SUPPLEMENTARY INFORMATION PACKET

Improving Diabetes Care through Group Visits and Patient-Centered Medical Home (PCMH) Principles

Presented by:
Karen A. Funk, MD, MPP, Vice President of Clinical Services, Clinica Family Health Services

Live Broadcast Date/Time:
Tuesday, March 18, 2014
11:30am–1:00pm Mountain Time / 12:30–2:00pm Central Time

Event Overview:
This webcast will introduce participants to a group-based care delivery model utilized at Clinica Family Health Services that has been transforming over the last ten years. Dr. Funk will outline the essential components of the unique care team that staffs group visits as well as the care team pods that support individual patient visits. She will explain how essential components of this care delivery model increase access to primary care and increase quality outcomes, and review core components of the this care delivery model that reflect the framework of a patient-centered medical home.

Learning Objectives:
Participants will:
1. Learn about a group visit model of care for chronic disease utilized at Clinica Family Health to care for diabetic patients.
2. Understand the components of the group visit Clinica care team that lead to improved quality outcomes for diabetic patients.
3. Be able to identify how the components of the group visit care delivery model can increase access and increase quality.
4. Be able to identify core components of the PCMH model that promote quality outcomes for diabetic patients at Clinica Family Health.

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Community Health Association of Mountain/Plains States (CHAMPS)
CONTINUING MEDICAL EDUCATION (CME) CREDIT
This Live activity, Improving Diabetes through Patient-Centered Medical Home (PCMH) Principles, with a beginning date of 03/18/2014, has been reviewed and is acceptable for up to 1.50 Prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Application for CME credit for the archived version of the event will be filed immediately following the live webcast.

CHAMPS ARCHIVES
This event will be archived online and on CD-ROM. The online version will be available within two weeks of the live event, and the CD will be available within two months. CHAMPS will email all identified participants when these resources are ready for distribution. For information about all CHAMPS archives, please visit www.CHAMPSonline.org/Events/DistanceLearning.html.

DESCRIPTION OF CHAMPS
Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, please visit www.CHAMPSonline.org.

SPEAKER’S BIOGRAPHY
Dr. Funk has been a family physician at Clinica Family Health Service’s Lafayette Clinic since 2004 and took on the role of Assistant Medical Director in 2012. She graduated with distinction from Swarthmore College where she spent a year at the London School of Economics and Political Science. She went on to the University of Chicago where she graduated with honors with a Master’s degree in Public Policy. Following graduate school, Dr. Funk served as the Quality Improvement Coordinator for Planned Parenthood of Greater Chicago. Somewhere along the way, someone convinced Karen that she would be a great physician and in 2001 she received her M.D. from the University of Illinois. Dr. Funk was an Albert Schweitzer Fellow, which involved working with a Community Health Center in Chicago providing group based education to teens on obesity prevention, healthy sexuality, and pregnancy prevention. With family ties in Colorado and a growing family, Karen completed her residency in Family Medicine at Rose Medical Center.
ADDITIONAL CHAMPS RESOURCES

Diabetes Treatment Resources
A compilation of resources to support the treatment of patients with diabetes, including evidence-based clinical guidelines and recommendations, articles and reports relating to diabetes, webcasts and other online CME opportunities, provider treatment tools, patient education tools, and other helpful links
www.CHAMPSonline.org/ToolsProducts/ClinicalResources/DiseaseConditionResources/Diabetes.html

Patient-Centered Medical Home (PCMH) Information and Resources
Materials to aid health centers who are brand new to PCMH, those who have started the process of becoming a PCMH, and those who have applied for PCMH recognition/accreditation and are continuing the transformation process; includes history, definitions, recognition/accreditation steps and guides, tools for building a PCMH, training sources, etc.
www.CHAMPSonline.org/ToolsProducts/CrossDiscResources/PCMH.html

Templates and Samples of PCMH Policies and Procedures
Samples of PCMH policy and procedure templates, including admission and scheduling, community collaboration, etc., as well as examples of PCMH recognition documents submitted by two health Region VIII health centers in their quest for 2008 NCQA Level 3 PCMH recognition
www.CHAMPSonline.org/ToolsProducts/CrossDiscResources/PCMH/PCMHPandPs.html

Patient Satisfaction/Experience Surveys and Patient Activation/Engagement Resources
Goals, information, and resources on measuring patient satisfaction and/or patient experience, and information about patient activation and engagement including strategies on activating/engaging patients to create better experiences and health outcomes
www.CHAMPSonline.org/ToolsProducts/CrossDiscResources/PCMH/PatientSatisfaction.html
IMPROVING DIABETES CARE THROUGH GROUP VISITS AND PCMH PRINCIPLES

Presented by:
Karen A. Funk, MD, MPP, with the support of Justin Wheeler, MD
Vice Presidents of Clinical Services,
Clinica Family Health Services

Tuesday, March 18, 2014
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POLL

Which of the following best fits your role at your organization?
POLL

How many total people are watching this event at your computer (yourself included)?

Objectives

- Participants will learn about a group visit model of care for chronic disease utilized at Clinica Family Health to care for diabetic patients.
- Participants will understand the components of the group visit Clinica care team that lead to improved quality outcomes for diabetic patients.
- Participants will be able to identify how the components of the group visit care delivery model can increase access and quality.
- Participants will be able to identify core components of the PCMH model that promote quality outcomes for diabetic patients at Clinica Family Health.
Primary care redesign at Clinica Family Health over the last ten years: a timeline

- **Patient-Centered Medical Home Journey**
  - 1977: Founded
  - 1998: Joined IHI Chronic Care Collaborative
  - 2000: Delivery System Redesign
  - 2001-04: Planned Care Approach to QI
  - 2004-2010: Spread & Sustain Improvements; NCQA Level 3 PCMH, NCQA DRP (Diabetes Recognition Program)
  - 2010-2014: Recertification NCQA PCMH all sites, recertification NCQA DRP all sites
  - FUTURE = care team redesign PODS 2.0 and patient activation!

Who is Clinica Family Health?

**Demographics**
- >40,000 active pts
  - Medical
  - Dental
  - Behavioral Health
  - Pharmacy
- 49% uninsured
- 56% <Poverty,
- 98% <200% Poverty
Growing Groups at Clinica

- 2000: Began office redesign process and looked at group visits as a method of alternative care
- 2001: Held first PDSA Initial Prenatal group visit
- 2009: Conducted 845 group visits = 3.4 groups per day that the clinic was open
- 2012: 1466 medical group visits

Clinica’s group visit model

- 9 Essential Elements for Designing and Managing Group Care
1. Assemble the right people

- Designing group visits should not be done in isolation.
- Group visits effect all areas of the clinic and require input from a cross functional team.

A Clinica Group Visit Committee

- Operations Manager (Front Office)
- Receptionist (Front Office)
- Nurse Manager (Back Office)
- Medical Assistant (Back Office)
- Case Manager (Care Provider/Group Facilitator)
- Provider (Care Provider)
- Behavioral Health Provider (Care Provider)
- Call Center Attendant (Scheduling/Call Center)
- Committee Facilitator
- Minute Taker
Key Components for a Successful Group Visit Committee

- Have a process for testing and retesting newly implemented groups -- Plan Do Study Act (PDSA)
- Get feedback from staff and patients! Be ready and willing to hear about the things that aren’t working....this is what you need to address at your next meeting
- Don’t take on too much at once. Create success, then move on

What do you think?

- Which one of the following individuals IS NOT part of a Clinica Family Health group visit committee?
  - 1. front desk staff
  - 2. cleaning crew member
  - 3. medical assistant
  - 4 provider
#2 Know what you want to accomplish

- Are you dealing with supply/demand challenge and want to improve access for your patient population? (Access Groups)
- Do you want to improve a specific population’s health outcomes? (Continuity Groups)

Clinica Diabetes Groups

- An example of a continuity group
- We draw patients from an individual provider’s panel or if we have trouble filling, all PCPs from the same care team
- Same group of patients will meet quarterly
- Planned care is organized around these visits
  1. HBA1C, self-management goals, blood pressure, BMI at every visit
  2. Visit #1 = cholesterol screening, creatinine screening, screening for urine microalbuminuria
  3. Visit #2 = foot checks, flu shots, pneumococcal shots
  4. Visit #3 = retinal camera screening for retinopathy
#3 Create and Use Tools to Assist You

Our big lesson learned:
“Don’t Recreate the Wheel”

Develop a design tool that asks the questions you need to answer in order to design and manage a smooth running group.

Designing a Group Visit

- **Continuity Group vs. Access Group**: Ask yourself: Will the patients in this group visit continue to meet with each other as a group (Continuity Group Visit) or will the patients that attend this group be together for a one-time group visit session only (Access Group Visit)?
- **Data needed to support the designing process**: Determine if there is data that should be collected that will aid in the designing process (actual demand for a visit type, data on health outcomes you are trying to improve, etc.).
- **Patient participation**: Ask yourself: For the group visit we are designing, which patients should we target to invite to the group visit? Example: specific ages, gender, diagnosis, etc. How will we identify the pts we want to recruit? How will we recruit the pts for the group? Do we need to track the group as a continuity group for future scheduling purposes? Who schedules the patient into the group visit schedule and how does that person know the patient wants to attend?
- **Staffing**: Ask yourself: What staff do we need in order to conduct the care that is being provided at the group visit? Based on the number of patients that will be scheduled, how many of each employee will we need at the group to ensure a smooth running group visit?
- **Minimum and maximum number of patients in group**: Ask yourself: Based on the group visit type, what is the maximum number of patients the provider and support staff can handle efficiently? How few patients can be scheduled before the ratio drops below a one-to-one ratio, after which it would no longer warrant a group setting?
Use the content thread concept to design your curriculum

- **Diabetes Group Visit Topic Checklist**
  - What is Diabetes?
  - Diabetes self-management
  - Healthy eating
  - Be Active
  - Medications
  - Monitoring blood sugar
  - Preventing complications
  - Problem solving skills
  - Controlling blood sugar
  - Controlling your weight

- Alcohol and smoking
- Blood pressure
- Cholesterol
- Healthy Coping
- Depression
- Stress and relaxation
- Sexual issues
- Changing your behavior
- Working with your PCP
- Retinal Camera Screening
What do you think?

- All of the following could be potential content threads or discussion topics for a diabetes group EXCEPT?
- 1. healthy nutrition
- 2. carbohydrate counting
- 3. benefits of breastfeeding
- 4. depression

#4 Communication

- For each group visit, determine who needs to know about the group visit
- For each group visit, determine when the staff and/or patients need to be notified and/or reminded of the group visit
- Develop processes and tools to ensure that communication occurs!

Ask yourself, “How will people know?”
#5 Be Prepared for the Group Visit

- Being prepared for the group visit is ESSENTIAL to the success of the group visit!
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An Improved Approach...

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Clinica
Family Health Services

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#6 Tracking and Coordination of Groups

Tracking and managing of group visit care is one of the most complicated and critical elements to a successful group visit process.
Things to consider when creating a tracking/managing system for group visits:

- What are your limiting factors on how many group visits you can conduct in a given day/week/month/year?
- Will one person have oversight of the group visit process or will multiple people manage it?
- Can the group have a permanent date/time schedule?
- How will the room be held/reserved for the group visit?

#7 Patient Recruitment – Build it and they will come

- Depending on the group visit type, recruitment can occur in various ways:
  - Provider recruitment
  - Flyers/postings
  - Registries/reports that generate cohorts that the clinic can solicit by calling/mailing
  - Group visit recruitment from previous group
  - “Opt Out”
  - Call center attendant offers group visit when patient calls for an appointment
#8 Measure Goals and Objectives

- Develop techniques that will allow you to know if the objective of the group is being met.

- Consider the purpose of the group and why you created it?
  - Are there health outcomes you want to achieve?
  - Are there visit/access numbers you are want to achieve?
  - How will you measure patient satisfaction with the group?
  - How will you measure the staff satisfaction with the group?
  - How will you measure success and with what frequency?
#9 Staffing Groups

- All of the hard work that the group visit committee puts into planning will not impact the success of group visits unless the staff participating in the group have proper training on their roles and expectations.

**Staff Training**

- Incorporate the expectations related to group visits into the employee job description and evaluation tools.
- Have and keep up to date the necessary training materials for each group visit type.
- Meet with staff prior to a new group visit type in the area where the group will occur and review the flow and materials related to the group.
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A Clinica Diabetic Group In Action

- Provider
- Medical Assistant or two depending on the size
- Case manager
- Nurse or dietician
- Office technician
- THE PATIENTS (and often other family members!)

Visit Design

- Check in – 30 min
  - vital signs
  - self-assessment
  - labs

- Group discussion -1 hour
  - Provider assessment in group
  - Case manager facilitation based on content thread
  - CM support with goal setting

- Wrap-up -30 min
  - Social time for patients
  - Provider follow-up assessment and charting
What do you think?

☐ Which one of the following is an essential item needed for a successful diabetic group visit?

☐ 1. paper chart
☐ 2. positive attitude of the patient
☐ 3. careful planning ahead
☐ 4. ½ a clinic day to hold the group

“I have found that a well-supported group (office techs, MA’s, nurse, CM) is the epitome of patient-centered, efficient care. We can accomplish so much education and problem-solving as a group that could never be done in 20 minute patient slots.”

~Dr Josh Messer
Overview of PCMH Framework: The Key Components

- Access to Care
- Care Team & Staffing
- Chronic Disease Care
- EHRs
- Patient-Centered Care
- Practice Efficiency
- Quality & Safety

What do you think?

- Group visits can INCREASE access for the patients in your practice.

- TRUE or FALSE?
Improving Diabetes Care through Group Visits and PCMH Principles

PCMH framework

Access to Care

- More patients seen “per hour”
- Reduced wait times for acute & chronic care

- 2 hours on the care team = six patient care slots 1:1
- 2 hours in diabetes group = eight to twelve patients in group
- Group visits enhance open access for our patients on the care team
Overview of PCMH framework

Access to Care

Care Team & Staffing
• Team comes together to deliver care.

Chronic Disease Care
• Systematic approach
• Focus on outcomes & planned care (Care Planner)
PCMH framework

- Access to Care
- Care Team & Staffing
- Chronic Disease Care

EHRs

- Systematic use of Diabetes Template

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PCMH framework

- Access to Care
- Care Team & Staffing
- Chronic Disease Care
- EHRs
- Patient-Centered Care

- Patient as agent of engagement/activation.

Patient-Centered Care

Patients need to be involved in self care activities and their own health assessment.
Patient Activation = Patient-Centered Care

- What Self-Management Support is not:
  1. Didactic patient education
  2. Waiting for patients to ask for help
  3. Sage on the stage
  4. You should…
  5. Finger wagging
  6. Lecturing

PCMH framework

- Access to Care
- Care Team & Staffing
- Chronic Disease Care
- EHRs
- Patient-Centered Care
- Practice Efficiency
- Quality & Safety

• Improved resource utilization
### PCMH framework

- **Access to Care**
- **Care Team & Staffing**
- **Chronic Disease Care**
- **EHRs**
- **Patient-Centered Care**
- **Practice Efficiency**
- **Quality & Safety**

*Improved metrics & quality outcomes*
Improving Chronic Disease Outcomes

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<th>Traditional</th>
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THE GOAL: A Patient-Centered HEALTH Home!
Questions?

Thank You for Joining Us!

Your opinions are very important to us.

Please complete the event Evaluation for this webcast. If you are applying for Continuing Medical Education (CME) credit, you must complete the CME questions found at the end of the Evaluation.

Each person should fill out their own Evaluation/Credit Survey.

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