Disclosures

- Theodore Friedman, MD, PhD reports no disclosures
- Mark Richman, MD, MPH reports no disclosures

Obesity is a big problem-What can we do about it?

- Los Angeles County is more populous than 42 individual states.
- 800,000 unique patients are served annually by LA County DHS.
- Because of the volume of patients treated by Los Angeles County DHS, innovative, high-volume, high-quality, low-cost programs are needed to address the obesity epidemic.

Group Visits

- Group models for care of patients began in 1907 at the Massachusetts General Hospital, when Pratt developed the first group program for tuberculosis.
- More recently, the “shared medical care” model, also known as a “group medical visit” as first described by Scott or “shared medical appointment” as described by Noffsinger have received increased attention.
- Randomized trials have shown that group interventions are associated with clinical significant improvement in a variety of medical, psychological, and behavioral outcomes, when compared with standard individual medical visits.

Obesity is a big problem-What can we do about it?

- The prevalence of obesity (BMI > 30 kg/m²) in LA County has risen from 13.6% in 1997 to 23.6% in 2011 (a 74% increase), with prevalence of diabetes increasing from 6.6% in 1997 to 9.9% in 2011.
- Both obesity and diabetes are more common in Hispanics and African Americans compared to whites.
- Diabetes is the 5th leading cause of death in LA County.
Group Visits

- Two crucial aspects of the patient’s health experience:
  - The patient’s own effectiveness in managing medical problems together with his or her health care team
  - The patient’s own community for support in integrating medical recommendations into his or her daily life.

P.O.W.E.R.

Group Visit

- Obesity Group Visit
- Encouraged by Dr. Angela Nossett, based on diabetes group visit.
- Work smarter, not harder.
- Replaced traditional “obesity clinic” at MLK-MACC started in 2009 by Dr. Friedman.

POWER format

- 1 to 1:30 registration, pretest, surveys and consents
- 1:30 to 2:15 Dr. Friedman’s overview lecture with audience participation and questions (breakout groups with dietician for return patients)
- 2:15 to 2:30 Instant Recess calisthenics video
- 2:30 to 3-Special topic: Dr. Zodkovitch-stress reduction, Dr. Eugenio-fast foods, YMCA, personal trainers, orthopedics, motivational speaker
- Recently joined by Dr. Nicole Alexander, internist and exercise expert, gives each patient an individualized exercise prescription
- 3 to 3:25-Elizabeth Driscoll dietician-Diabetes Prevention Program curriculum
- 3:25 to 3:30 wrap up-setting goals, post-test and prizes

POWER logistics

- Prepopulated progress note
- Encounter form generated after visit
- Nurse for vitals and check in
- Spanish translator for Spanish sessions
- Phentermine (on DHS formulary for obesity clinics)
- Must come for 2 months and lose 8 pounds

POWER group visit-dynamics

- Started in January 2013
- 4 cadres of patients, each cadre meets weekly on Monday afternoon (some patients want to come every visit)
- 1st, 3rd and 4th Mondays-English, 2nd and 5th Mondays-Spanish
- Better group dynamic with bigger group
- Open to all DHS patients
POWER group visit-data
- Now about 20 patients per group visit
- 439 unique patients
- 1122 patient visits
- IRB approval October 2013
- 198 IRB consented subjects
- 29 (15%) patients lost at least 8 pounds, 22 (11%) patients lost 5% of their weight, 9 (5%) subjects lost 10% of their weight.
- 45 (23%) subjects came to all of their visits and 74 (37%) subjects came to at least half of their visits

POWER group visit-demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Gender</th>
<th>n</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Race</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>African American</td>
<td>17</td>
<td>65</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11</td>
<td>99</td>
</tr>
</tbody>
</table>

POWER group visit-HbA1c

<table>
<thead>
<tr>
<th>Baseline HbA1c (Mean ± SD: 7.6 ± 1.3)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low than 7.7</td>
<td>29</td>
<td>10%</td>
</tr>
<tr>
<td>5.7 - 6.4</td>
<td>69</td>
<td>38%</td>
</tr>
<tr>
<td>6.5 - 7.9</td>
<td>50</td>
<td>28%</td>
</tr>
<tr>
<td>8.0 or greater</td>
<td>18</td>
<td>18%</td>
</tr>
<tr>
<td>Total subjects with baseline HbA1c</td>
<td>188</td>
<td></td>
</tr>
<tr>
<td>No HbA1c test in chart (other participant asked to go to lab or no lab was ordered by provider)</td>
<td>17</td>
<td>9%</td>
</tr>
<tr>
<td>Total Subjects Consented</td>
<td>188</td>
<td></td>
</tr>
</tbody>
</table>

Outcomes
- Hoping to implement obesity group visits at other DHS facilities (Hubert H. Humphrey Comprehensive Health Center, Harbor-UCLA Medical Center, or Olive View) via videoconference.
- Let me know if your center is interested

POWER group visit-quality care
- This non-traditional patient visit model has resulted in
  1. Improved patient access
  2. Increased provider productivity
  3. Improved patient outcomes and life style changes
  4. High patient satisfaction scores-overall satisfaction score > 90%

POWER PR
- Featured in Los Angeles Times "Group meetings turn doctor visits inside out" September 17, 2013, p. 1, 9, http://www.latimes.com/local/la-me-group-doctor-visits-20130917,0,5085574,full.story
In progress
• Mobile texting - partnering with Caremessage startup mobile texting company in SF
• Patient appointment reminders, surveys and goal reminders
• Approved by County Board of Supervisors-June 2014.
• Pilot for larger county-wide use
• Still working out some of the snags

PCORI Grant
• Patient-Centered Outcomes Research Institute
• Applied May 2014 - Addressing Disparities RFA - unscored
• Other large obesity grants funded
• Comments mostly fixable

Thanks
• CTSI/DHS (UL1TR000124) for funding
• POWER staff for all their hard work
• Dr. Angela Nosset for her vision and support
• Dr. Elizabeth Driscoll for outstanding dietician contribution
• Judy, Maria, Chris, Stephanie for assistance with vital signs and tracking
• Juan and Cindy for translating and data entry
• Study coordinator extraordinaire Petra Duran

Diabetes Group Visits

What If You Could Achieve….
• Better outcomes
• HEDIS measure compliance
• More fun
• Expanded capacity
• With same or fewer resources

Financial Model
• Increased productivity
  – See 8-12 patient/half-day
• Provider visit is billable
• Education is not billable in group setting
Individual Appointments, Group Setting
- Learn from other patients
- 8-12 patients
- Accommodates non-private exams (e.g. foot exam) and brief private visits
- Patient privacy: screens, separate rooms
- Billable

Where?: Room
- Accommodate 8 or more patients, plus staff
- Space for privacy: nearby room or curtained-off/screened-off area beyond earshot
- Register in primary care clinic
- Avoid patient needing to return to clinic for discharge, labs, radiology, referrals

Not Like This

Like This

Which Patients Are Right For This?
- Want to do it
- Comfortable sharing health information in a group
- Language concordance

Not All Patients Are Ideal Candidates
- Hearing impaired
- Cognitively impaired
- Needing extensive private provider
- Refuse to maintain confidentiality
Staffing

- Certified Diabetes Educator
- Provider: MD or NP

Timing

- Registration to discharge: ~2 hours
- In-clinic registering & introduction: 30 min.
- Provider time: 1.5 hours
- Finish on time with all charts completed

Days Pre-Session

- Primary Care Clinic
  - Calls patients
    - Remind them of visit

Session Day: Pre-Session

- Patients arrive 30 min. before group session
  - Registration
  - English/Spanish confidentiality statement (to sign each time)
  - Med refill needs – assess on back of confidentiality statement form
  - Provider explanation of clinic
    - Why
    - How
    - Confidentiality

Certified Diabetes Educator

- Education
- Transfers enthusiasm
- Drives open, energetic conversation
- Facilitating phrases
  - Engage group
  - One patient’s experience teaches others
- Promptly/tactfully stops side conversations
- Lifestyle change advice
- Keeps provider on time
  - Point to watch
  - “Let’s come back to this point…”
Session Day: Provider (Physician or NP)

• In front of other patients
• Goes from patient to patient
• Foot exam
• 2 min./patient
• At end of visit, review i2i to see if need DM or lipid med adjustment
• Short, private examinations at end, if patient desires or clinical status indicates

Documentation

• Templated note with CPT codes to meet i2i health maintenance requirements
• Focused documentation

Foot screen (2028F)

Education (diabetes) (97802)

Right Foot: [x] Unremarkable except for:

[] Callous:
[] Dry skin
[] Neuropathy:
[] Onychomycosis:
[] Nail(s) yellow:
[] Elevating nail(s):
[] Pulses:
[] Structural problem (eg, bunion, hammer toe):
[] Skin or nail issues (eg, dry, onychomycosis, sore, ulcer):
[] Ulcer/sore:

Education:
Patient was educated about diabetes self management, including diet and exercise, the importance of fixed-protein and lipid management, the meaning of lab results, and foot care, including:
Check foot daily
Dry and light feel
File nails top to bottom and side to side.

Assessment/Plan

Diabetes:
[] Hemoglobin A1c:
[] ESR, CRP:
[] Ankle-brachial index:
[] Refer to DM education class
[] Refer to Retinal Screen Clinic

Used Interpreter:
Name:
Interpreter ID:

Promotion/Recruitment
Scheduling
• Patients referred in from Podiatry Clinic and any adult primary care clinic
• Called the primary care clinic under whose auspices Group Clinic MD was working

How We Did
• 1st year
• 193 patients
• Average
  – 8 patients/session
  – 2.5 hours, including documentation and medication management