

Group Medical Visits for Chronic Conditions

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Abstract

Background or Problem/Issue: Chronic conditions are the leading cause of death and the largest financial burden in the United States. The Military Health System faces challenges in providing quality care for chronic conditions.

Clinical Question or Purpose: Clinical Question: for primary care patients with chronic conditions, do group medical visits compared to standard individual visits, improve or match health and wellness outcomes? Purpose: Introduce healthcare providers to the Group Medical Visit (GMV) model for the treatment of chronic conditions in primary care.

Project Design: The Iowa Model Revised: Evidence-Based Practice guided the project design. The project had two parts, “Introduction to GMVs for Chronic Conditions” and “GMV Working Group.” The goals of the project were to increase knowledge about GMVs, assess perceptions about GMVs, and to inspire the clinic to implement GMVs. The setting was Winder Family Medical Clinic (FMC), Madigan Army Medical Center, Tacoma, WA.

Analysis of the Results: The literature demonstrated that care provided by GMVs outperformed or matched standard individual visits in health metrics for multiple chronic conditions. GMVs have high levels of patient and provider satisfaction and encourage patient empowerment, allow for shared decision-making, and facilitate peer support. For part one of the project, “Introduction to GMVs for Chronic Conditions,” 53 participants attended, and 20 (46%) answered affirmatively to wanting to start GMVs if there were resources. For part two, “GMV Working Group,” 44 participants attended, of which 20 participants (46%) answered affirmatively as interested in seeking more information on GMVs. Twenty-one participants (49%) plan to be part of a GMV team, including two provider champions.

Organizational Impact/Implications for Practice: Two stakeholders, who are providers at Winder FMC, expressed a strong desire to champion GMVs and are establishing a team. However, Winder FMC will need command support for resources and time for successful implementation of GMVs.

Group Medical Visits for Chronic Conditions

Chronic conditions are responsible for significant suffering and healthcare costs across the United States. Chronic conditions, such as obesity, arthritis, heart disease, and type II diabetes, are long-term, costly, and mostly preventable (World Health Organization, 2016). Chronic conditions cause seven out of 10 deaths, and 86% of United States' health care costs (National Center for Chronic Disease Prevention and Health Promotion, 2016). Treatment for chronic conditions is done mainly in outpatient settings, and health care providers are struggling to utilize current care models to meet the challenges (Holman & Lorig, 2000). Approximately 40% of outpatient office visits are for chronic conditions (Ashman, Rui, & Okeyode, 2014). Current care models are insufficient to address this growing healthcare crisis. The United States health system needs to make innovative changes to address the needs of patients with chronic conditions.

The Military Health System (MHS) faces similar chronic condition disability and cost challenges. The Defense Health Agency (DHA) highlighted the need for effective and efficient patient-centered frameworks for the treatment of chronic conditions (Defense Health Agency, 2015). In 2015, the Army Surgeon General, Lieutenant General Nadja Y. West outlined her vision for meeting these difficulties when she described the need for a “paradigm shift in our care delivery model,” and included group medical visits (GMV) as a possible solution (West, 2015).

Significance and Relevance to Military Healthcare System

According to 'Health of the Force,' an average of 12.7% of active duty Army Soldiers have at least one chronic condition, but rates vary from 8.2% to 33.8% depending on U.S. military installations (U.S. Army Public Health Center, 2017). Chronic conditions affect combat

readiness by decreasing Soldiers ability complete physically demanding missions or missions in remote locations. Cardiovascular disease, including hypertension, is the most common chronic condition diagnosed in Soldiers (7.4% of all Soldiers), other commonly diagnosed chronic conditions are “asthma, arthritis, chronic obstructive pulmonary disease (COPD), and diabetes” (U.S. Army Public Health Center, 2017, pg. 42). In 2013, MHS patients aged 25-44 with a chronic condition, had the highest per-person outpatient cost at \$9,338 compared to the same age with non-chronic conditions at \$2,288 (Defense Health Agency, 2015). When compared to private health systems, the MHS had similar prevalence rates of “hypertension, major depression, diabetes, tobacco dependence, ischemic heart disease, severe mental illness, persistent asthma, and stroke” (Gibson et al., 2009). The MHS hospitalizations for diabetes was up to 50% higher than non-military and veteran populations (Gibson et al., 2009). Evidence-based, high-quality care is essential for meeting the challenges of treating chronic conditions in the outpatient setting (Institute of Medicine, 2001).

Beginning in 2008, the MHS started transitioning from primary care clinics to the Patient-Centered Medical Home (PCMH) model to enhance the quality of care (Marshall et al., 2011). A unique aspect of the model is that behavioral health is integrated into the PCMH and work closely as a primary care team. Integrated behavioral health providers present an opportunity to incorporate behavioral interventions in care for chronic conditions (Marshall et al., 2011).

Group Medical Visits

Group medical visits are a care delivery model in which patients receive all their medical care in a group setting instead of standard individual visits. Group medical visits consist of eight to twenty patients, last 90 to 120 minutes, and can be open access or organized by diagnosis or

population. Group medical visits have several different models and are known as Shared Medical Appointments, Drop-in Group Medical Appointments, Cluster Visits, Cooperative Health Care Clinic, and other names (Noffsinger, Sawyer, & Scott, 2003). Team members have four primary roles: team leader, medical clinician, behaviorist, and support staff. The team leader can be any member of the team. They are responsible for ensuring the overall success of the GMV by assigning tasks, planning meetings, and ensuring that everyone and everything is in order. Medical clinicians (nurse practitioners, physicians, pharmacists, physician assistants) are responsible for meeting the medical needs of the patient. They are responsible for the history of present illness, physical exam, diagnosis, and orders (i.e., medications and diagnostic studies). The behaviorists are responsible for facilitating discussion in support of the medical clinician and attending to the interpersonal dynamics of the various group attendees. The support staff are responsible for logistics and completing work to their highest level of licensure.

- Example Outline:
 - 10 min: Behaviorist: welcome, explanation of group visit, review of rules, HIPAA reminder (support staff collects vitals around group)
 - 35 min: Medical Clinician assesses medical concerns
 - 10 min: break
 - 30 min: Intervention-diet, exercise, medications, or others.
 - Concurrent: Medical Clinician pulls patients to conduct individual physical exams that cannot be done in a group
 - 10 min: wrap up

GMV as a Solution

Group Medical Visits are a potential solution for MHS treatment of chronic conditions. The GMV framework encourages coordination of interdisciplinary team members and patient empowerment, which align with the goals outlined by the Defense Health Agency (Defense Health Agency, 2015). At Joint Base Lewis-McChord, GMVs can improve treatment of chronic conditions resulting in patient-centered care and further integration of behavioral health care into primary care clinics.

Significance and Relevance to Nursing

Group Medical Visits are an innovative solution, which answers the nursing concern of providing timely, quality, and evidence-based care to meet the needs of the patient. During a 20 minute standard individual visit, there are significant barriers to maintaining a patient-centered approach. It is difficult to gather information about symptoms, complete a physical examination, develop a comprehensive care plan, educate the patient, and confirm the patient's understanding of the treatment plan in a 20-minute visit. Conversely, GMVs have barriers too; care model changes are a process, patients and providers may have negative perceptions about groups, and not all conditions or populations are appropriate to be treated in a group setting. However, effective management of chronic conditions requires drastic lifestyle and behavioral changes. Group Medical Visits bring diverse perspectives to improve the patient's health and wellness (Lavoie et al., 2013). Group medical visits encourage patient empowerment, allow for shared decision-making, and facilitate peer support.

Clinical Question

Formulation of the clinical question was based on the prevalence of chronic conditions and the vision of the Army Surgeon General to explore a medical paradigm shift (Gibson et al., 2009; West, 2015). Answers to the clinical question will determine if GMVs are appropriate

evidence-based care models equal to or better than current care for those with chronic conditions. The clinical question is: for primary care patients with chronic conditions, do group medical visits compared to standard individual visits, improve or match health and wellness outcomes?

Focus Areas

The project had two focus areas: providing education on GMVs and facilitation of a GMV working group. The initial focus presented information about GMVs for chronic conditions and included a presentation, an opportunity for sharing previous experiences with this model, and a survey of perceptions about GMVs. The second focus was facilitating a working group to determine clinically relevant goals and elements of the GMV, clinician roles, and system challenges. Surveys queried interest in starting GMVs, being part of planning teams, and potential barriers.

Project Short and Long Term Goals

The short-term goals were to present evidence supporting the use of GMVs, assess staff perceptions of GMVs, and facilitate an implementation working group. Additionally, an intermediate goal was to encourage leadership support for GMVs in the clinic through a brief to command. The long-term goals were to increase awareness and inspire the clinic to pursue innovative care models to improve health and wellness outcomes.

Anticipated Global Impact

The Army Surgeon General has requested that MHS providers shift healthcare paradigms. Introducing innovative care models will challenge the status quo and help stimulate creative solutions to MHS's pressing care challenges. Additionally, discussion of GMVs will help to extend the understanding of how behavioral science is beneficial in treating chronic conditions.

Organizing Framework

The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care shaped this project, see Appendix A, *Figure 1* (Iowa Model Collaborative, 2017). The Iowa model has proven to be a practical step-by-step guide for the evidence-based process (Buckwalter et al., 2017). The model contains seven tasks with three decision points. This project progresses through the model until the fifth step, *Design and Pilot the Practice Change*, see *Figure 2* in Appendix A.

Project Design

The first step of the Iowa model is *Identify Triggering Issues/Opportunities*. The triggering issue is the poor healthcare outcomes and overall healthcare costs of providing care for chronic conditions, and the opportunity is utilizing GMVs as a model. The PICO question addresses the second step, *State the Question or Purpose*. Then, the first decision point, *Is This a Priority?* The project is a priority as evidenced by Army Surgeon General guidance and the nature of the PCMH model. The third step is to *Form a Team*. The team consisted of the two Doctor of Nursing Practice (DNP) students co-leading the project, Major Faith Grzesik, Major Douglas Taylor, and project mentor Lieutenant Colonel Douglas Dillon, DNP and site director Lieutenant Colonel Brad Franklin, DNP. Furthermore, identification of key stakeholders at Winder Family Medicine Clinic, Major Elizabeth Poindexter, DNP and Major Deanna Sheets, DNP, who provided continuous feedback and suggestions throughout the project. After forming a team, the fourth step is to *Assemble, Appraise, and Synthesize Body of Evidence*, which is discussed in the next few paragraphs. Upon completion of step four it was determined there was sufficient evidence to move past the second decision point, *Is there sufficient evidence?* The fifth step is to *design the change*, which was initiated by education by PowerPoint presentation and a

workbook to introduce the tools necessary for adoption and implementation by the PCMH team. Additionally, participants had the opportunity to receive two hours of Continuing Medical Education or two hours of Continuing Nurse Education.

The literature review sought to find articles with group medical visits as the primary intervention and was limited to articles published between 2006 to 2016, peer-reviewed, and in English. The search utilized PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, Excerpta Medica dataBASE (EMBASE), and Cochrane Database. See Appendix A, *Figure 3*. for PRISMA Flow Diagram of methods and results (PRISMA, n.d.). The search identified 592 articles. After reviewing titles, abstracts, and adding articles identified through bibliographies, 29 articles were reviewed in full text. Ten articles were eliminated, and 19 articles were appraised and retained for synthesis.

Appraisal of Evidence

The 19 articles retained for evidence appraisal included multiple types of studies with varying levels of quality. ‘Level of Evidence’ and ‘Quality of Evidence’ of each article was established by using the Johns Hopkins Nursing Evidence-Based Practice Appendix D: Research Evidence Appraisal Tool (The Johns Hopkins Hospital/Johns Hopkins University, 2013). Concerning the level of evidence, two articles were systematic reviews/meta-analysis, one was a systemic review without meta-analysis, three were randomized control trials, five were quasi-experimental with control, five were quasi-experimental without control, and three were qualitative studies (see Appendix A, *Figure 4*.). Eight articles were high quality, eight were good quality, and three were low quality or majorly flawed.

Evidence Relevance to the Question

There were nine studies with evidence indicating GMVs outperform standard of care in lowering hemoglobin A1c levels (Bastiaens et al., 2009; Clancy, Huang, Okonofua, Yeager, & Magruder, 2007; Edelman et al., 2012; Housden, Wong, & Dawes, 2013; Jaber, Braksmajer, & Trilling, 2006; Kirsh et al., 2007; Riley, 2013; Sanchez, 2011; Taveira, Dooley, Cohen, Khatana, & Wu, 2011). There were eight studies with evidence that suggest GMVs meet or outperform standard of care for one or more of the following: increased disease knowledge, lower blood pressure, improved cholesterol levels, weight loss/lowered BMI, decreased pain, decreased insomnia, decreased smoking, and improved COPD symptoms (Bastiaens et al., 2009; Edelman et al., 2012; Gustavsson, Denison, & von Koch, 2011; Harris, Silva, Intini, Smith, & Vorderstrasse, 2014; Jaber et al., 2006; Riley, 2013; Sanchez, 2011; Taveira et al., 2011). Importantly, GMVs only need to match health and wellness outcomes of standard individual visits to be a relevant tool for primary care and there are 12 studies to support matching of care outcomes (Bastiaens et al., 2009; Clancy et al., 2007; Desouza, Rentschler, & Haynatzki, 2010; Edelman et al., 2012; Gustavsson et al., 2011; Harris et al., 2014; Housden et al., 2013; Jaber et al., 2006; Rautio et al., 2012; Riley, 2013; Sanchez, 2011; Taveira et al., 2011). Furthermore, two qualitative studies suggest that GMVs have high levels of patient and provider satisfaction, and they provide numerous contextual benefits such as patient empowerment, shared care delivery decisions, and peer support (Cohen, Hartley, Mavi, Vest, & Wilson, 2012; Heyworth et al., 2014; Lavoie et al., 2013). Most studies mentioned financial concerns, but it was not regularly measured. Due to multiple variables (i.e., location, population, various reimbursement models) monetary outcomes could not be generalized, results included savings, neutrality, and increased costs (Edelman et al., 2012; Jaber, Braksmajer, & Trilling, 2006).

Several themes arose from the literature that helped identify how to choose patients for group visits and how to shape the intent and structure of the model. When selecting patients, there are best outcomes when a patient is ready for change (Bastiaens et al., 2009; Riley, 2013). Theoretical models based on Social Cognitive Theory, Change Theory, Motivational Interviewing, Goal Setting, and Action Plans, shaped the style of studied groups (Eisenstat, Ulman, Siegel, & Carlson, 2013; McCuiston et al., 2014; Naik et al., 2011). To successfully implement GMVs into a clinic it is suggested to have an interdisciplinary team approach, a clinical champion heading implementation, support from leadership, and an established GMV framework (Kirsh et al., 2007; McCuiston et al., 2014; Riley, 2013; Watts et al., 2009). See Appendix B for Evidence Appraisal Table.

Setting

The Winder Family Medical Clinic (Winder FMC), Madigan Army Medical Center, Joint Base Lewis-McChord hosted the project. Winder Clinic is a Patient and Soldier-Centered Medical Home. Project participants were all Winder FMC staff members.

Winder FMC is an established PCMH and was an ideal location for this project. Winder FMC offers services such as primary care, aviation medicine, behavioral health, immunizations, laboratory, optometry, pharmacy, and physical therapy to active duty and other MHS beneficiaries. There were several conference rooms already used for patient education and fit groups of 20-30 people. Recently, Winder FMC began conducting a smoking cessation education group which demonstrates clinic interest in group appointments. This project will help Winder FMC become a leader in GMVs at Joint Base Lewis-McChord.

Procedural Steps

Preparation:

Step 1. Vice President for Research (VPR) submission approval from Uniformed Services University

Step 2. Submit to Madigan Army Medical Center Institutional Review Board (IRB) for approval or exemption.

Step 3. Work with Phase II site director and Senior Mentor to identify location and timeline for the project. See Appendix A, *Figure 5.* for the timeline.

Step 4. Orient to PCMH and identify stakeholders

Step 5. Created Educational Powerpoint “Introduction to Group Medical Visits for Chronic Conditions” and “GMV Working Group” workbook. See Appendix C

Step 6. Applied for CME and CNE credit.

Focus 1: Introduction to GMVs for Chronic Conditions

Step 7. Conduct Stakeholder assessment and educational brief about GMVs

1st Session: Introduction to GMVs for Chronic Conditions

<u>Time (mins)</u>	<u>Topic</u>
0-2	-Presenter Introduction
2-12	- Discuss the Problem: Chronic Conditions in Primary Care
12-15	- Introduce GMVs, explore experiences with GMVs
15-17	-Present Clinical Question
17-35	-Review Methods/Results/Findings of Literature Review (Highlight specific studies)
35-45	-Review a Case Study
45-50	-Clinic Specific Considerations: Who/What type of patients/conditions

50-60 -Questions and Survey

Objectives: 1. Introduce and define GMVs; 2. Outline quality and level of evidence for the use of GMVs; 3. Review a case study; 4. Discuss clinical relevance for the use of GMVs

Focus 2: GMV Working Group

Step 8. Review Survey results from initial session and adjust the working group facilitation plan, as needed.

Step 9. Conduct a working group on GMVs for future implementation.

2nd Session: GMV Workbook

<u>Time (mins)</u>	<u>Topic</u>
0-2	-Introduction and Centering Exercise (Progressive Muscle Relaxation)
2-5	- Review GMVs Introducing different GMV Models
5-15	-GMVs in Clinic: population, diagnosis, Goals/Outcomes, Elements/Structure
15-25	-Introduce and assign roles in relation to elements
25-35	-Logistics (space, resources, timeline, booking, coding, scheduling, HIPAA/Consent)
35-45	-Recruitment and selection of patient population
45-55	-Barriers and way forward
55-60	-Questions and Surveys

Objectives: 1. Explore and select appropriate GMV model for the clinic, 2.

Identify goals and elements of GMV for the clinic to address a specific care need,

3. Identify and assign roles for GMV, 4. Clarify target patient population for the clinic, 5. Address barriers and the way forward for GMVs in the clinic

Dissemination

Step 10. Project and findings disseminated through posters and presentations at MAMC and USU Research Days 2018.

HIPAA Concerns (IRB)

This project required submission to the IRB Exemption Official at Madigan Army Medical Center. There is a low risk of patient harm in this project. The project will not include a direct change to patient care, but indirect change by assessing and providing information to clinic staff. The project Exempt Determination Application was sent for approval October 18, 2017, and approval was granted October 19, 2017, by the MAMC Exempt Determination Official. See Appendix D for CITI Certificates, USU (VPR) Form 3202N, and MAMC Exemption Determination Letter.

Project Results

The first focus of the project, ‘Introduction to GMVs for Chronic Conditions,’ was conducted on January 4th, 2018. Fifty-three (53) participants (Winder staff) attended the training. After the classroom instruction, participants were asked to complete a written survey (see Appendix C for an outline of educational instruction and Appendix E for survey). Forty-three participants filled out at least some portion of the survey, see Appendix F for results. The average time worked in Primary Care was six years, with the longest reported time 20 years and the shortest one year. The average time worked in health care was 13.2 years, with the longest reported time 40 years and the shortest one year. Thirty-one respondents confirmed this project introduced GMVs as a model to treat chronic conditions; the remainder had no response (12).

Considering perceptions of GMVs, twenty respondents (46%) answered affirmatively to wanting to start GMVs if there were no barriers, two answered negatively, two were unsure, and nineteen did not respond.

The second focus, GMV Working Group, was conducted on February 1st, 2018. Forty-four (44) participants attended the training. See Appendix C for an outline of the workbook provided to each participant and outline of a 'GMV Resource Guide' provided to the Nursing Supervisor. After the working group, a participant survey collected data (See Appendix E for survey and Appendix F for results). Forty-four (100%) participants filled out at least some portion of the questionnaire. Twenty participants (46%) answered as interested in seeking more information about group medical visits, four answered negatively, and twenty were indifferent. Twenty-one participants (49%) answered plans to be part of a team that implements GMVs, five answered no, and 17 were indifferent.

Between the two education sessions 30 people attended both episodes of training, 24 only attended the first class, and 14 only attended the second class.

Analysis of the Results

Winder FMC faces many barriers to implementing GMVs into their practice. The top five barriers to implementing GMVs were identified as time, staffing, resources/money, scheduling, and buy-in (patient, provider, command) which is consistent with the literature (McCuistion et al., 2014). The education and tools provided by this project acknowledged the barriers and initiated momentum for starting GMVs at Winder FMC. First, this project helped the Winder FMC identify how GMVs can address the clinical issues of chronic conditions. The top four conditions staff identified to use GMVs were hypertension, obesity, lower back pain, and diabetes, which are the same challenging conditions highlighted in 'Health of the Force' which

suggests that Winder FMC is representative of Army PCMHs (U.S. Army Public Health Center, 2017). Additionally, by educating most of the clinic, it was identified that over 45% of personnel have a positive attitude towards GMVs, while the rest were indifferent and only two were against the idea. Importantly, several key stakeholders (registered nurses and nurse practitioners) on the Winder FMC team self-identified as wanting to be GMV champions. McCuiston et al. (2014) found that introducing GMVs into a large multispecialty medical group is best accomplished by ensuring a provider champion, management support, and financial sustainability. The article highlighted that the most critical factor of successful implementation was a provider champion, while management support eased implementation and widespread utilization. Furthermore, the perceived barriers identified by the participants are consistent with the barriers found within the literature. The results of this project established an impetus to initiate GMVs and a group of clinic leaders who want to lead the change.

Organizational Impact/Implications to Practice & Policy

Educating and providing tools for Winder FMC to implement GMVs made an organization impact and had several implications for MAMC practice and policy. Immediately, participants had the opportunity to apply for two hours of either continuing medical education or continuing nursing education which contributes to the credential and licensure needs of MAMC. Currently, the clinic conducts smoking cessation groups, and this project provided ideas for performance improvement topics, such as including a provider and correctly coding the intervention. Organization impact will be significant if Winder FMC implements GMVs. If Winder FMC creates policy related to GMVs, there will be lasting implications for MAMC and the primary care service line.

Future Directions for Research and Practice

Group medical visits have the potential to help the Military Health System become a leader in providing the highest quality care in the world. At Winder FMC two of the providers have established a GMV implementation team. For Winder FMC to successfully implement GMVs, leadership from MAMC must provide the resources necessary for implementation. Furthermore, the GMV champions are considering applying to the Tri-Service Nursing Research Program for grant funding of the pilot project. A grant-funded GMV pilot will highlight the importance of utilizing GMVs to treat chronic conditions and provide much-needed resources to ensure success and sustainment. Additionally, this project has created a starting point for clinics who are interested in GMVs and would like more information. Lastly, future projects and research should assess whether GMVs improve or match health and wellness outcomes in relations to costs in the military setting.

Conclusion

Group medical visits are an innovative care model that is proven to help patients manage their chronic conditions. The MHS faces many challenges in influencing patients to improve their wellness. Change to care delivery models in the MHS requires an understanding between higher-level leadership and front-line clinicians. This project synthesized the evidence of a topic identified by the highest level of MHS leadership, the Army Surgeon General, then introduced the concept and discovered that 46% of clinic level providers are willing to make the change. An opportunity exists for the MAMC leadership to use the momentum created by bridging leader's vision to clinician level understanding to implement GMVs. Additional training sessions could increase clinic motivation to implement GMVs. Group medical visits will succeed if MAMC leadership supports Winder FMC in overcoming implementation barriers. This project was a

significant first step in implementing the evidence-based practice of GMVs for the treatment of chronic conditions.

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Appendix A

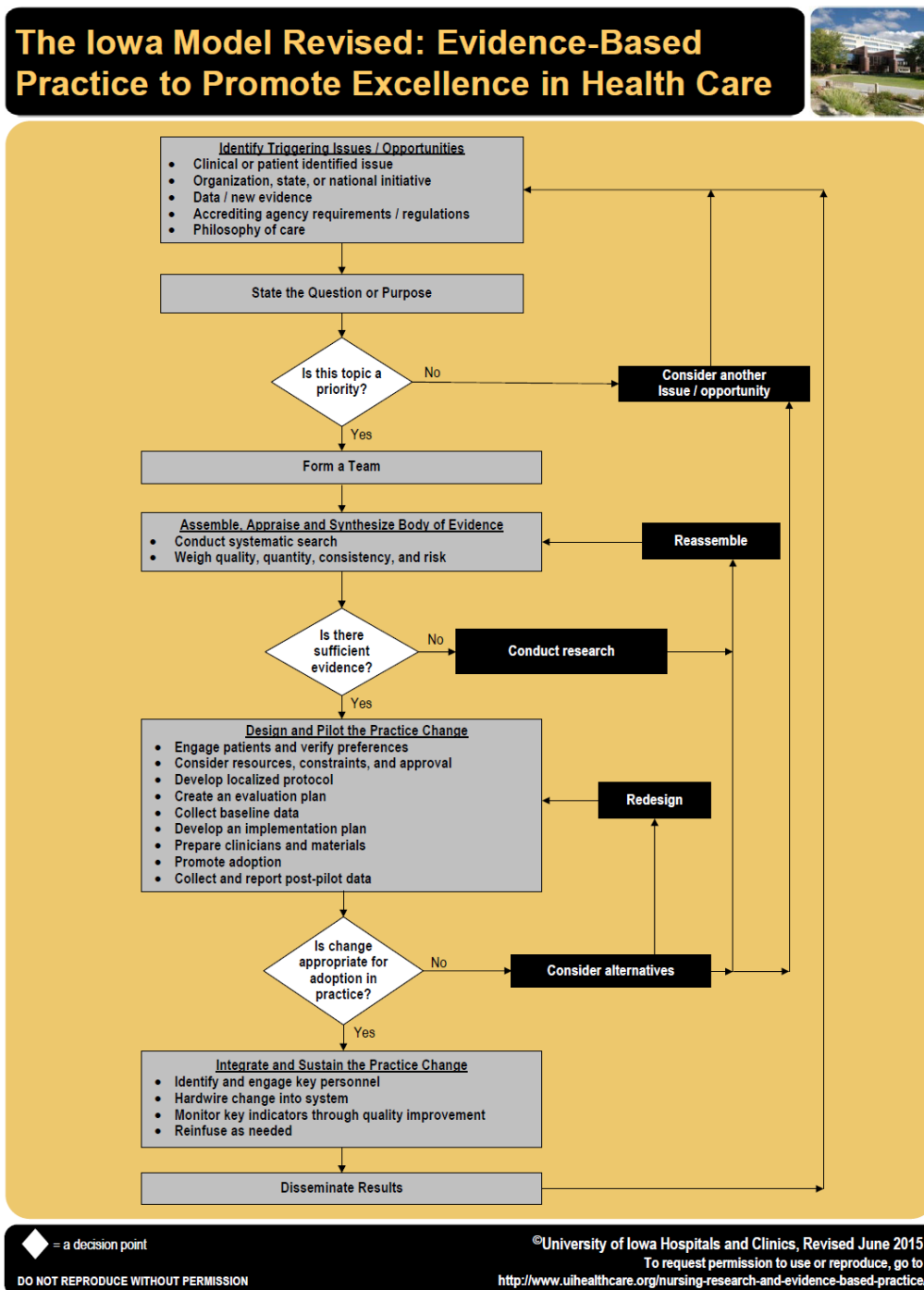


Figure 1. Evidence Based Process. This figure illustrates ‘The Iowa Model Revised’

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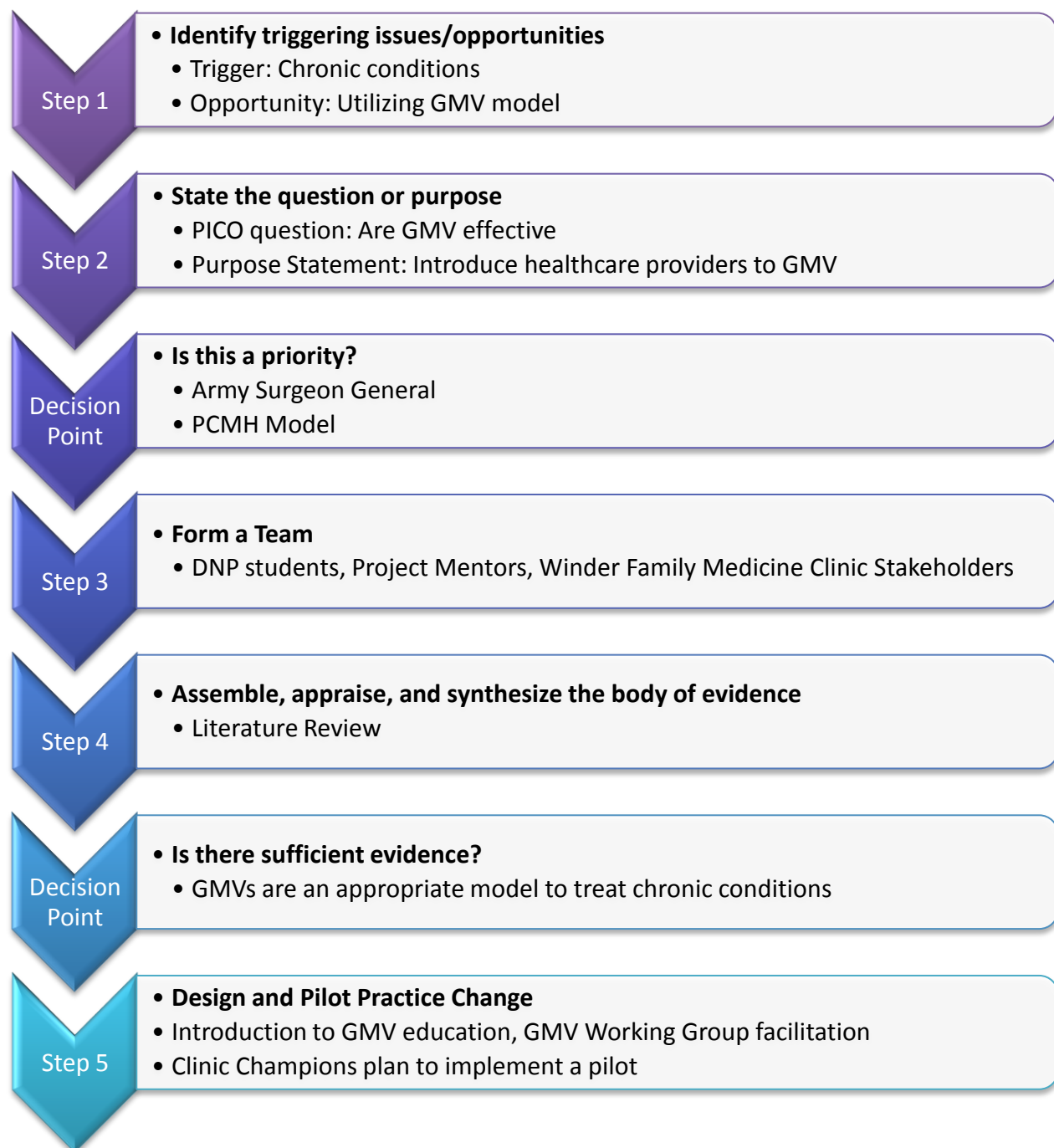


Figure 2. Project Progression. This figure illustrates project progression through ‘The Iowa Model Revised’

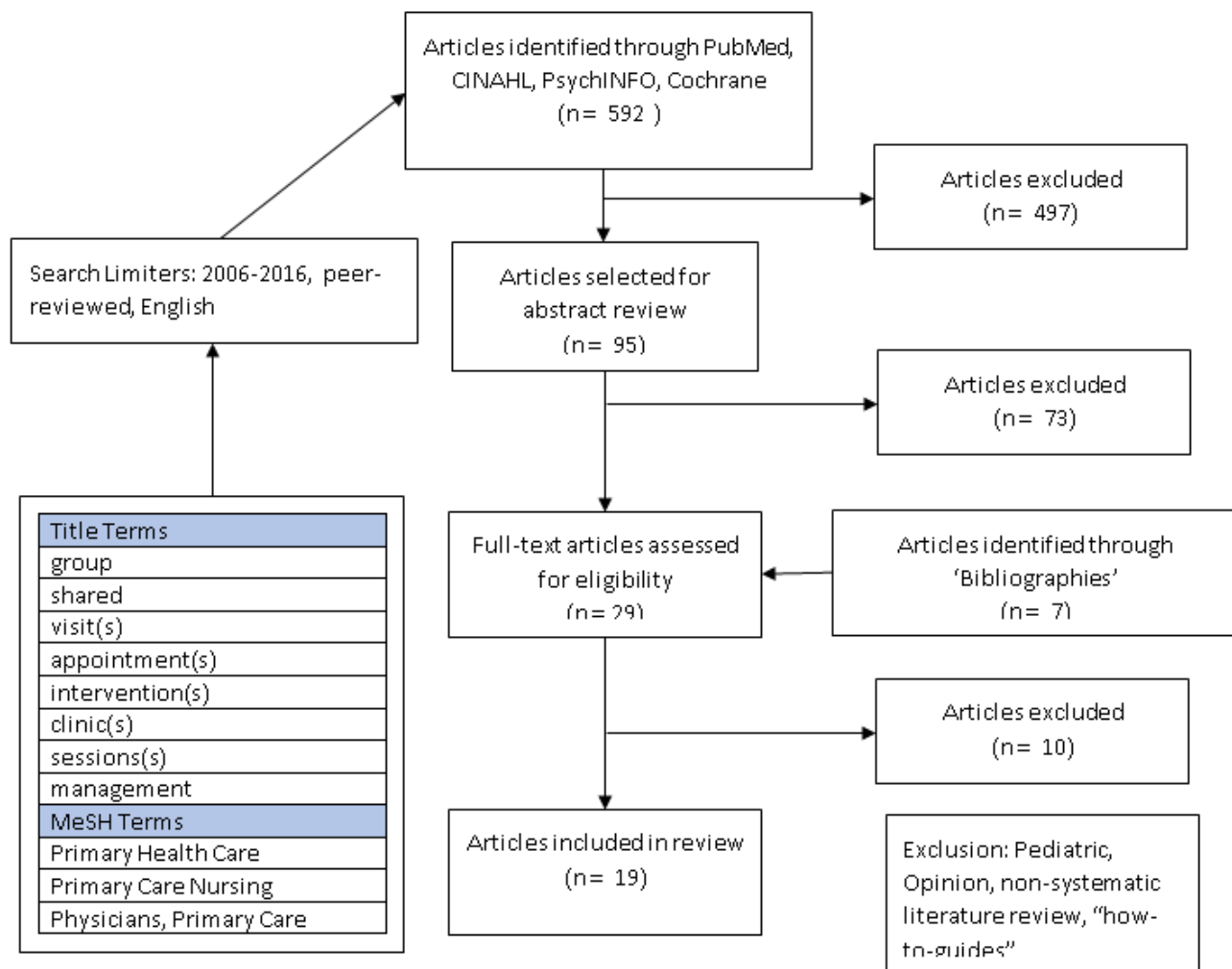


Figure 3. Literature search process. This figure illustrates 'PRISMA Flow Diagram of Methods and Results'

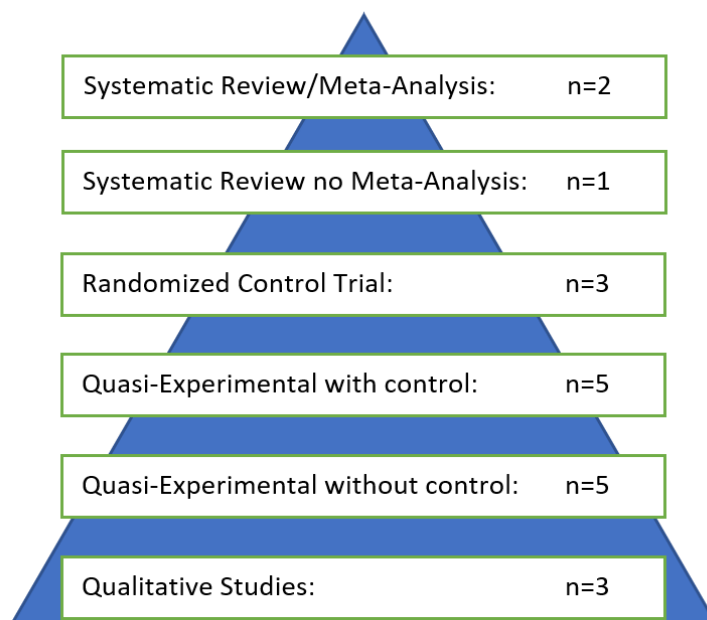


Figure 4. Classification of articles. This figure illustrates the type articles utilized for appraisal of evidence.

Project Year 1 (2017)												
Activity/Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
USU VPR Submission and Approval										X		
Site IRB Submission and Approval										X		
Project Planning									X	X	X	X
Project Implementation/Data Collection												
Data Analysis												
Dissemination												

Timeline

Project Year 2 (2018)												
Activity/Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
USU VPR Submission and Approval												
Site IRB Submission and Approval												
Project Planning												
Project Implementation/Data Collection	X	X										
Data Analysis		X	X									
Dissemination				X	X							

Figure 5. Project Timeline. This figure identifies the timeline of the project.

Appendix B

Evidence Appraisal Table

Evidence Appraisal Table									
Study	Purpose	Sample	Research Design	Independent Variable	Dependent Variable	Statistical Tests	Relevant Results	Level of Evidence	Quality of Study
Bastiaens et al., 2009	To develop and implement a group self-management education program for people with T2DM at the community level in primary care.	Diabetes: n=44; T2DM affect persons living in Belgium study area and receiving less than 2 insulin injections a day	Quasi-Experimental: Pilot Study: Longitudinal intervention with pre- and post-measures, no control	Participation in the group program, group reoccurred 5 times, no controls.	Dietary habits (Questionnaire), physical activity (IPAQ), emotional distress (PAID), self-reported HbA1C, BMI, 3-day food diary, 3-day pedometer	SPSS 14.0: PAID-Score and HbA1C (<30 pairs, Shapiro Wilk, $p<0.05$): Non-parametric tests, Wilcoxon signed ranks 2-tailed; BMI (>30 pairs, Shapiro Wilk, $p=0.262$): paired-sample <i>T</i> -tests	HbA1c 0.6% decrease at 12 months but not 18-month follow-up, Emotional distress improved 10 points after 12 months, BMI decreased 0.5 kg/m ² at 12 and 18-month follow-up.	Level III: Non-Experimental	B: Good Quality
Clancy, Huang, Okonofua, Yeager, & Magruder, 2007	To evaluate the effect of group visits on clinical outcomes, concordance with 10 American Diabetes Association guidelines.	Diabetes: n=186; >18 years with poorly controlled DM (HbA1c>8.0%); Adult Primary Care Center, Medical University of South Carolina	Randomized Control Trial	group visits; traditional patient-physician dyad	HbA1c levels, lipid profiles, blood pressures, adherence to ADA process-of-care indicators	SAS 9.1: Comparison between group visit and control: <i>t</i> -test for continuous outcomes and nonparametric Wilcoxon rank sum test for ordinal outcomes. 2 level statistical analysis: (1) cross-sectional analysis comparing group differences at each data collection point (<i>t</i> -test, Fisher's exact test, or nonparametric Wilcoxon rank sum test). Linear regression models for 6- and 12-month covariate-adjusted data; (2) longitudinal modeling analyzing data from all 3 data collection points	HbA1c, BP, and Lipid levels did not differ significantly between groups. At 12-month group visit, patients exhibited greater concordance with ADA process of care indicators and high screening rates for cancers of the breast and cervix.	Level I	A: High quality

Cohen, Hartley, Mavi, Vest, & Wilson, 2012	To explore patient satisfaction and perception of the value related to participation in following programs: MOVE, MAGIC, and smoking cessation.	Veterans: n=17, purposive sample; Salem, Virginia; Outpatient medical care in Veterans Affairs facility	Qualitative: five focus group sessions			Audio recordings transcribed and analyzed by four researchers using N'Vivo software and exploratory process to obtain consensus regarding themes. Inter-rater reliability $K=0.68$ ($p<0.001$).	High levels of satisfaction with SMAs. Themes: empowerment, peer support, awareness, positive provider, characteristics, teamwork, benefits, convenience	Level III: Qualitative	A: High Quality
De Vries, Darling-Fisher, Thomas, & Belanger-Shugart, 2008	To describe the outcomes of a nurse practitioner-facilitated group medical appointment for chronic obstructive pulmonary disease.	COPD: n=6, medical records from convenience sample of established pulmonary patients in a Midwest specialty clinic	Quasi-Experimental: Pilot Study: Retrospective Cohort Study, no control	Group Medical Appointment	healthcare services utilization, exercise tolerance (6MW distance), use of pharmacological and nonpharmacological interventions	SPSS 13.0: assess demographic data, determine changes in outcomes pre- and post-GMA participation	Improved exercise tolerance	Level III: Non-Experimental	C: low quality and major flaws
Desouza, Rentschler, & Haynatzki, 2010	To determine the effectiveness of group medical clinics to maintain diabetes control in complex diabetes patients over 2 years when compared to usual primary care.	Diabetes: N=56, n=29 in Group Diabetes Clinic, n=27 followed by PCP; Omaha VA medical center, Nebraska	Quasi-experimental, retrospective cohort study	Group diabetes clinic, primary care provider as usual	BMI, HbA1c, LDL, blood pressures	SAS 9.2: Analysis of Covariance (ANCOVA) model for each response variable for either the relative change between baseline and month or with repeated measures on variable month	HbA1c, LDL, and BP not statistically different at 2 years between groups	Level III: Non-Experimental	B: Good Quality

Edelman et al., 2012	To summarize the effects of SMA on staff, patient, and economic outcomes and to evaluate whether the impact varied by clinical condition or specific intervention components.	Non-Specific Care: n=25 articles (1104 unique citations from search)	Systematic Review, Meta-analysis	Shared medical appointments, usual care	Patient and staff experience, treatment adherence, quality measures, symptom severity, functional status, utilization of medical resources, health care costs	Basic analyses by Review Manager (RevMan) 5.1.4/Meta-regression analyses by Comprehensive Meta-Analysis software (Version 2): Outcomes analyzed qualitatively and by meta-analysis when appropriate with a weighted difference of the means when same scale and standardized mean differences when scales differed. Heterogeneity examined by graphical displays and test statistics (Cochran's Q and I ²) and explored by subgroup analyses for categorical variables and meta-regression analyses for continuous or discrete variables. Robustness score created and used. Sensitivity analyses by using only type 2 diabetes-focused studies.	The evidence in most cases is insufficient. 13 good quality RCTs consistently showed intervention lowered A1C levels in diabetes. 5 RCTs showed intervention lowered BP in hypertension. Positive experience in older adults and possibly lower health care utilization. Recommendation: utilizing SMA intervention for chronic conditions other than diabetes remains speculative.	Level I	A: High quality
Gustavsson, Denison, & von Koch, 2011	To compare long-term effects of a multicomponent pain and stress self-management group intervention (PASS) and individually administered physical therapy (IAPT) on patients with persistent	Neck Pain: N=156, PASS n=77 (57 returned questionnaire), n=79 (50 returned questionnaire); 18-65 years of age with tension-type neck pain persistently more than 3 months; Nine Primary Health Centers in eight towns in	Randomized Control Trial and 2-year questionnaire follow-up	Pain and stress self-management group intervention (PASS), individual administered physical therapy (IAPT)	Pain intensity (numerical rating), analgesic use, pain control (Coping Strategies Questionnaire (CSQ)), self-efficacy (Self-Efficacy Scale), disability (Neck Disability Index), catastrophizing (CSQ-Subscale),	SPSS 18.0: Linear mixed models for repeated measures analysis to evaluate differences in pain control, self-efficacy, satisfaction, and use of skills acquired. Compound symmetry covariance structure for mixed model analyses except for NDI which used unstructured covariance structure.	Superior long-term (2 years) effects with intervention in coping with pain, pain control, self-efficacy, and catastrophizing.	Level I	B: Good Quality

	tension-type neck pain in a primary health care setting.	Sweden			depression and anxiety level (Hospital Anxiety and Depression Scale), Satisfaction with care, Use of skills acquired	Pair-wise comparisons for variables with significant interaction effect at each time point. Bonferroni corrections for analyses of simple main effects. X^2 test between-group differences in analgesic use, satisfaction, use of skills.			
Harris, Silva, Intini, Smith, & Vorderstrasse, 2014	Evaluate effectiveness of a monthly diabetes self-management education intervention on HbA1c and knowledge levels in patients with T2DM	Diabetes: N=51, patients who participated in group diabetes self-management education (DSME); Primary Care practice in rural, eastern North Carolina with patient with T2DM	Quasi-experimental: Retrospective cohort study, no control	Participation in group DSME	HbA1c levels, diabetes knowledge (Diabetes Knowledge Questionnaire (DKQ))	Paired <i>t</i> -test used for differences pre and post of DKQ mean scores. Random coefficients regression model used to evaluate the trajectory of changes in HbA1c over 6 month period. Three separate random coefficient regression models to determine if HbA1c levels related to demographic characteristics. <i>z</i> test for differences between cases at or below 7. Level of significance set at .05 for the non-direction statistical test.	No decrease in HbA1c for either group. Knowledge level increased with intervention	Level III: Non-Experimental	B: Good Quality

Heyworth et al., 2014	To examine overall satisfaction and patient-centered care experiences across key domains of the patient-centered medical home among patient attending SMAs vs. usual care appointments.	Non-Specific Care: Usual Care n= 921 (31% returned questionnaire); SMAs n=921 (40% returned questionnaire); patient attended at least one internal medicine office visit from 2008-2010; 14 practices in Massachusetts with an established SMA program	Quasi-Experimental: Partially randomized Longitudinal survey (patients stratified by primary care clinician and survey mailed to 200 randomly selected patients)	Shared medical appointments, usual care	medical experience (questionnaire developed by Press Ganey)	SAS version 9.3: Selection bias due to descriptive statistics limited by the use of propensity score. Patients matched one to one between the group and any extras excluded. Multivariate logistic regression to examine differences in overall satisfaction and other patient-centered care with matched patients. Analyses of SMA only multivariate logistic regression analysis used to evaluate differences stratified by number of SMAs attended and patient characteristics. Trends in SMA satisfaction over time ascertained by using the Cochran-Mantel-Haenszel test	SMA patients more satisfied with care rated care as more accessible and more sensitive to their needs. Usual care patients reported greater satisfaction with physician communication and time spend during appointment	Level III: Non-Experimental	A: High Quality
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Housden, Wong, & Dawes, 2013	To review the evidence of the effectiveness of group medical visits for patients with diabetes	Diabetes: N=26 studies, n=13 RCTs	Systematic Review, meta-analysis	group intervention, usual care group	HbA1c, Blood Pressures, Total cholesterol, HDL cholesterol, triglycerides, weight, BMI	Review Manager software (RevMan, version 5.1, Nordic Cochrane Center) for RCTs/Stata software version 12.1 (StataCorp LP) for meta-regression analysis: RCT effect size calculated to determine the mean differences between intervention and control groups at longest reported time after the intervention. Mean differences pooled into a fixed-effects model. X^2 test for heterogeneity. Hedge's method used for calculating standardized mean differences. Meta-regression analysis to determine if the length of time patients spent attending group medical visit was related to effect size and if the number of group visits a patient attended in a year was related to effect size.	Group medical visits led to significant reductions in HbA1c. Duration of intervention (i.e., 6 months versus 3 months), but not frequency (i.e., once monthly versus once weekly), showed the greatest drop in HbA1c. Intervention showed no statistically significant effect on other outcomes.	Level I	A: High quality
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Jaber, Braksmajer, & Trilling, 2006	Summarize current group visit research and develop suggestions for furthering the care model.	Non-Specific Care: N=18 articles	Systematic review with qualitative synthesis (unable to complete meta-analysis because SORT criteria not met)	group intervention, usual care group	Patient Satisfaction, Health Service Utilization, Quality of Care, Health Behaviors, Self-Care, Self-Efficacy, Physical Function, Depression, Quality of Life, Disease-Specific Outcomes, Satisfaction of Physicians, and Cost of Care	Qualitative review and summary of literature from 1974 to 2004	Intervention improves patient and physician satisfaction, quality of life, and quality care indicators. Intervention tends to lead to fewer emergency room and specialist visits. Health behavior and self-efficacy improvement are linked closer to facilitator's skills in motivational interviewing, the presence of behavior-specific objectives, and patient confidence level. Depression not shown to improve in any study, but no study chose to cater intervention to improve depression.	Level II	A: High quality
Kirsh et al., 2007	To assess a quality improvement project to improve intermediate outcome measures for diabetes patients with highest cardiovascular risk.	Diabetes: n=44; 112 patients met entry criteria, and all were contacted by letter with 39% agreeing to participate; primary care center in the Veterans Healthcare System, Cleveland, Ohio	Quasi-experimental: non-randomized control trial; Pre-test, Posttest design.	Shared medical appointments, researcher identified comparable series of control patients	A1C, LDL-c, SBP, and qualitative data from patients and staff	SPSS Version 13: Paired t-test to evaluate the impact of the intervention on A1C, LDL-c, and SBP. Independent t-tests used for between-group comparisons. Changes in the percentage of patients meeting targets analyzed with χ^2 or Fisher Exact tests. Group differences in dichotomous variables assessed with χ^2 .	Reduction in A1c by 1 percentage point. SMAs can be feasibly implemented using a group interdisciplinary team approach.	Level II	B: Good Quality

Lavoie et al., 2013	To explore dimensions identified as key in the patient-centered literature in the context of primary health care services delivered in a group setting.	Non-Specific Care: n=34 providers, n=29 patients; Primary Care in rural communities in the Canadian province of British Columbia	Qualitative study; purposive and theoretical			Atlas TI software: Interviews digitally recorded, transcribed, and cleaned of any personal identifiers. Interpretive thematic analysis to identify links to theoretical perspectives, recurring patterns, or contradictory patterns. Data coding scheme developed.	Overall patient and provider satisfaction with GMV format due to 3 sub-categories: social event, affiliation (power shift from provider to the patient), and co-production of the GMV (group format driven by the provider and patient feedback).	Level III: Qualitative	A: High quality
Ramos et al., 2010	To compare the effectiveness of intensive group and individual interventions for smoking cessation in a primary health care setting.	Tobacco Smoking: N=287, n=81 in intensive individual intervention (III), n=111 in intensive group intervention (IGI), n=95 in minimal intervention (MI); Primary health care setting in Mallorca	Quasi-Experimental: Randomized clinical trial, three-pronged	Intensive Individual (III), Group (IGI), Minimal (MI)	Subjective smoking cessation report, CO-oximetry	SPSS 11.5: Chi-squared, Anova, and Kruskal-Wallis tests to ascertain randomization at baseline and to compare interventions. Continuous variables checked for normal distribution with Kolmogoroff-Smirnoff test. Bivariate analysis performed to determine variables associated with smoking cessation. To determine variables other than group allocation associated with smoking cessation a multivariate logistic regression performed.	III showed higher abstinence rates at 12 months than IGI and MI, but not statistically significant. No other difference noted between groups.	Level II	C: low quality and major flaws

Rautio et al., 2012	To describe socioeconomic characteristics of participants and their effect on uptake and completion of implementation of the project for a Finnish T2DM prevention program and to assess the effectiveness of individual vs. group interventions at one-year follow-up.	Diabetes: N=10,149, n=1067 men and n=2122 women at 1 year follow up. Primary care setting in Finland	Quasi-Experimental, Non-randomized cohort study	Group intervention, individual intervention	Weight, BMI, Waist, Systolic BP, Diastolic BP, Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Triglycerides, SCORE: 10-year risk for fatal CVD	PASW Statistics 18.0 and SAS 9.2: Cross-tabulation and Chi-square test used for group differences between categorical variables. Independent sample t-test used for categorical and continuous variables. Analysis of variance (ANOVA) used for changes in adjusted cardiovascular risk factors between interventions. Multinomial logistic regression analysis for changes in glucose tolerance between interventions.	Both intervention types equally effective with few exceptions, but people preferred individual appointment type.	Level II	B: Good Quality
Riley, 2013	To develop a group visit model that improves A1C, BP, lipids, depression, and satisfaction among patients with diabetes that can be used in primary care practice settings.	Diabetes: N=22; small, private primary care practice in semirural southern state in United States	Quasi-Experimental: Pilot study: no control, pre/posttest descriptive	Group visit	A1C, BP, lipids, depression, satisfaction	SPSS: Paired <i>t</i> -tests to calculate outcomes and descriptive statistics.	A1C reduced by 1.1 points, weight decreased by 3.01 pounds, diastolic BP improved by 5.76 mmHg, depression improved (Beck Depression Inventory), and satisfaction improved (Seattle Outpatient Satisfaction Questionnaire)	Level III: Non-Experimental	B: Good Quality
Sanchez, 2011	To implement diabetes self-management education in primary care using the Chronic Care Model and shared medical appointments (SMA) to provide evidence-based interventions to	Diabetes: N=70; Private internal medicine clinic in Hidalgo County, Texas along the US-Mexico border.	Quasi-Experimental: Pilot study, no control, pre/posttest descriptive	Group visit	A1C, BP, cholesterol, triglycerides, LDL, urine albumin levels, ophthalmologic exam, aspirin use in those over 40	SPSS 15.0 (student version): descriptive statistics to determine percentage of patients who maintained recommended clinical practice recommendations.	Improved A1C, self-management skills, and satisfaction. Buy-in from healthcare team not sufficient to sustain intervention.	Level III: Non-Experimental	B: Good Quality

	improve process and measure outcomes.								
Taveira, Dooley, Cohen, Khatana, & Wu, 2011	To test the efficacy as assessed by attainment of an A1c <7% of pharmacist-led group SMA visits, Veterans Affairs Multidisciplinary Education in Diabetes and Intervention for Cardiac Risk Reduction in Depression (VA-MEDIC-D), in patients with T2DM.	Diabetes: N=88, n=44 in VA-MEDIC-D, n=44 in standard of care; Providence Veterans Administration Medical Center, Rhode Island	Randomized Control Trial	VA-MEDIC-D and standard care, standard care only	A1c, SBP, LDL-C, Non-HDL-c, Tobacco use	Stata SE 11.0: Student t-tests for continuous variables and ratio X^2 tests for discrete variables. Stepwise logistic regression for a percentage of participants who attained A1C<7% at 6 months controlling for baseline values and other variables. Linear regression model for change from baseline A1C values.	With intervention greater attainment of glycemic control, a decrease in A1C, and cut number of cigarettes in half, but no change in ADA goal achievement. Tighter control of medications leading to increased dose and use of antihypertensive and antiglycemics resulting in a reduction of lipid levels and BP.	Level I	A: High quality
Thompson, Meeuwisse, Dahlke, & Drummond, 2014	To generate insights that could be used to guide the development of an inner-city community health center's GMV services.	Diabetes: N=9; Marginalized and vulnerable inner-city patient population served by community health center, Canada	Qualitative: exploratory interview			Nvivo qualitative analysis software: Conventional qualitative content analysis: subjective interpretation of text data through systematic identification, coding, and classification of emergent themes and patterns.	Themes identified: Describing the group, what makes a good facilitator, peers as change agents, change process, and feedback/suggestions.	Level III: Qualitative	C: major flaws

Appendix C

Outline of Presentation, GMV Workbook, Resource Guide Outline

GMV Evidence and Education Presentation Outline:

Outline

- Chronic Conditions in Primary Care
- Introduce Group Medical Visits
- Clinical Question
- Methods/Results/Findings
- Case Study
- Clinic Specific Considerations
- Questions and Survey

GMV Working Group: Workbook**Group Medical Visits: Working Group**

Presented by: MAJ Faith E. K. Grzesik & MAJ Douglas A. Taylor

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Uniformed Services University, Doctor of Nursing Practice Students

February 1, 2018

Learning Objectives:

- 1) *Explore and select an appropriate GMV model for the clinic*
- 2) *Identify goals and elements of GMVs for the clinic to address a specific care need*
- 3) *Identify and assign team member roles for the GMV*
- 4) *Clarify target patient populations for the clinic*
- 5) *Address barriers and the way forward for GMVs in the clinic*

This educational material was adapted from the following resources:

Putting Group Visits Into Practice – Mass General Hospital

www.massgeneral.org/stoecklecenter/assets/pdf/group_visit_guide.pdf

VA Shared Medical Appointments for Patients with Diabetes

<https://www.queri.research.va.gov/tools/diabetes/shared-med-appt.pdf>

Group Health – Group Visit Starter Kit

http://www.improvingchroniccare.org/index.php?p=Critical_Tools&s=162

GMV Overview

Activity

Introduction to Group Medical Visits

- Overview of different types

Working Group Activity

- Population
- Diagnosis
- Goals of the GMV and measurable outcomes
- Elements/Structure

Team Roles

Resources

Recruitment

Barriers/ Way Ahead

Additional Resources:

Billing and Coding

Confidentiality Agreement

How to Schedule a GMV in 30 Seconds

Introduction to Group Medical Visits for Chronic Conditions**Problem:**

- Chronic conditions cause 7 out of 10 deaths, and 86% of United States' health care costs.
- The standard primary care office visit is unable to meet the needs of patients with chronic conditions.

The Intervention:

- Group Medical Visits combine medical care, patient education, and peer support. Group visits are usually 8-12 patients who are seen as a group by an interdisciplinary team.

The Benefits:

- GMVs have high levels of patient and provider satisfaction and they provide numerous contextual benefits such as patient empowerment, shared care delivery decisions, and peer support.

The Evidence:

- Group Medical Visits outperform standard of care in lowering hemoglobin A1c levels.
- Group Medical Visits have been shown to meet or outperform standard of care for one or more of the following: increased disease knowledge, lower blood pressure, improved cholesterol levels, weight loss/lowered BMI, decreased pain, decreased insomnia, decreased smoking, and improved COPD symptoms.

The Potential:

- Group Medical Visits have the potential to improve our patient's quality of life.

Defining Group Visits

Group Medical Visits are known by a variety of names. In general each GMV has three areas of focus:

- 1) Access to care
- 2) Education about the medical condition
- 3) Behavioral changes and skills development

Groups may also differ on the staffing, techniques, and structure. These will be discussed during the working group activities today.

Types of Groups			
Main Focus of the Group	ACCESS To improve access to care and address medical needs	EDUCATION To provide health education and teach skills for self management	BEHAVIORAL CHANGE To promote and enhance strategies for lifestyle and behavioral change
Examples of Groups by Focus	- Shared medical appointments - Group medical clinics, veterans administration hospital	- Diabetes self-management education groups by CDE diabetes nurse educators - Health coaching	- Group medical visits - Group psychotherapy - Patient peer-to-peer support groups
Table was adapted from: <i>Putting Group Visits Into Practice</i> , Massachusetts General Hospital			

Group Visits in 10 steps	
1.	A group of patients are invited to meet as a group with medical professionals
2.	The session is scheduled for 90 to 120 mins
3.	Prior to the group visit a chart review or checklist is completed
4.	Upon arrival the patient is greeted, vitals are obtained and any surveys are completed
5.	At the start of group the leader explains the format and obtains HIPAA consent
6.	The medical review for each patient is integrated into the session as determined by the clinic
7.	Disease related education is provided. Examples: a. Health targets, prevention strategies, and complications b. Medications used, benefits, and potential side effects c. Special circumstances, such as diabetes sick day management d. Meal planning, exercise, or stress reduction
8.	Facilitated discussion (conducted by provider, nurse, or behavioral specialist)
9.	Incorporation of a relaxation or meditation exercise with the group
10.	Complete any visit documentation, referrals, or follow up services
Table was adapted from: <i>Putting Group Visits Into Practice</i> , Massachusetts General Hospital	

Working Group Activity

Working in your group, discuss the population you would like to consider for GMVs. *List your population including diagnosis type on the tent card.* Use the remainder of the time discussing the goals of your GMV and elements you would like to include in the visit.

Population

Diagnosis (there may be multiple diagnoses to include if the goals and structure is appropriate for their care)

Goals & Measurement (Targets, knowledge, behavioral changes, utilization, etc.)

Elements/Structure of the Group Visit (Requirements for standard of care and coding)

Other considerations to brainstorm: size of group, time of day, # of sessions if a series of groups.

Team Roles

Include the medical providers (and champions), behavioral or interventionists, and support staff.

Name	Roles
Others you might need to include:	

Example Roles:

Team Leader: This person can be any member of the team. They are responsible for ensuring the overall success of the Group Medical Visit by assigning tasks, scheduling planning meetings, and ensuring that everyone and everything is in order for the group visit to be successful.

Medical Clinician: This person is responsible for ensuring that the medical needs of the patient are met. They are responsible for the History of Present Illness, physical exam, diagnosis, and orders (meds, labs, rads).

Behaviorist: The person is responsible for facilitating discussion in support of the medical clinician and attending to the interpersonal dynamics of the various group attendees.

Support Staff: These people are responsible for the logistics of the group visit and completing work to their highest level of licensure. For example, support staff are responsible for booking patients for the group, answering questions prior to the group visits, reviewing charts, and alerting the medical clinician of any recent lab or radiological work.

Resources

This may include space, equipment, technology, administrative time, group facilitation training...

Recruitment Ideas

Consider methods, timelines, scheduling process, and inclusion/exclusion checklists. Recruitment focuses can be for both patients and providers.

Strategies that have been successful for other practices include:

- 1) Frame the group visit as part of the practice's standard of care
- 2) Use personal language ("I want to personally invite you to...") *see additional resource
- 3) Give promotional materials or scripts that use patient-friendly language at an appropriate reading level
- 4) Promote the group visit based on patient feedback and testimonials
- 5) It is critical to know the populations needs, use marketing strategies to accurately address the patient's concerns

Barriers/ Way Ahead

(Examples: Patient attendance, facilitation skills, clinic time, preparation, administrative support, etc.)

Billing and Coding

Billing codes for care delivered in a group visit are determined by:

1. The professional qualifications of the provider leading the group
2. The content of the care provided

Poor understanding of billing standards and requirements is a common barrier to implementing financially sustainable group visits. Although CPT coding requirements are set by national standards, there is wide variation among clinicians regarding the coding requirements and documentation levels. Below is a scale summary of reimbursement levels according to who leads the group visit.

Billing and Coding Group Visits			
Reimbursement	CPT Code	Group Visit Leader	Notes
\$\$	Level 3 E&M 99213 + 96153	Physician, PA, NP + Mental Health Specialist	The medical provider and the mental health specialist can both bill for their respective services as long as the codes do not overlap (For example, a PA and a Psych NP cannot bill in the same category, i.e. 99213 and 99212)
\$	Level 3 E&M 99213	Physician, PA, NP	The provider led group visit is facilitated by support staff

Table was adapted from: *Putting Group Visits Into Practice*, Massachusetts General Hospital

CONFIDENTIALITY AGREEMENT*

CONSENT FOR RELEASE OF INFORMATION, FOR MAINTAINING CONFIDENTIALITY, AND FOR PARTICIPATING IN GROUP MEDICAL VISITS

Group Medical Visits (GMVs) are medical appointments with your provider that occur in a group setting with other patients and their family members or support persons. During group session, you will receive medical treatment from your medical team. Much of what normally occurs during your regular medical visits will also happen here—such as your vital signs being taken, injections and routine health maintenance being updated, prescriptions being reviewed and renewed, and other medical services delivered.

Understandings and requirements for participation include the following:

- You understand that your medical care will be delivered by the provider in front of others, and this is acceptable to you;
- You agree both to not reveal the identities of others in the group and to not discuss their health information with anyone once the group appointment is over;
- However, you are welcome to take anything of a general nature that is helpful to you in your own health care management home with you and share it with others that have a need to know; however, by signing this document, you agree not to reveal the identities or health issues of others when so doing;
- You understand that, if you have a private medical need or issue to discuss with your provider, you can always ask to be seen briefly in private—which will most likely occur towards the end of the group so as to not interrupt the flow of the GMV session;
- If you need to leave early, you are still welcome to attend; however, you will need to tell the provider or a GMV staff member about this at the start of the session in order to ensure that you will receive your medical care before leaving; and
- In the future, you understand that you can still have traditional individual office visits just like before—and that the GMV simply represents an additional health care choice that is now available to you.

➤ **Participation is voluntary** and you still have the same right to individual medical appointments as before.

Your Signature at the bottom of this form indicates:

- That you have thoroughly read this document and understand it;
- That you have had the opportunity to ask any questions that you might have about the GMV;
- That you voluntarily agree to participate;
- That, except for what you have specifically stated above, you consent to the release of your private medical and psychosocial information in the GMV
- That you will respect the privacy of all in attendance by keeping all information about others confidential;

Patient's Signature: _____ Date: _____

Signature of Support Person Accompanying Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

* Note: This example is meant to be for illustrative purposes only. Each health care system must develop its own confidentiality agreement based upon its own regulations and requirements.

How to Schedule a GMV in 30 Seconds

Schedulers, first take these 3 steps:

First, when a patient calls for an appointment, try to convert the call to a GMV when appropriate by offering both the first available GMV appointment and the next available individual appointment. (i.e., Dr. _____ can see you on (first GMV date) or (next available appointment)).

Second: Allow patient to respond.

Third: Confirm appointment and explain the GMV and its many patient benefits in approximately 30 seconds.

Things to say when offering the GMV – try to do so in approximately 30 seconds:

- Dr. (provider's name) would like to invite his/her patients to attend his/her Group Medical Visits the next time they need to be seen.
- Dr. _____ can see you next (day of GMV) at (time of appointment). (GMV Appt.'s. are typically offered once a week)
- The appointment consists of a 90-minute session with the doctor.
- Each patient's individual concerns will be addressed by the provider during the session. However, if a personal concern needs to be discussed or a private exam needs to be provided, the doctor will briefly see the patient one-on-one in the exam room located next to the conference room area.
- You will be in a conference room setting with 8-12 of the doctors other patients dealing with similar issues and concerns.
- Everything is on a first name basis. There is a lot of information and medical care provided—plus some laughter and fun. Confidentiality waivers will be signed before the appointment begins by each patient attending and their support person. (The confidentiality waiver is filed in each patient's medical record).
- If you need to leave early, you can do so. However, if you do not stay for the whole appointment, you will probably not get the full amount of support and patient education that you would if you were to attend the entire appointment. If you cannot stay for the entire session, then notify the nursing staff or the doctor—by doing so, they will try to treat you towards the beginning the session.

13

Resource Guide Table of Contents:

- Introduction and literature review
- How to create lists and document groups in Genesis
- Guides to Implementing Group Visits
 - o VA Shared Medical Appointments for Patients with Diabetes: Maximizing patient and provider expertise to strengthen care management (2008)
 - o Putting Group Visits into Practice: A practical overview to preparation, implementation, and maintenance of group visits at Massachusetts General Hospital (2012)

- o Group Visit Starter Kit: Group Health Cooperative (2001)
- Supporting Literature Table of Contents

Appendix D

CITI Certificates, USU (VPR) Form 3202N, USU Completion Form, MAMC PAO Clearance,
and MAMC Exemption Determination Letter

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Faith Grzesik (ID: 4983981)
- **Email:** faith.grzesik@usuhs.edu
- **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
- **Institution Unit:** GSN
- **Phone:** 2174934246

- **Curriculum Group:** OUSD P&R Human Research (Current)
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Biomedical Investigators

- **Report ID:** 16957763
- **Completion Date:** 08/24/2015
- **Expiration Date:** 08/23/2018
- **Minimum Passing:** 80
- **Reported Score*:** 100

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Records-Based Research (ID: 5)	08/22/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/24/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/24/15
FDA-Regulated Research (ID: 12)	08/24/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/22/15
Informed Consent (ID: 3)	08/24/15
History and Ethics of Human Subjects Research (ID: 498)	08/24/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/24/15
Genetic Research in Human Populations (ID: 6)	08/24/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/24/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/24/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/24/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/24/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/24/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/24/15
Assessing Risk - SBE (ID: 503)	08/22/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: <https://www.citiprogram.org>

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

• **Name:** Faith Grzesik (ID: 4983981)
 • **Email:** faith.grzesik@usuhs.edu
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• **Curriculum Group:** OUSD P&R Human Research (Current)
 • **Course Learner Group:** Biomedical Investigators and Research Study Team
 • **Stage:** Stage 1 - Biomedical Investigators

• **Report ID:** 16957763
 • **Report Date:** 08/24/2015
 • **Current Score**:** 100

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT
History and Ethics of Human Subjects Research (ID: 498)	08/24/15
Informed Consent (ID: 3)	08/24/15
History and Ethical Principles - SBE (ID: 490)	08/22/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/24/15
Defining Research with Human Subjects - SBE (ID: 491)	08/22/15
Belmont Report and CITI Course Introduction (ID: 1127)	08/22/15
Records-Based Research (ID: 5)	08/22/15
The Federal Regulations - SBE (ID: 502)	08/22/15
Genetic Research in Human Populations (ID: 6)	08/24/15
Assessing Risk - SBE (ID: 503)	08/22/15
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	08/24/15
Informed Consent - SBE (ID: 504)	08/22/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/24/15
Privacy and Confidentiality - SBE (ID: 505)	08/22/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/24/15
Research with Children - SBE (ID: 507)	08/24/15
FDA-Regulated Research (ID: 12)	08/24/15
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	08/24/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/24/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/24/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/24/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/22/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/24/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/24/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/24/15

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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 Phone: 305-243-7970
 Web: <https://www.citiprogram.org>

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

• **Name:** Douglas Taylor (ID: 4992649)
 • **Email:** douglas.taylor@usuhs.edu
 • **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
 • **Institution Unit:** GSN
 • **Phone:** 7605774628

• **Curriculum Group:** OUSD P&R Human Research (Current)
 • **Course Learner Group:** Biomedical Investigators and Research Study Team
 • **Stage:** Stage 1 - Biomedical Investigators

• **Report ID:** 16994468
 • **Completion Date:** 08/26/2015
 • **Expiration Date:** 08/25/2018
 • **Minimum Passing:** 80
 • **Reported Score:** 95

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Records-Based Research (ID: 5)	08/26/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/26/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/26/15
FDA-Regulated Research (ID: 12)	08/26/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/26/15
Informed Consent (ID: 3)	08/26/15
History and Ethics of Human Subjects Research (ID: 498)	08/26/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/26/15
Genetic Research in Human Populations (ID: 6)	08/26/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/26/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/26/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/26/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/26/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/26/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/26/15
Cultural Competence in Research (ID: 15166)	08/26/15

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)
COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

• **Name:** Douglas Taylor (ID: 4992649)
 • **Email:** douglas.taylor@usuhs.edu
 • **Institution Affiliation:** Uniformed Services University of The Health Sciences (ID: 395)
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 • **Course Learner Group:** Biomedical Investigators and Research Study Team
 • **Stage:** Stage 1 - Biomedical Investigators

• **Report ID:** 16994468
 • **Report Date:** 08/26/2015
 • **Current Score**:** 95

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES

MOST RECENT

History and Ethics of Human Subjects Research (ID: 498)	08/26/15
Informed Consent (ID: 3)	08/26/15
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	08/26/15
Records-Based Research (ID: 5)	08/26/15
Genetic Research in Human Populations (ID: 6)	08/26/15
Vulnerable Subjects - Research Involving Children (ID: 9)	08/26/15
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	08/26/15
FDA-Regulated Research (ID: 12)	08/26/15
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	08/26/15
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	08/26/15
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	08/26/15
Cultural Competence in Research (ID: 15166)	08/26/15
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	08/26/15
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	08/26/15
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	08/26/15
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	08/26/15

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USUHS FORM 3202N
DANIEL K. INOUE GRADUATE SCHOOL OF NURSING
EVIDENCE-BASED PRACTICE/PERFORMANCE IMPROVEMENT PROPOSAL

VPR Date Stamp

Project Number: GSN-61-9576 (VPR will assign)

Project Title: Group Medical Visits for Chronic Conditions

SECTION A: STUDENT POC INFORMATION

1. Name (Last, First, MI): Grzesik, Faith E. K. Student E-mail: faith.grzesik@usuhs.edu

SECTION B: COMMITTEE CHAIR / SENIOR MENTOR INFORMATION

3. Name (Last, First, MI): Dillon, Douglas

4. Telephone: 301-295-0742 Fax: _____ E-mail: douglas.dillon@usuhs.edu

5. USUHS Building/ Room No.: Building E Room 1009

SECTION C: PROJECT INFORMATION

6. Attach the Abstract for the proposal, including the following sections: Site Location of the Project, Title, Authors, Background or Problem/Issue, Clinical Question/Purpose, Project Design, Anticipated Organizational Impact/Implications for Practice and also include the Proposed Timeline. Single space the abstract and use Times New Roman font, size 12.

7. Is this proposal related to an active research project of the Chair/Senior Mentor identified in Section B? ☐ Yes ☒ No
If yes, complete below; if no, proceed to Part 8.

Project Number: _____

Project Title: _____

Project Start Date: _____ Project End Date: _____

8. Anticipated period of performance: Project Start Date: 11/1/2017 Project End Date: 1/31/2017

9. Performance Site(s): Winder Clinic, Madigan Army Medical Center, Joint Base Lewis McChord, WA

10. Does this project involve any classified information? (Contact the USUHS Security Office for guidance) ☐ Yes ☒ No

11. Do you have a funding source for this project? ☐ Yes ☒ No ☐ NA

If yes, specify the funding agency and the amount provided: _____

SECTION D: SIGNATURES

The following signatures attest to the validity of the above information:

Associate Dean for Research, GSN

(Signature and Date)

Dean, DKI Graduate School of Nursing

(Signature and Date)

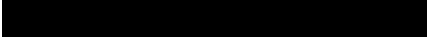
Date



Appendix J: Daniel K. Inouye Graduate School of Nursing
DNP Project Completion Verification Form

**DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form**

The DNP Project titled: Group Medical Visits for Chronic Conditions
was completed at Joint Base Lewis-McChord, WA by the following student(s):

<i>(type student name)</i>	<i>(signature)</i>	<i>(date)</i>
<u>Faith E. F. Grzesik</u>		<u>2 May 2018</u>
<u>Douglas A. Taylor</u>		<u>2May2018</u>

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation of DNP project to the leadership/stakeholders at the Phase II Site,
- Abstract/Impact Statement (*Appendix F*), and
- DNP Project written report.

Verified by:

<i>(type name)</i>	<i>(signature)</i>	<i>(date)</i>	
<u>Douglas Dillon, DNP, LTC</u>		<u>2 May 2018</u>	Senior Mentor
<u>Brad Franklin, DNP, LTC</u>	<u>//S//LTC Brad Franklin, 3May2018</u>		Team Mentor & Phase II Site Director

Form Version: 26 Aug 2017



DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
9040 JACKSON AVENUE
TACOMA, WASHINGTON 98431-1100

MCHJ-ISN

DATE: 19 October 2017

TO: MAJ Faith Grzesik and MAJ Douglas Taylor
FROM: Exempt Determination Official

SUBJECT: Not Research Determination
STUDY TITLE: Group Medical Visits for Chronic Conditions

REFERENCE #: 007

ACTION: Determination Letter

REVIEW TYPE: Not Research

1. This project has been reviewed and determined to be exempt from the regulatory requirements of 32 CFR 219.

2. This opinion is based on federal regulation 32 CFR 219 and associated OHRP (Office of Human Research Protection) guidance. The following is the basis for this opinion.

Federal regulation at 32 CFR 219.102(d) defines research as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

3. This project does not constitute research because the activity is a systematic investigation but is not designed to develop or contribute to generalizable knowledge (draw inferences or a general conclusion from) yet it does obtain information from living individuals to be used for clinician training purposes only. This project aims to introduce and equip healthcare providers with an evidence-based solution for providing quality care for chronic conditions by incorporating Group Medical Visits (GMVs) at Winder Family Medicine Clinic on Joint Base Lewis-McChord. You have stated your short-term goals are to present on GMVs and the evidence to support their use and to facilitate a working group for the implementation of GMVs. The long-term goal is to increased awareness of alternative care models, and an expanded understanding of utilizing behavioral science in chronic care. You plan to use surveys at the end of each educational session to assess the knowledge gained and the perception of GMVs by those who received the education. This is a standard educational practice; surveys must be anonymous and completed voluntarily by clinicians attending your sessions. This project is determined to be "not research" and no further action is necessary. You may begin your project.

4. You are not authorized to take project data away from the institution.

MCHJ-ISN

SUBJECT: Not Research Determination

5. Please note that any future changes to the project may affect its exempt status. In the event that the study requires any change, you are required to resubmit the study for another review in order to determine its exempt status.

6. The Department of Clinical Investigation (DCI) reminds you that a publication clearance is required for all written materials (i.e. manuscript, abstract, or slides) being submitted for publication/presentation.

7. If you have any questions, or need further assistance, please contact the undersigned at 253-968-3695, or e-mail at mary.s.mccarthy1.civ@mail.mil.


MARY S. McCARTHY, PhD, RN, FAAN
Exempt Determination Official
Center for Nursing Science & Clinical Inquiry
Madigan Army Medical Center

CLEARANCE REQUEST FORM v5.2Requirements based on MAMC Reg 360-2 = <http://go.usa.gov/xkMbx>

Attach approval documents by clicking Edit PDF to the right, and then link button on top menu.

Submission Title*: Group Medical Visits for Chronic Conditions**Submission Type*:** Outside Madigan lecture**Subject Type*:** ☐ Human Subjects Only ☐ Animal Subjects Only
☒ Other: DNP Project, IRB exempt**Authors:**

Faith E. K. Grzesik, BSN, RN, MAJ, AN, Psychiatric Mental Health Nurse Practitioner Student,
Uniformed Services University
Douglas A. Taylor, BSN, RN, MAJ, AN, PMHN-BC, Psychiatric Mental Health Nurse Practitioner
Student, Uniformed Services University

Enter all authors in the form of *firstname lastname, suffix, separated by a semicolon (;)*.

First Madigan Author:**Email:** douglas.a.taylor48.mil@mail.mil**Dept/Serv:** Nursing

Other:

Chief Email: sandra.j.barr.mil@mail.mil**Destination of Item:**

1. Manuscript stored at USUHS Library 2. Powerpoint lecture of DNP project
results presented at USUHS in May 2018, and 3. Poster presented at
USUHS Research Week, May 2018

Journal name or Conference, Date, Location or Destination (whichever is applicable)

Protocol/Determination # N/A *Enter protocol/determination number***Funds requested?*** ☒ No ☐ Yes

Provide Author's signature and Author's Department chief on the next page before submitting.

Signature of author:



Signature of Department Chief;



Signature of Public Affairs Officer rep:



Signature of OPSEC rep:

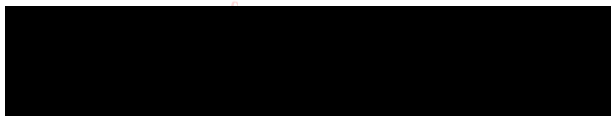


Signature DCI Administrator:



Human Protections Administrator/Veterinarian (If required):

Chief, DCI



Appendix E

Focus 1 Survey and Focus 2 Survey

Focus 1 Survey:

Introduction to Group Medical Visits: Part 1

- 1) Your Current Roles: _____
- 2) Years in Primary Care: _____ Years in Healthcare: _____
- 3) Was the activity effective in addressing and closing the following gaps?
 - a) Primary care team to consider utilizing alternative care modalities such as Group Medical Visits to treat chronic conditions in a multidisciplinary group setting.
 - a) Yes b) No
- 4) Based on your participation in this activity, what new strategies do you plan to use in your practice that you haven't used before?
- 5) Did this education introduce any new concepts about Group Medical Visits?
- 6) Can you identify patients currently in your practice that may benefit from this model? What are the primary conditions?
- 7) Is there anything about Group Medical Visits that you still have questions about?
- 8) Are there any other innovative care models that you are interested in using your practice?
- 9) If you were emperor of the military health system and had all the resourced you needed, would you implement Group Medical Visits?
- 10) Other:

Focus 2 Survey:

Group Medical Visits Survey

11) What is your role in the clinic?

(i.e. RN, NP, MSA etc.)

12) Do you plan to pursue more information about Group Medical Visits after today?

- a) Yes b) Indifferent c) No

Is there any specific information you're interested in?

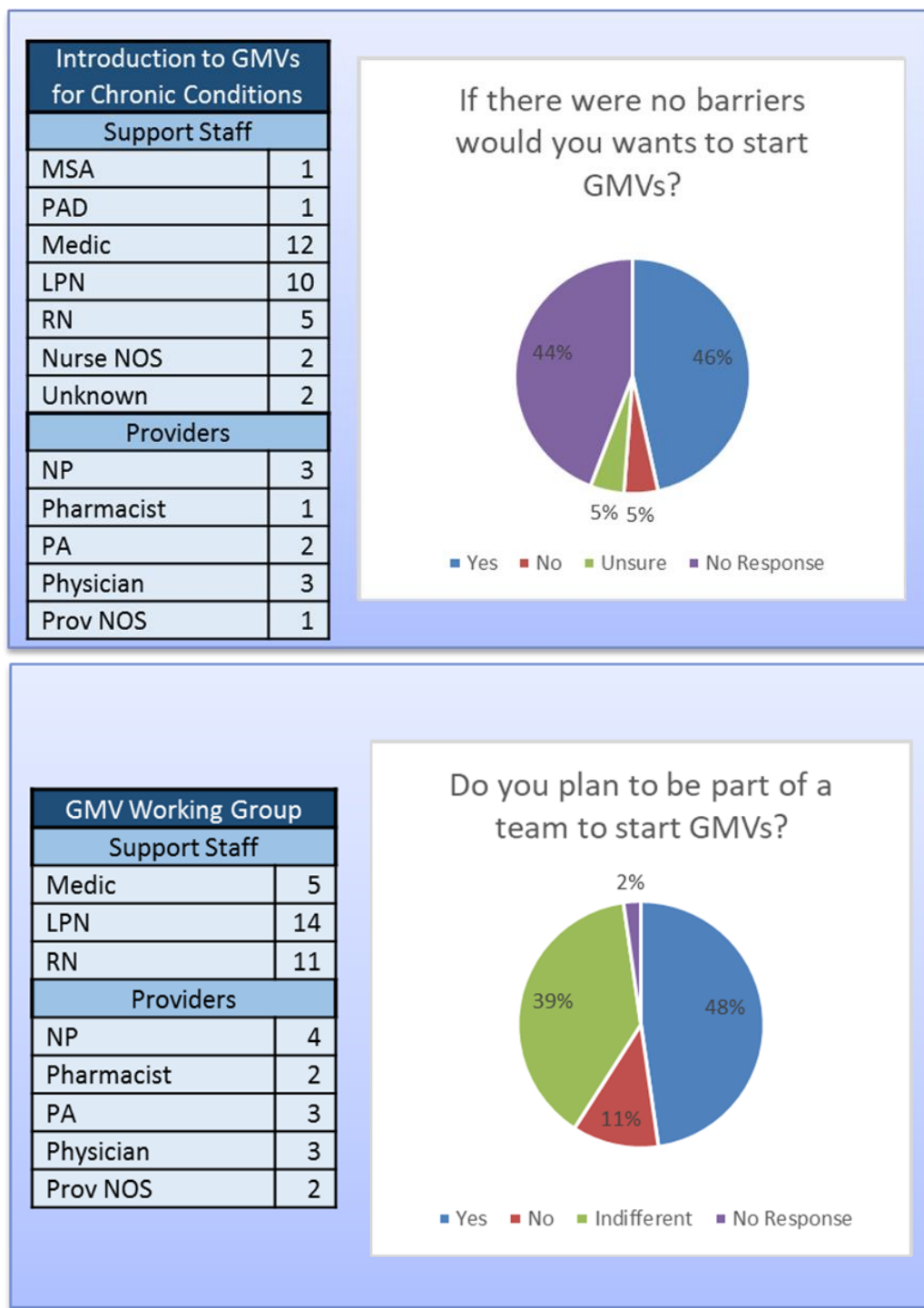
13) Do you plan to be part of a team that implements Group Medical Visits?

- a) Yes b) Indifferent c) No

14) Please list the top two or three barriers for your clinic for Group Medical Visits?

Appendix F

Results



Interested in seeking more information

