrition, disease management, and drugs.⁵

Trento, et al also demonstrated that group visit patients exhibit improved quality of life, diabetes knowledge, and health problem identification. After four years, patients who had participated in group visits showed less progression of retinopathy, lower A1C results, and improved diabetes knowledge and quality of life when compared to a control group receiving conventional 1 on 1 care.⁶

We would like to know what your patients think of Diabetes Group Visits! Please have your patients complete the survey and the patient activation measurement tool on the following pages and send it to:

**Greater Flint Health Coalition
c/o Diabetes Group Visit Project
Commerce Center
519 South Saginaw Street, Suite 306
Flint, Michigan 48502**

Or via email at:
gfhc@flint.org

Or via fax at:
(810) 232-3332

These surveys are also useful as you work to improve your facilitation of diabetes group visits.

⁵ R. Jaber, A. Braksmajer & J. Trilling : Group Visits: Our Experience With This Adjunctive Model To Chronic Care Management . *The Internet Journal of Family Practice*. 2005 Volume 4 Number 1

⁶ Trento M, Passera P, Marco T, et al. Group Visits Improve Metabolic Control in Type 2 Diabetes. *Diabetes Care*. 24(6) 2001: 995-1000.

Patient Satisfaction Survey:

MD: _____

Date: _____

Have you ever attended a Diabetes Group Visit before? **Yes** **No** If yes, how many? _____

Have you completed this survey before today? **Yes** **No**

Thinking about this particular appointment, how would you rate the following:

(Circle one number on each line.)

	Excellent	Very Good	Good	Fair	Poor	
1. Availability of Appointment	5	4	3	2	1	
2. Helpfulness of the goal follow-up calls	5	4	3	2	1	
3. Courtesy and helpfulness of medical team	5	4	3	2	1	
4. Time spent with the medical team	5	4	3	2	1	
5. Explanation of what was done for you	5	4	3	2	1	
6. Technical skills (thoroughness, carefulness, competence) of the medical team	5	4	3	2	1	
7. The personal manner (courtesy, respect, sensitivity, friendliness) of the medical team	5	4	3	2	1	
8. The visit overall	5	4	3	2	1	
9. In general, would you say your health is	5	4	3	2	1	
10. Would you recommend the diabetes group visit to your family or friends?	Definitely yes <input type="checkbox"/>	Probably yes <input type="checkbox"/>	Probably not <input type="checkbox"/>	Definitely not <input type="checkbox"/>		
13. Are you (patient) male or female	Male	Female				

Please turn this page over.....→

Is there anything you particularly liked about today's appointment?

Is there anything you particularly disliked about today's appointment?

Have you participated in any other diabetes education programs in the past? If so, please list them below.

Thank You! We appreciate your feedback!

Patient Activation Measure

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by **circling your answer**. *Your answers should be what is true for you and not just what you think the doctor wants you to say.* If the statement does not apply to you, **circle N/A**.

When all is said and done, I am the person who is responsible for managing my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
Taking an active role in my own health care is the most important factor in determining my health and ability to function.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know what each of my prescribed medications does.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can follow through on medical treatments I need to do at home.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I understand the nature and causes of my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know the different medical treatment options available for my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I have been able to maintain the lifestyle changes for my health condition(s) that I have made.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know how to prevent further problems with my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident I can figure out solutions when new situations or problems arise with my health condition(s).	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

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Chapter 17

Statistical Overview of Diabetes Morbidity/Mortality in Genesee County & Michigan

STATISTICAL OVERVIEW OF DIABETES MORBIDITY/MORTALITY IN GENESEE COUNTY & MICHIGAN

Table 1

Number of deaths with Diabetes as Leading Cause by Age, Michigan Residents, 2004

All Ages	<20 yrs.	20-44 yrs	45-74 yrs	75+ yrs.
2,954	5	108	1,217	1,627

Source: Michigan Department of Community Health, 2004

Table 2

Number of Deaths and Age-Adjusted Death Rates (100,000 population) with Diabetes as Leading Cause by Race & Sex, Michigan Residents, 2004

	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Deaths	2,954	1,413	1,541	2,416	1,172	1,244	456	206	250
Rates	28.4	32.7	25.1	26.3	30.9	22.8	42.5	46.7	39.3

Source: Michigan Department of Community Health, 2004

The following tables details the number of Genesee County, Michigan residents with Diabetes by Age, Sex, and Race, 2004

Table 3

Estimated Number of Adults with Diabetes, by Sex and Race in Genesee County, Michigan, 2004

	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Genesee County	26,300	11,800	14,500	19,100	9,100	10,000	6,700	2,500	4,200

Source: Michigan Department of Community Health, 2004

Table 4

Total Number of Deaths with Diabetes as Leading Cause, by Age, in Genesee County, Michigan, 2004

All Ages	<20 yrs.	20-44 yrs	45-74 yrs	75+ yrs.
156	0	8	84	64

Source: Michigan Department of Community Health, 2004

Table 5

Total Number of Deaths and Age-Adjusted Rates with Diabetes as Leading Cause, by Sex and Race in Genesee County, Michigan, 2004

	All Races			White			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Deaths	156	76	80	114	58	56	30	13	17
Rates	35.7	39.4	32.1	31.3	36.4	26.6	44.7	*	*

* Insufficient data to compute a stable rate (number of events <20).

Source: Michigan Department of Community Health, 2004

GR-8D21 statistical.overview.mort.morb.mi.gc.052109cn

Chapter 18

Michigan Quality Improvement Consortium (MQIC) Guidelines for the Management of Diabetes Mellitus

The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Patients 18-75 years of age with type 1 or type 2 diabetes mellitus	<p>Periodic assessment</p>	<p>Assessment should include:</p> <ul style="list-style-type: none"> • Height, weight, BMI, blood pressure [A] (adult target of < 130/80) • Assess cardiovascular risks (smoking, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age > 40) • Comprehensive foot exam (including monofilament testing annually) [B] • Screen for depression [D] • Dilated eye exam by ophthalmologist or optometrist [B], or digiscope [B] 	<ul style="list-style-type: none"> • At least annually and more frequently as needed • In the absence of retinopathy repeat in 2 years
Laboratory tests		<p>Tests should include:</p> <ul style="list-style-type: none"> • A1C [D] • Urine microalbumin measurement [D] • Serum creatinine and calculated GFR [D] • Fasting lipid profile 	<p>A1C 2 - 4 times annually based on individual therapeutic goal ; other tests at least annually</p>
Education, counseling and risk factor modification		<ul style="list-style-type: none"> • Comprehensive diabetes self-management education (DSME) from a collaborative team or diabetic educator if available • Education should be individualized, based on the National Standards for DSME [B] and include: <ul style="list-style-type: none"> • Assessment of patient knowledge, attitudes, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns [C] • Description of diabetes disease process and treatment, safe and effective use of medications; prevention, detection and treatment of acute and chronic complications • Importance of nutrition management and regular physical activity [A] • Role of self-monitoring of blood glucose in glycaemic control [A] • Cardiovascular risk reduction • Smoking cessation intervention [B] and secondhand smoke avoidance [C] • Self-care of feet [B]; preconception counseling [D]; encourage patients to receive dental care [D] 	<p>At diagnosis and as needed</p>
Medical recommendations		<p>Care should focus on smoking, hypertension, lipids and glycaemic control:</p> <ul style="list-style-type: none"> • Medications for tobacco dependence unless contraindicated • Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of < 130 systolic [B] and < 80 diastolic [A] • Prescription of ACE inhibitor or angiotensin receptor blocker in patients with hypertension or albuminuria [A]² • Statin therapy for primary prevention against macrovascular complications in patients with diabetes who are ≥ age 40 or who have an LDL-C ≥ 100 mg/dl [A]³ • Anti-platelet therapy [A]: low dose aspirin daily for primary prevention in adults at increased cardiovascular risk with type 1 [C] and type 2 [A] diabetes, unless contraindicated • Adjust the plan to eventually achieve normal or near-normal glycaemia with an A1C goal for most patients of < 7%. Less stringent treatment goals may be appropriate for patients with a history of severe hypoglycemia, patients with limited life expectancies, very young children or older adults and individuals with comorbid conditions. More stringent treatment goals (i.e., a normal A1C < 6%) for individual patients and in pregnancy. Note: Insulin and sulfonureas sometimes result in weight gain. • Assurance of appropriate immunization status (tetanus, diphtheria, pertussis, influenza, pneumococcal vaccine) [C] 	<p>At each visit until therapeutic goals are achieved</p>

¹ See http://care.diabetesjournals.org/content/vol31/Supplement_1/

² Consider referral of patients with serum creatinine value >2.0 mg/dl (adult value) or persistent albuminuria to nephrologist for evaluation.

³ Target LDL-C < 100 mg/dl [B]. For patients with overt CVD, a lower LDL-C goal of < 70 mg/dl is an option [B].

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources, including the 2008 American Diabetes Association Clinical Practice Recommendations (www.diabetes.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Chapter 19

Prescription Drugs Approved For Use by Diabetic Patients

PRESCRIPTION DRUGS APPROVED FOR USE BY DIABETIC PATIENTS

THE FOLLOWING SPREADSHEET CONTAINS THE NAME, CLASS, AND GENERIC AVAILABILITY OF PHARMACEUTICALS APPROVED FOR TREATMENT OF DIABETES AND ITS ASSOCIATED CONDITIONS AS OF JULY 1, 2009.

Brand Name	Generic Name	Generic Availability	Drug Class
Accupril	Quinapril	Y	ACE-I
Accuretic	Quinapril/HCTZ	Y	ACE-I/Diuretic
Aceon	Perindopril	N	ACE-I
ACTOplus met	Pioglitazone/Metformin	N	Thiazolidinedione/Biguanide
Actos	Pioglitazone	N	Thiazolidinedione
Advicor	Lovastatin/Niacin	N	Statin
Altace	Ramipril	Y	ACE-I
Altoprev	Lovastatin Extended Release	N	Statin
Amaryl	Glimepiride	Y	Sulfonylurea
Antara	Fenofibrate Micronized	N	Fibrate
Apidra	Insulin Glulisine	N	Insulin
Avandamet	Rosiglitazone/Metformin	N	Thiazolidinedione/Biguanide
Avandaryl	Rosiglitazone/Glimepiride	N	Thiazolidinedione/Sulfonylurea
Avandia	Rosiglitazone	N	Thiazolidinedione
Byetta	Exenatide	N	Incretin Mimetic
			Statin/Calcium Channel
Caduet	Atorvastatin/Amlodipine	N	Blocker
Capoten	Captopril	Y	ACE-I
Capozide	Captopril/HCTZ	Y	ACE-I/Diuretic
Cozaar	Losartan	N	ARB
Crestor	Rosuvastatin	N	Statin
DiaBeta	Glyburide	Y	Sulfonylurea
Diabinese	Chlorpropamide	Y	Sulfonylurea
Diovan	Valsartan	N	ARB
Diovan HCT	Valsartan/HCTZ	N	ARB/Diuretic
Fortamet	Metformin Extended Release	N	Biguanide
Glucophage	Metformin	Y	Biguanide
Glucophage XR	Metformin Extended Release	Y	Biguanide
Glucotrol	Glipizide	Y	Sulfonylurea
Glucovance	Glyburide/Metformin	Y	Sulfonylurea/Biguanide
Glumetza	Metformin Extended Release	N	Biguanide
Glynase	Glyburide Micronized	Y	Sulfonylurea
Glyset	Miglitol	Y	Alpha-Glucosidase Inhibitor
Humalog	Insulin Lispro	N	Insulin, Rapid Acting
	Insulin Lispro/Lispro		
Humalog 50/50	Protamine	N	Insulin, Mix
	Insulin Lispro/Lispro		
Humalog 75/25	Protamine	N	Insulin, Mix
Humulin	Insulin Regular	N	Insulin, Regular Acting
Humulin 50/50	Insulin Regular/Isophane	N	Insulin, Mix
Humulin 70/30	Insulin Regular/Isophane	N	Insulin, Mix
Humulin N	Insulin Isophane	N	Insulin, Intermediate Acting

Brand Name	Generic Name	Generic Availability	Drug Class
Janumet	Sitagliptin/Metformin	N	DPP-4 Inhibitor/Biguanide
Januvia	Sitagliptin	N	DPP-4 Inhibitor
Lantus	Insulin Glargine	N	Insulin, Long Acting
Lescol	Fluvastatin	Y	Statin
Lescol XL	Fluvastatin Extended Release	N	Statin
Levemir	Insulin Detemir	N	Insulin, Long Acting
Lexxel	Enalapril/Felodipine	N	ACE-I/Calcium Channel Blocker
Lipitor	Atorvastatin	N	Statin
Lofibra	Fenofibrate	N	Fibrate
Lopid	Gemfibrozil	Y	Fibrate
Lotensin	Benazepril	Y	ACE-I
Lotensin/HCT	Benazepril/HCTZ	Y	ACE-I/Diuretic
Lotrel	Benazepril/Amlodipine	N	ACE-I/Calcium Channel Blocker
Mavik	Trandolapril	Y	ACE-I
Metaglip	Glipizide/Metformin	Y	Sulfonylurea/Biguanide
Mevacor	Lovastatin	N	Statin
Monopril	Fosinopril	Y	ACE-I
Monopril/HCT	Fosinopril/HCTZ	Y	ACE-I/Diuretic
Novolin	Insulin Regular	N	Insulin, Regular Acting
Novolin 70/30	Insulin Regular/Isophane	N	Insulin, Mix
Novolin N	Insulin Isophane	N	Insulin, Intermediate Acting
Novolog	Insulin Aspart	N	Insulin, Rapid Acting
Novolog Mix 70/30	Insulin Aspart/Aspart Protamine	N	Insulin, Mix
Orinase	Tolbutamide	Y	Sulfonylurea
Prandin	Repaglinide	N	Meglitinide
Pravachol	Pravastatin	Y	Statin
Precose	Acarbose	Y	Alpha-Glucosidase Inhibitor
Prinivil	Lisinopril	Y	ACE-I
Prinzide	Lisinopril/HCTZ	Y	ACE-I/Diuretic
Riomet	Metformin Solution	N	Biguanide
Starlix	Nateglinide	Y	Meglitinide
Symlin	Pramlintide	N	Amylin Mimetic
Tarka	Trandolapril/Verapamil	N	ACE-I/Calcium Channel Blocker
Tolinase	Tolazamide	Y	Sulfonylurea
Tricor	Fenofibrate	N	Fibrate
Triglide	Fenofibrate	N	Fibrate
Trilipix	Fenofibric Acid	N	Fibrate
Uniretic	Moexipril/HCTZ	Y	ACE-I/Diuretic
Univasc	Moexipril	Y	ACE-I
Vaseretic	Enalapril/HCTZ	Y	ACE-I/Diuretic
Vasotec	Enalapril	Y	ACE-I
Vytorin	Simvastatin/Ezetimibe	N	Statin
Zestoretic	Lisinopril/HCTZ	Y	ACE-I/Diuretic
Zestril	Lisinopril	Y	ACE-I
Zocor	Simvastatin	Y	Statin

Chapter 20

Greater Flint Health Coalition: Diabetes Group Visit Project Terms of Reference

GREATER FLINT HEALTH COALITION

TERMS OF REFERENCE

DIABETES GROUP VISIT WORKGROUP (2008)

MISSION:

In the area of diabetes, to support the mission of the Greater Flint Health Coalition:

- Improve the health status of residents of Genesee County
- To improve the quality and cost effectiveness of the health care system in our community.

VISION OF THE COALITION:

A healthy Genesee County community practicing healthy lifestyles with access to the best and most cost effective health and medical care.

CORE VALUES:

Consensus
Collaboration
Fairness
Integrity
Continuous Improvement
Innovation
Public Participation

VISION OF THE WORKGROUP:

To reduce the morbidity related to diabetes and diabetes related illnesses by improving the quality of life of individuals with diabetes. Special emphasis will be placed on patient/support system interaction, adherence to drug therapies, patient education, and improved self-management and understanding of the disease and its long-term complications.

OUTCOME OPTION:

1. To support the continuation/expansion of Diabetes Group Visits within McLaren Regional Medical Center's Family Medicine Residency Program.
2. Develop strategies for the expansion of the Diabetes Group Visit concept to other healthcare organizations within Genesee County, including Genesys Regional Medical Center, Hurley Medical Center, Hamilton Community Health Network, and any other potential Genesee County organizations exhibiting significant capabilities/interest.
3. Promote education related to diabetes self-management to those affected by the disease and their support systems.
4. Promote improved health outcomes and lower overall costs of care associated with diabetes and comorbidities of diabetes.
5. Improve patient access, enhance patient and physician satisfaction and increase physician productivity.

OUTCOME OPTION IMPACT ON 2007 - 2012 GOAL FRAMEWORK

Improved health status is promoted collectively through the focus areas of access, quality, cost, and health improvement. Specifically, promoting the continuation and expansion of diabetes group visits within Genesee County increases access (options #1,2). The quality of diabetes related healthcare is impacted by promoting education related to diabetes and improving the efficiency of physicians treating diabetic patients (option #3,5). Cost is impacted as self management of the disease is improved and comorbidities are reduced (option#3,4). Health Improvement is impacted as Genesee County residents are educated about diabetes and how to properly care for the disease. Improved education related to the disease will increase both patient and provider satisfaction (option #3,5).

MEASURABLE HEALTH OUTCOMES:

Collectively, this initiative's approach to care will seek to reduce diabetes mortality and morbidity, with considerable focus on the racial disparity that is present. The following five year goal is achievable by 2012:

	Overall Genesee County rate	Genesee County African American rate	Genesee County White rate	GFHC FIVE YEAR GOAL (2012)
Baseline Year:	2004	2004	2004	
Diabetes Mortality rate:	35.7	44.7	31.3	30.0

*Rates per 100,000 population / Rate Source: GCHD & MDCH
Goal Source: Healthy People 2010*

TASK FORCE MEMBERSHIP:

All individuals will either be appointed by their organizations' chief executive officer/director or the president of the coalition. The individuals should be senior enough to be able to influence and represent their organization's policies on the subject matter.

Commitments: The task force will meet monthly for one and a half hours at the coalition offices with a time to be determined by members. Additional commitments of time will occur through specific working groups.

The membership will be categorized by the Coalition's "sectors":

Providers (6)	Genesee County Medical Society Genesee County Osteopathic Society Genesys Health System Hamilton Community Health Network Hurley Medical Center McLaren Regional Medical Center
Government (1)	Genesee County Health Department
Insurers (3)	Blue Care Network/Blue Cross Blue Shield of Michigan HealthPlus of Michigan Genesee Health Plan
Consumers/ Community Residents (2-4)	UAW/GM Community Health Initiatives
Chair (1)	Paul Dake, M.D., McLaren Family Practice Residency Program
Ex-officio Members:	President, Greater Flint Health Coalition Chair, Greater Flint Health Coalition

REPORTING:

The workgroup will report to the Cost & Resource Planning Committee.

STAFFING:

The staffing of the workgroup will be handled by the Greater Flint Health Coalition.

BUDGET:

External funding will be pursued.

On October 18, 1999 the board approved the REACH Task Force Terms of Reference. In doing so, the board recommended the vision and outcome option of REACH (Racial and Ethnic Approaches to Community Health) become part of the operational terms of reference of every committee/task force of the Coalition.

THE REACH TASK FORCE

Vision:

To keep before the Coalition the issue of ethnic & racial disparities in health care.

Outcome Options:

To assist a broad base of community leaders in health care in understanding the multifaceted challenges of race relations and its impact on individual community member's health.

- To keep front and center the issue of ethnic and racial disparities in the work of the Coalition.

Approved by the Executive Committee on February 29, 2008.

Approved by the Board of Directors on September 15, 2008.

GR-8D21 termsofreference.110608jv

Chapter 21

Resources for Diabetics

Resources for Diabetics

For more information relating to diabetes management, please contact:

American Diabetes Association (ADA)

ATTN: National Call Center
1701 North Beauregard Street
Alexandria, VA 22311
1-800-DIABETES (342-2383)
www.diabetes.org

Michigan Department of Community Health – Diabetes

www.michigan.gov/mdch/diabetes

Michigan Partners on the Path

www.mipath.org

Michigan Organization of Diabetes Educators (MODE)

www.modeonline.org

National Diabetes Education Program (NDEP)

www.ndep.nih.gov

American Association of Diabetes Educators (AADE)

www.diabeteseducator.org

Michigan Diabetes Outreach Network

www.diabetesinmichigan.org

Juvenile Diabetes Research Foundation (JDRF)

www.jdrf.org

If you have any patients who you feel may benefit from additional diabetes education classes, please see the list that follows this page. The cost of

many of these programs is covered by insurance. Have your patient contact their insurance provider to learn more.

2009 Community Diabetes Education in Genesee, Lapeer, & Shiawassee Counties

Facility	Programs Available	Facility Criteria to Enroll	Peds/ Adult	Educators Certified	Notification of attendance to physician	Contact
Genesys Regional Medical Center One Genesys Pkwy Grand Blanc, MI	Group classes 3 3-hr classes Member can have 1:1 if necessary Start insulin pumps	Referral from PCP	Adult Classes Peds and gestationals are seen individually Provide follow up with patient on how doing with long term goals	Yes	Yes	Registration 810-606-7720 Kathy Peshke,MS,RD,CDE Trissa Torres MD, Medical Director Fax – 810-606-7747
Hurley Medical Center 1 Hurley Plaza, Flint, MI	Adult classes, 10 hrs Also offer 1:1 classes Free Pre-Diabetes Classes	Referral from PCP	Adult and Peds Classes available	Yes	Yes	Diabetes Adult Program 810-239-0485 Gestational: 810-257-9126 Pediatric Registration: 810-762-6162

Facility	Programs Available	Facility Criteria to Enroll	Peds/ Adult	Educators Certified	Notification of attendance to physician	Contact
Lapeer Regional Hospital (through McLaren)	<p>Members are seen 4 times (total of 9 hrs) initially.</p> <p>Follow up offered in 6 mos.</p> <p>1:1 if necessary.</p>	<p>Referral from PCP</p>	<p>Adult Classes</p> <p>Teens (16 and older) with Type II</p>	<p>Yes</p>	<p>Yes</p>	<p>Registration # for classes / questions:</p> <p>810-342-4110</p> <p>Manager of Wt Mgmt, Diabetes Ed and Wellness:</p> <p>Bethany Maurer</p> <p>Fax 810-342-4428</p> <p>New Address – G3200 Beecher Rd</p>
Loving Hands Free Clinic	<p>Adult Classes- Group 2 hours/week</p>	<p>Call for appointment</p>	<p>Adults Classes</p>	<p>Yes</p>	<p>Yes</p>	<p>Schedule classes by calling 810-667-8933</p>

Facility	Programs Available	Facility Criteria to Enroll	Peds/ Adult	Educators Certified	Notification of attendance to physician	Contact
Memorial Healthcare, 826 W. King St. Owosso, MI	<p>1:1 sessions for Type 1 and gestational diabetes</p> <p>Type II group classes with 1:1 on request.</p> <p>Evening and morning group classes</p> <p>10 working days to schedule initial assessment</p>	Referral from PCP	<p>Adult classes</p> <p>Can work with pediatric members over age 6 yrs.</p>	Yes	Yes	<p>Registration:</p> <p>989-729-4712</p> <p>Martha Ade, CDE</p> <p>Fax 989-729-7762</p>

Facility	Programs Available	Facility Criteria to Enroll	Peds/ Adult	Educators Certified	Notification of attendance to physician	Contact
<p>McLaren Regional Medical Center</p> <p>401 S. Ballenger Flint, MI</p>		<p>Referral from PCP</p>	<p>Adult Classes</p> <p>Teens (16 and older) with Type II</p>	<p>Yes</p>	<p>Yes</p>	<p>Registration # for classes / questions:</p> <p>810-342-4110</p> <p>Manager of Wt Mgmt, Diabetes Ed and Wellness:</p> <p>Bethany Maurer</p> <p>Fax 810-342-4428</p> <p>New Address- G3200 Beecher Rd</p>

Chapter 22

How to Observe a Diabetes Group Visit in Genesee County & Contact Information

ADDITIONAL INFORMATION

For more information on the Diabetes Group Visit Project, please contact:

Greater Flint Health Coalition
519 S. Saginaw Street, Suite 306
Flint, Michigan, 48502
(810) 232-2228
gfhc@flint.org
www.gfhc.org

OBSERVE A DIABETES GROUP VISIT

To observe a Diabetes Group Visit in Genesee County, please contact:

Paul Dake, M.D.
McLaren Family Practice Residency Program
G-3230 Beecher Road
Flint, Michigan 48532
(810) 342-5656
paulda@mclaren.org

