
Minnesota Senior Health Options
Clinical Integration and
Care Management Forum

Ninth in a Series

**Promoting Self-Efficacy
in Older Adults through a
Group Visit Model for Primary Care**

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Table of Contents

Welcome and Introductions	3
Promoting Self-Efficacy: Lessons Learned from Kaiser's Cooperative Health Care Clinic	4
Interactive Discussion:	10

Welcome and Introductions

Speakers

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Good morning , I'm Pam Parker, Director of Minnesota Senior Health Options (MSHO). I want to welcome you this morning to our ninth MSHO Technical and Educational Assistance Forum. We are very indebted to The Robert Wood Johnson Foundation for the funds to carry out these forums. It's quite a luxury I think, and we're thankful. We're also thankful to the National Chronic Care Consortium for putting this all together and soliciting your ideas. In particular, thanks to the NCCC's Deb Paone who coordinates these for us and does a wonderful job of using the topics that you have been telling us you want to hear about.

Before I get started this morning, I had a question earlier this morning about MSHO's current enrollment. Not everyone is aware of this, so I just wanted to let you know that as of September 1, we have 3,120 enrollees. We are within 50 people of the number of enrollees we projected in 1994 when we submitted this project. So we think we've done fairly well. We thank all of you for your interest and your participation and for telling the seniors out there what this project is all about.

We're excited about the speaker we have today, and I can tell by the attendance here that there is a lot of interest in the topic of promoting self-efficacy in older adults. Dr. John Scott is a practicing physician at Kaiser Permanente in Colorado. He is board certified in internal medicine and geriatrics and is a fellow of the American College of Physicians. Dr. Scott received a bachelor of arts degree at Holy Cross College in Worcester, Massachusetts and his medical doctorate from Georgetown University in Washington, D.C.

He is the founder of a group visit model known as the Cooperative Health Care Clinic at Kaiser Permanente. Over his 20-year career with Kaiser, he has gained extensive clinical and administrative experience and continues to explore how to improve care delivery to his patients, particularly, I think, focusing on the chronic care issues of the kind of population that we serve. So we are excited to have him here, and I'll turn it over to him now. Dr. Scott, welcome, and it's great to have you here.

Promoting Self-Efficacy: Lessons Learned from Kaiser's Cooperative Health Care Clinic

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Thank you very much. A friend of mine describes himself as a "defrocked" clinician. He is now a full-time administrator. I've gone the other way so I'm a "defrocked" administrator and primarily a 100 percent internal medicine, geriatric care deliverer. I see that a lot of you are administrative types, so I can answer a lot of those questions from several years on that side of the fence. For those of you who are primary care deliverers, I'm there too. Our organization is 350,000 members, 550 doctors, and about 40,000 Medicare members. So we're involved in geriatric care as an organization.

What I'd like to do this morning is

1. tell you why I think I was invited here,
2. tell you a little bit about our work, that is, the Cooperative Health Care Clinic (CHCC),
3. present some data from a two-year study that has just been finished, again, funded by The Robert Wood Johnson Foundation,
4. tell you about the application of this model of care across the spectrum,
5. finish with a ten-minute video clip of focus group interviews with patients who participate in this kind of care.

What I'd like you to do is think about your own world and how this model might fit, either for you directly or for the people who work for you. How would you buy this; how would you

sell it? That's what I'd like you to do.

So, first let me tell me why I think I was invited. I was reading in one of the NCCC's publications about some of the work you do, and part of it struck a chord for me: "We know from research that people with poor coping skills will suffer more disability due to their conditions than people with good coping skills. The influence of patient attitude and behavior is profound. What we need to do is restore older people's sense of control over their own lives. Providers, however, need additional support in working with patients with chronic conditions. Physicians in particular are frustrated by their limited ability to help patients adapt to chronic conditions through the promotion of behavioral and dietary modification and the development of coping skills."

Why can't providers deliver the goods in changing behaviors and developing coping skills? We all know why. We don't have time. You don't have time, the doctors don't have time, and the nurses don't have time. Nobody has enough time to do what we know we need to do. We all have guidelines, formats, checklists. What we don't have is time to do it. All of us who have taken care of patients have answered questions with our hands on the door knob and have left the room knowing that there were more things to deal with. What this model does, this CHCC model that we're going to talk about, is give you time.

The Cooperative Health Care Clinic

Now I'd like to describe the model. Every month we meet with 20 to 25 of our patients for a group doctor office visit. This is not an educational conference. This is not a lecture. This is a group doctor office visit. Doctors identify these patients as high-utilizing, needful, older folks. We have a standard invitation form where we explain what we're doing and ask if they are interested. One of your questions, I noticed, was whether there was a particular group pre-disposed to self-efficacy. The answer is yes. We send these invitations out, and, this is a consistent experience with several groups going now, 40 percent of the patients will say, "Thanks, but no thanks, I value my privacy. I don't want to have anything to do with groups." Twenty percent will say, "Maybe, give me some more information. I might come, I might not." And another 40 percent will say, "Absolutely, yes, when do we start?" That's the 40 percent we go after. We ignore the 20 percent. I'll show you why later.

The group doctor office visit happens every month at the same time and same place so the folks get used to it. We have a 2 1/2 hour block of time. That block of time is broken down into 1 1/2 hours of group time and 1 hour of one-on-one time as needed. The group time starts with a social time. This is when the group builds the "groupness" of the group. We started doing this not knowing how powerful it was going to be. In the first three or four sessions, we spend about ten minutes doing what psychiatrists call reminiscence therapy. For example, we ask, "What was Christmas like for you when you were ten years old?" The group is sitting in a U-shape arrangement, and the doctor is in the middle. We just go around the group, and pretty soon they find out they

were dryland farmers on the plains, had no electricity, and had one piece of fruit for their Christmas presents, etc. And that starts to build some connections.

By the third or fourth visit, they're starting to talk about what we'd like them to talk about—their own coping skills for the diseases that they have. They share information that is incredibly powerful. You might think that they would be a little embarrassed to speak up about things. One of these groups, average age of 74 years, took off talking about sexual abuse as children. When is the last time we even thought about that with a 74-year-old? It's powerful.

Some of these groups have been going for nine years now. Because of the interaction that occurs, the relationships that develop are often a stronger support system than the patient and family support system. People who might walk by the room, may look in and say, "That's fluff." It's not fluff, as I'll show you in a bit.

The next part is the educational piece. The educational piece, very key here, is very interactive. We'll take a topic like advanced directives or cardiac disease in the elderly, and then we will say, for example, "Has anyone here ever had a heart attack?" Two or three hands will go up. And you let each tell his or her story. Each story is a little different. The physicians then fill in missing information, emphasizing key points that have been brought up. What we're doing at the same time that we're educating people is validating the patient as a source of reliable information that is experience based. Then people in the group realize that they can ask each other about this and that.

My favorite vignette is when I was talking about arthritis one day, and this little voice in the back of the room says, "You mean I'm going to have to

live with that; how am I going to live with that?" And the lady sitting right next to her said, "Honey, see this?" she had rheumatoid claws (her hands), "At the break I'll tell you how to live with this." There isn't a rheumatologist in the country that could have answered her question better. It was just wonderful. That happens all the time. So that's the educational piece.

When we finish the educational piece, we move on to what we used to call a break. It's not a break at all. It's a very interactive care delivery kind of thing. Again, picture the U-shape. The nurse starts down one side, the doctor down the other side. If we have a guest speaker, say from urology, physical therapy or pharmacology (occasionally we bring in guest speakers), they also start mingling. We go through and we check blood pressures, give immunizations, fill out paperwork for durable medical equipment, parking stickers, etc., all the things they used to make appointments for. We go around, and they'll say things like, "Oh, doctor, what about this?" or "I had a friend who . . ." and we'll take care of all that stuff, cross each other, and come back to the front of the room. When we get back to the front of the room, the nurse has two or three people who have asked to see the doctor afterwards during that one-on-one time, and we usually bring back two or three good questions that instead of answering one-on-one, we bring back to the whole group. That's the break. It started out being ten minutes, but gradually expanded into whatever time it takes, usually about 20 minutes or so.

During the time that we're going around, process A—the socialization element—continues. By the second or third visit everyone knows what everyone else has and what medicines they're taking, whether they're on chemotherapy, etc. They continue that process of educating each other. So that process of sharing information

and learning the coping skills that we don't have time to teach, is happening.

After that, we have a question and answer session, usually 10 or 15 minutes, and it can be on anything. It can be on what was on channel nine last night, or it can be on how the guest speaker talked about cutting drugs in half to save money. It can be on *anything*. But what happens, and what's really powerful is, again, we make it interactive. Somebody will ask a question, and the first thing I do is ask if anyone has an answer—validating experience, involving patients in their care. You facilitate that, plugging in information that needs to be there and validating information that comes out of the group. What then happens is that people feed off of each other. You ask one question, and someone else remembers another question, and so it continues. By the time you have answered the question, whatever it is, you've hit multiple facets of it. As we all know, there is no one answer for any one question. That's why we like to present this kind of data in groups.

What happens then, is we ask them what they want to talk about next time, and they choose. The first year we give them the perception of choice. We have six core topics that we want to cover in the first year, things like advanced directives, cardiovascular disease, how to use the system, what they need for routine health maintenance, what they need and don't need, with a full explanation of both so they're not thinking they want something because someone on channel nine said they should have it. We then decide who's bringing the "goodies," the treats for next time. They're involved even in the baking, and that's really good—good for all of us!

After the group session, we have one-on-one time. Virtually all of the doctors who start this program (we

probably have 50 or 60 doctors doing this now), said, “Oh my gosh, 25 people are going to want to see me afterwards. I can’t do it.” Since 1991, the average number of people who want to see a doctor afterward, out of a group of 20 to 25, is about seven. Actually, only three or so want to see a doctor to ask about some problem with their disease, some intermittent flare-up, some new thing that has come up. Then additionally, the doctor has picked out ahead of time those that need routine health maintenance, physical exams, checks on their diabetes checklist, etc.

It’s remarkable how quick and efficient and clinical you can be during that hour. In our first study we actually measured hands-on time with a stopwatch. Hands-on time for a congestive heart failure, i.e., checking the neck veins, listening to the heart, listening to the lungs, checking for edema, etc., is three minutes. A complete physical on a male is five minutes and on a female, it’s seven minutes. That’s the hands-on time. The rest of the time in a doctor office visit is the, “Hi, how are you, how is the family?” component and the patient talking about one thing or another, asking questions—all the things we’ve already done in the group. So the efficiency of the physical part is just great.

So that is how we spend the 2 1/2 hours. Now for you administrators, don’t punish your people for their efficiency. The first couple of years that we did this, we said, “Great, you saw 25 of your most difficult patients, now we’re going to book you with four more the next hour.” Let them catch up on their practices. You’ll make your money.

Recent Study Data

I’m going to show you data from a study which is at the two-year mark of a two-year, randomized, controlled,

clinical trial, with a really rigorous analysis for those of you in the group who are statisticians. This includes people who said they were going to come to the group visit and ended up in the hospital for a month and never came at all. We did this in collaboration with the University of Colorado. The University of Colorado people in the geriatric unit said that nowhere in the geriatric literature has a statistically significant slowing of the rate of functional decline been shown—not with case management, not with assisted living, nowhere. This does. This is measuring their IADLs, their ability to stay independent and functional. Now I should have mentioned that this intervention is not targeted at the frail. This is the 90 percent of the geriatric population that is not frail, frail meaning impaired in two or more IADLs. Those are outcomes, those are real hard outcomes. That’s what you want for your parents. You want them to stay in the home and be independent and functioning and go grocery shopping and do all those things, even if they have five different medical problems, which is the average with this group.

Quality of Life

The experimental group in this study rated their quality of life at a statistically significant higher level than the control group. Some clinicians think this is soft data, that it’s subjective. We use a measured scale for it. Look at the statistical significance of that. For those of you who don’t know, and probably everyone in this group already knows, the patient’s perception of wellness or illness is a direct predictor of utilization over the next year. These people think they are pretty well.

Feelings of Self-Efficacy

The experimental group rated their self-efficacy skills at a statistically significant higher level than the control group. They communicate

better with us. They're not afraid to. We communicate better with them because we have the time. Someone once said that the secret to good medical practice is to ask until you understand and to teach until they understand.

Compliance

Informed noncompliance is a wonderful learning experience for caregivers. Instead of patients being noncompliant on their own, they now feel free to share it with us so we know what adjustments we can make and how we can negotiate a settlement in dealing with these medical issues.

Cost Comparison

This is an issue for everyone. I think the item to focus on here is hospitalizations. The main savings are in the big ticket items such as hospitalizations, emergency room use, ambulance use, specialist referrals, nursing home time. In all of these, the numbers come down for the experimental group. Price in the clinic stays about the same, maybe a small increase.

How many of you live in a PMPM (per member, per month) world? We do at my organization. If I came to my organization 5,000 years ago and said, "I have invented the wheel; it's a wonderful device and will cost you 50 cents per member, per month," I'd be laughed out of the room. We would still be dragging things around. The difference here is \$50 per member, per month. That translates for us into a couple million dollars a year with our population.

In terms of emergency room utilization, emergency room usage was 53 percent for the control group and 35 percent for the study group. It's because they know what to worry about and what not to worry about. In hospitalizations, 39 percent were

admitted over the two-year period versus 27 percent for the study group.

Change in Patient Satisfaction with Primary Care Provider

We've also seen significant impact on patients' satisfaction with their doctors. This is interesting. If you're a caregiver, you want your patients to be happy. If you're an administrator, you want your patients to be happy. If you don't have happy doctors, you're not going to have happy patients. You have to make everyone happy. Look at this. There are 20 doctors in the study. The experimental group reported greater satisfaction. The statistical significance of that is 0.003, and here's the powerful piece about this information. It's the same doctor. The control and study groups are talking about the same doctor. These patients are randomized within the doctor's panel. So, for instance, I'll have 25 control patients, and I'll have 25 study patients. They're all my patients, but they rate their experiences differently—same doctor, but in a different format.

Change in Patient Satisfaction with Un-hurriedness

Probably every administrator in this room knows it doesn't matter how many degrees or how much paper a doctor has hanging on the wall. A patient's perception of quality is based on how much time and how much communication he or she has with the doctor. We call this "unhurriedness," and our data again show that study patients perceive their doctors as less hurried than do the patients in the control group.

Overall Quality of Care

We're a class act outfit. You can't get into our outfit unless you're boarded, and most of us are double boarded. And you need to keep up your education. We get rid of doctors who

don't fit. For the patients, the quality of the physician's training and education is assumed. Their perception of quality of care relates to how much time you're spending with them, how nice you are, if you're answering their questions, etc.—that's what a patient will change plans over.

Amount of Healthcare Education Provided

Kaiser Permanente has medical educators in every department, in every clinic, in every building it has in this country. We spend millions making videos, pamphlets, all sorts of things. It's remarkable how many millions of dollars we spend. However, look at this data. Study patients feel better educated and better informed than control patients, even though both groups have access to the full range of Kaiser's educational offerings. The significance is 0.001. So, should we be doing our education in the format that I just told you about or in the standard, "We're going to talk about angina today, would you please dim the lights?" The standard medical lecture is not the interactive kind of program that we're doing. The CHCC model is good medicine. It's also good business. These people don't leave us, not voluntarily.

Providers reported patients teaching each other what to do, and the providers actually learned from the patients what to do and what not to do. It's really very powerful and provides a rewarding experience for the doctors. I think we have 60 doctors who are doing this now apart from the study, those who decided they didn't want a control group but just wanted to take care of their patients. Only two out of those 60 have decided that they don't want to continue.

Applications Across Systems

Now you know what the CHCC is and that it works. Now, on to the applications across the system. What I want you to do is think about formats for yourself, whether you are an educator or not. Let me tell you where this model has been applied.

The primary care of the pediatric department decided they could do well baby checks like this. And they're also doing attention deficit disorder but without inviting the kids. The GI department, internal medicine, is doing it in functional bowel and in fibromyalgia, a very needful, high-utilizing group. GI took the idea and started their own functional bowel group because they don't like to spend 45 minute consults talking about gas, and administrators would much rather have them scoping people. The cardiologists are going to start doing it with congestive heart failure (CHF). The mortality for CHF is 50 percent in five years; it's a serious, bad disease, worse than diabetes. The endocrinologists are doing it with diabetes; we're doing it with diabetes.

To answer one of your questions, I used to and am going to start up again, doing hypertensive groups in exactly the same format, except they only have to meet once or twice a year. You have an hour and a half to explain what the medicines are, why they're on particular ones, etc. You explain everything. I used to do it twice a year. We had 52 patients, and we administered the same patient satisfaction evaluation. Not one of those people would want to go back to the regular doctor office visit where they have to block out and waste half of a work day. We start those groups at 7 a.m. so everyone can get to work.

Those are just some of the applications in primary and specialty care. In

addition, what we started doing a few months ago is taking this program off campus to a place that has assisted living and independent living. I have 11 people from each side of that house. We use the assisted living facility's exam room, nurse, medical records, and meeting facilities. There is no overhead. I ask the owners what they get out of it, and they say that elderly people talk with each other; it's good marketing. You can take this program off campus as well.

Hopefully you'll soon read about our work with the orthopedic department for total hip, total knee replacements. We will do the pre-op visit in a CHCC kind of session with the patient and the caregiver. Then we will admit them to the hospital in small groups so that they're roommates and they go to physical therapy together, etc. Again, we're trying to take advantage of that dynamic of coping skills. Then they will have three visits in the year following the surgery, and those will be in the CHCC format. Hopefully that will be very powerful. We're going to incorporate geriatric screening into the routine pre-op exam. We'll look for dementia as a predictor of delirium; we'll look for the presence of social support. We're not going to do an extensive geriatric screening.

So it goes across the spectrum, from the folks at home, to the folks in the nursing home, to the folks in the hospital. You can play with it a lot of different ways.

Interactive Discussion

Q: You said people make the choice to be involved in the program. Who gets offered the choice?

A: It's through an administrative dataset from which we know how many people are calling or contacting us twice a month, either coming in to the clinic, emergency room, or hospital or calling us. That number comes to several thousand of our folks. We have them broken down by doctor and patient population. There's an administrative mandate that we get 100 groups up and going, so we now go out to the doctor and say, "You have 72 patients that fit this parameter. We would like you to do groups. Are you interested? We'll teach you how to do groups, give you time to do them, orient you, teach you facilitation skills. We'll get it going for you. We'll teach you what you need to know, but these are the patients." I'm freed from some of that, and some of my groups I just build like a cocktail party. I have these needful, whiny people. If you're a provider you know who they are. You invite a few of those but you don't invite all of those. You need the bell curve. You need the ones with great coping skills who are going to teach the whiners how to do it. If you built a whole group of needful whiners, it would be a nightmare I would think, although a couple of our doctors have done that and said it was hell on wheels for the first three or four months.

Q: Do you find a mix of good and poor coping skills among high-utilizers?

A: Yes. You all know people who are very sick and cope very well, and you also know people who have gas and constipation who think they are dying.

Q: How are the participants invited once they have been accepted into the program?

A: We used to just send them a letter and wait for the response. Now what we do is send them the letter and then call them. If the person seems unsure about wanting to participate, we let them know that we probably won't need them.

Q: What if they're really shy and would like to do it and benefit from it, but are hesitant?

A: That's why we call them now, to give them some kind of flavor of what this is about. Then again, I'm sure there is some gray area where they're a little too shy and we say, "I'm sorry."

Q: What about people who change their minds?

A: I tell them that we've been doing this for nine years and that people love it. If they don't like it, they need to let me know immediately because I will put in their place someone who does like it. If they don't come, they can't continue because they're taking up slots that other people would use. Then I tell them, if they don't come, I can't prove that it is economically beneficially and we can't keep doing this. So there is a commitment. The

only time they can not be there is if they are sick or on vacation. It's a two-way street. We're not doing things to these people, we doing things with these people. So they have to be there. They support each other, but it isn't some stylized support group.

Q: Are there issues you deal with around managing group dynamics?

A: The first two meetings are a little different. The first meeting is norming the group. They're there, they're interested, and they know roughly what is going to happen. We explain it in a little more detail, and then we ask how we will deal, for instance, with side conversations or the person who talks too much. Every group has its own rules. Some groups have a cut-off sign. Some groups designate the doctor. One group has a sergeant at arms who keeps order for them. In general, these are 74-year-old, very respectful, lovely folks who still love the medical profession and regard us as professionals.

Now, let me answer that another way. People will ask if this is personality dependent. Do you have to be a stand-up comedian to make this happen? We had one of our doctors say he wanted to be a part of this. This is a person who speaks in a monotone with no facial expression, in a word—boring. But he wanted to do it so we sent the nurse over for the first session to help get it going, norm the group, etc. At the end of that session, the group stood up and applauded. That's why they had picked him. They liked his personality. You don't have to be a

stand-up comedian. You have to be yourself, and they will love it.

Q: What is the frequency of general clinics.

A: First of all, it's not a class, it's a doctor office visit, and it's once a month. Some of these groups have been going since 1991. When the study is over, the doctors won't let go of it, and the patients won't let go of it. When a doctor leaves, almost everyone in that group hooks up with another doctor who uses this model.

Q: Most clinic facilities don't have room for that size group. Would it be effective with five to ten people instead?

A: It really doesn't take that much space. If you don't have it, take it off campus. Would five or ten work? No. We know the economics of it as well. The economics demand 15 to 20. After we had been doing this for about five years, I decided to go back and figure out why this works. Well, psychiatrists have been doing this for years, so I went to the psychiatric literature. I find it fascinating that nearly 100 years ago, they were saying that for group dynamics, if it's smaller than 15, it's too hard to get energy going in the group. This is what our doctors say as well. If it gets larger than 25, you lose the intimacy of the group. I find it fascinating that 100 years ago when they started doing this, they came up with the same numbers.

Q: Can people be in more than one group, and how do they get to the group? Is transportation arranged?

A: We don't want them in more than one group. As a matter of fact, we explain to them that we don't want them to come in between meetings because that will drive costs up. The

reason we can do this is because we can prove to our organization that it is cost effective. I met a guy in Orange County, California, and he told his group at the very first meeting that if they came in between time, they wouldn't let him do the group. Patients can come in for emergencies, but if they come for a physical in between times, that affects the cost. It has an economic impact on the organization. In Oregon they actually have people sign an agreement that they won't come in. I wouldn't want to go to court with that one.

Q: How do you go about selecting the educational topics?

A: I talked about that core group of topics. After that it's up to them. Again, it's not doing it *to* them it's doing it *with* them. I'll give you a short vignette. During the social session with one of my groups, three or four months ago, one of the ladies said she fell in her tub and couldn't get out. She was there for 12 hours. The group really supported her, sharing their fears that that could happen again. During the question and answer period, somebody brought up Gertrude's experience and asked if there weren't safety devices for that kind of situation. Someone mentioned the walkers they get from a medical equipment company and wondered if they might have something. So they said they wanted to hear about something like that next time. So I called this company, an independent company that supplies medical equipment to 350,000 of our members, and they were more than happy to send someone over to show all the devices, warning devices, grab bars, etc. We spent the whole next session with that guest speaker. One lady got robbed, and we spent one session then talking about safety. We even invited the police and fire department out.

Q: How do you do the health maintenance kinds of things, and how do you match what they want with what you want?

A: In the second session they get a personal care notebook, a loose-leaf file that we provide for them. It has their problem lists, medication lists, their advance directives, and copies of their last EKGs. That's for starters. Then it's tailored. For instance, those who have diabetes get diabetic checklists; those with heart failure get that checklist. They all have a list of what they're supposed to get. It's up to them to make sure that we fill out the checklist. It's up to them to make sure that they have their physical done. We explain to them that if they have been in the hospital, they've already had their physicals, or if they've had prostate cancer, they don't need a PSA, etc. So we actively involve them in monitoring their own care, and we get a chance to communicate well. They bring this book with them every time. We now have the scoring form too.

Q: How long are these groups together?

A: Once you start a group, it's ongoing. It's how they get their medical care from that point on unless they opt out. Very few opt out. The next question is whether we run out of things to talk about. Would you ever see a new patient and say, "I'm going to see you for six months, and then we won't have anything else to talk about"?

Q: Of the patients who do leave, do you have any data on why they left?

A: For the vast majority, probably 90 percent, it's because they died. Virtually none leave because they are unhappy. A few leave because they move from the area.

Q: As patients become more ill and frail and need more individual attention and hospitalization, changing the economics, how do you deal with that?

A: We give them the care they need. We don't kick them out of the group. The focus is quality of care for the patients. It just happens to save money. The way it saves money is not by denying sick people care, it's by teaching people who are not sick what to worry about and what not to worry about. It's by giving the patient a copy of their EKG with an obvious deficit noted so that when they go to the emergency room, the doctors have the information and don't need to admit them. That's how we save money.

But people in the groups die. At some point before death, most of them become frail. Their spouses or caregivers bring them, and the reason they come is for the moral support, the support of friends they've known for years. Probably one of the most powerful personal things that I've experienced was to go to the funeral of one of these people, and in the eulogy they were talking about how proud this person was to be part of a new experiment in healthcare. It's the support that keeps them coming even when they do become frail. I have great trepidation taking this model into a nursing home and expecting that we're going to get the same kind of benefit. We might get the same kind of medical benefits. But that may not be the case over on the administrative side.

Q: How do you deal with memory problems?

A: That's an interesting question. The incidence of dementia at age 65 is approximately four percent, and it doubles every five years. So in these groups, we're going to have people

with that problem. But it's their caregivers that we're caring for. In the early stages of Alzheimer's, which goes on for 9 to 12 years, the first 5 or 6 years, a person is still pretty functional. They like the social contacts, etc. We haven't really had a problem with that. Now, when I went to the nursing facility it was more of a concern.

Q: Has there been any word of mouth carryover from patients inside the group to patients outside the group?

A: Yes! In the first study, the worst problem we had was keeping the control group out.

Q: What is your turnover, and how do you introduce new patients into the group? How do you keep it at 25 members?

A: The average age of these folks in this second phase is 74 years. So, they die. Very few of them leave us voluntarily. How do you keep the group size up? Well, we used to think that you had to go through that orientation process and skill building for communication, and what we did in the early years was, I'd have two groups going and when one group hit 15 and the other group hit 12 or 14, we'd combine them. That's one way of doing it. We found out later because of this second study that we didn't have to spend much time orienting new people. We had to add patients fairly quickly because it was a much bigger study, and you can just drop people in. They have a lot more skills in life than we give them credit for.

Q: Are your groups organized by disease?

A: Initially, in 1991, when we decided we were going to do this, we

started going through the charts (we weren't computerized then) and said we're going to get several cardiac disease, and several of this, etc. We found out very quickly in the first sessions working through the charts that they all have the same stuff. There is commonality of problems—everyone has arthritis, everyone has hearing problems, everyone has some kind of heart disease, etc., and if they don't have it, they're going to get it. So they're very interested in hearing about it.

Q: Do you have any comments on the pros and cons of having a heterogeneous versus a homogeneous group in terms of diagnosis?

A: It's all heterogeneous. As I said before, we tried to sort them out when they're just dealing with CHF or diabetes. But with the geriatric groups I'm talking about, they have a commonality of problems. The coping skills that you learn from one disease are applicable to other diseases.

Q: Heterogeneous sounds better to me except there is such a trend for diagnosis specific interventions.

A: We're getting a lot of diagnosis specific groups out in California that are more aimed at taking care of the doctor than taking care of the patient. Not that they're bad; they're excellent. They're that drop-in group medical appointment (DIGMAs) that's in your handouts. It's a fascinating concept, but it's aimed in a slightly different direction. It's aimed at access and aimed at the doctor's life rather than at the patient's life.

Q: Has there been replication of this model in other parts of the country?

A: Yes, I think it is fair to say all across the country, from Hawaii to the

mid-Atlantic states. It's mandatory in a couple of places. I think northern California has hired someone full-time whose job is to promote group care in one form or another. There are some other references I put in your handouts. And there are some big universities using the model for research. The most notable I think is Stanford doing a two- or three-year project.

Q: Do you see a difference in participation rates between males and females?

A: The difference is roughly what you would expect by age distribution.

Q: Is anyone experimenting with a more frail group, people in their own homes but maybe with more ADL involvement?

A: No, no one is. We're at the point where we're just looking at the breakpoint between assisted living and independent living. I think that there is probably a breakpoint in efficiency right in there. I think when you get to the frail there isn't a single study anywhere, and I don't even want to try. We need to care for those people. We need to spend our resources on them. It's the right thing to do, but we're not going to get any economic advantage from it.

Q: Have you done this model with non-English-speaking populations?

A: No. We don't have the diversity of a Los Angeles, for example. I think the answer in our Los Angeles area would probably be yes. It would have to be. But in Denver, no. Unfortunately, we only have a couple of doctors who speak Spanish. We're working on that.

Q: Do you have to dictate into the

charts afterwards on the patients you see?

A: Yes. How do we keep records on people afterwards? We send the records upstairs to the exam rooms. We're completely computerized. We type in the notes, etc. I'll tell you about what we're doing off-campus. If you're computerized, you can either just write the note like a regular doctor office visit or you can write it and scan it into the computer system.

Q: You said you charted on those patients you do an exam on. Do you do any kind of charting on the patients who are just part of the group?

A: Yes, and on the group session itself. The patients used to have their charts right in front of them and we'd kneel down in front and ask what they needed that day. If they needed a potassium shot, we'd write that in the chart, do the order, and be done. Now we have computerization, and we just had a meeting on how to do that with a computer in the room instead of 20 charts. That's an interesting little challenge, but we have a lot of ways to get around that too, including writing the note right in front of the patient and scanning it.

Q: As a follow-up to that, do the patients like having their own chart? That might be something they think is taken away from them.

A: They love it. This is a novelty for them. We actually spend one session translating the charts for them. "What does COPD mean?" And then they read through the consults of the specialist, and the specialist has written "this very nice lady"—they love it! If you get up against a hard translation, always tell the truth. If the chart says this person looks depressed, explain that that is how he or she comes across. It's another powerful

piece.

Q: What about privacy?

A: That's been the big concern for everyone. What about confidentiality? That's our problem; that's not the patient's problem. That's what we hide behind so we don't have to do something differently. They get in there, and everybody knows who's on chemotherapy, what they're doing, how they're doing. That's how they teach each other to cope. That example I gave you earlier about the group that took off on the subject of sexual abuse as children, they spent the entire hour and a half on it, and I just stood off to the side, amazed. Confidentiality is not an issue. It might be for some people who choose not to do this model, but for the people who choose this model, no problem.

Q: Is there any type of training for the physicians?

A: There is now. Initially we thought we'd just see one, do one, teach one. And under one roof that works pretty well. But now we have a nurse assigned to pick out the patients, contact the doctors, and then train the doctors. Doctor and nurse—this is a dual thing. This isn't just the doctor. The question that comes up right after that for many people is whether a physician's assistant or nurse practitioner can do this. Anyone who regularly sees patients and who could benefit from increased communication, whether you're a nurse educator or physician assistant, can do this.

Q: Has this group session had any impact on practice patterns of the primary care providers?

A: We don't have data on that, but from my own personal experience, and I probably speak for 20 of my friends,

you learn a lot from this. You learn to listen to the patients. You learn to not fight noncompliance but instead go with it. It makes you a better doctor. These patients will open up to you in a group session more than they would sitting on an exam table covered in paper. It's a lot better communication.

Q: So has the buy-in from the physicians in Kaiser been mostly because you have this experiment, and then administration realizes it saves some money and mandates it? Or have the physicians been generating their own interests? There is the potential to apply this to the network model because maybe the physicians would get interested enough in it to do it.

A: Wonderful question. The reason our doctors do it is because they want to do it. You cannot mandate this. You cannot say to a doctor that whether they like it or not they're going to do it. It is totally dependent on the energy that a doctor brings to it. The reason our doctors do it, and this is why we went into medicine, is to communicate with our patients, to care for them, to do a good job, instead of running from room to room, knowing that each time we close the door, there is more stuff that should have been talked about. It just plain feels good as a physician to walk out at the end of the day and know that you have taken care of 20 to 25 of your folks, and you've done it well. Because most days you walk out, and you say, "What did I miss?"

Q: How about the economics of doing this in a clinic where not everyone is on a managed care program?

A: I'm in a total managed care environment. I can tell you that at Stanford they have 80 percent that are not managed care, fee-for-service and 20 percent who are managed care, and they're going to do it. How does it

work? The billing systems vary. Some of the groups bill the group time as educational time and bill the visits afterwards as individual office visits. Other people have started using hospital facilities where they have their own Pharm.D.s come in and talk to the patients once a year and do medicine checks—brown bags checks we call them. They have pharmacy come in; they have physical therapy come in; they have dietitians and social workers come in. What they do is use the hospital staff to do that in the hospital area. Apparently they just bill for that, and then they bill the one-on-one care as a doctor office visit. Right now there's no CPT code for this. So what we would like to do is to get you interested and publishing and putting pressure on people, saying, "This is better medicine at a lower cost—why aren't we doing this?"

Q: I want to go back to your skepticism about using this model in the nursing home. It seems to me that the nursing home would be ideal for at least some of this, at least for those residents who are more cognitively aware. If you have doctors and nurse practitioners already going to the nursing home once a month, which is required by law, there are no transportation issues. It seems like it would be ideal. What would be the issue there? Is it that there wouldn't be a payoff in terms of utilization because they're already at so high a level?

A: First of all, thank you for thinking about how this might work in your particular world. I couldn't disagree with any of that. I would have to be inside the organization to know. From our vantage point in our organization, the big-ticket savings are in the hospital and emergency room. I doubt that you would see much change in that, although you might. I think if you do it, you really ought to make it a study that you could publish because it is a great question.

Q: What percentage of the people who attend these have case management or care coordinators?

A: It's a little difficult to say. But basically when you say care coordination, I think there are probably five different levels for that, everything from meals on wheels to delivering oxygen. There's a whole spectrum there. I would guess that probably 20 percent of these groups have the nurse who runs the group intervene in the world for them, so it's an informal care management. Another 20 percent would be grouped by needs and wants.

Q: How dependent is this model on the fact that you have a staff model in your HMO. I would say that in our clinics and HMOs, the staff model is probably less predominant. We have a big staff model HMO but a lot of it is contracted. So we're mostly a contracted model. I'm wondering if there has been any experimentation among contracted physicians not in a staff model.

A: Yes, there has, but I'm not aware of outcomes. I know for example that Duke University sent people out to see this and decided that they were going to do it, but they couldn't do it until their hospital became part of their organization. Their hospital was on separate books, and as you saw, you save most of your money on hospitalization downstream costs. So with their hospital on a separate booking system, it wasn't economically feasible to do it. That's the only answer I can give to that question.

Q: You showed the slide that showed significant differences between the control and experimental populations as an attitudinal thing. I'm curious when you put people in the control group, were they people who opted

into the experimental group but didn't get in?

A: Yes. We randomized this study after they accepted coming in. We didn't choose the 40 percent who said they didn't want anything to do with it. They were offered the same and then randomized from there.

Q: You showed us some of your measures and results. Do you have other indicators that you use?

A: Yes. I only brought some of the data. We're going to be mining the data for a couple of years. Of virtually everything we measured, probably 40 percent of our results are statistically significant, the kind of results you just saw. The other 60 percent were positive trends. There was nothing negative. There were a couple of neutral areas, interestingly enough. Every year we bring in Pharm.D.s for the education session on medication management. We have them sit down with each of the patients and go through all their drugs during a half-hour intervention. It made no difference in their drug utilization compliance. It was a surprise to us. The other one was depression. Half way through the study it looked like there was going to be a huge separation, but at the end of two years it didn't make any difference. Those were the two neutral events. Everything else was positive.

Q: Regarding the neutral results with pharmacology and depression, are you looking at other ways to deal with these?

A: No. I think we treat depression the way we always do, with drugs. We thought the group dynamic would somehow improve depression, but it doesn't. So we haven't looked for another way to treat it, other than drugs. We let the psychiatrists do that.

Q: How could we operationalize this within our system where we and the system are capitated for certain services yet we contract with physicians who are not capitated, who are not part of a single group, a single culture? Can you envision that there would be value in having these clinic sessions where you bring people together but you don't have the physician, you have other healthcare people providing the education, providing the opportunity for mutual support, that sort of thing? Would there be a value to that if you're not integrally involving your physician?

A: These are questions about if you're capitated and you contract out, how can you make use of this kind of thing, when the people you're contracted to don't do it. Or if this doctor has two patients, this one has five, this one has one, but we have them all, and we'd like to pull them together, but there isn't one physician managing all of them. I don't know how much control you would have over that. It would be a dream kind of answer. Can you contract those patients out to those doctors who do it? Can you say to a doctor, "Let me teach you this, and I will give you 20 patients"? I don't know.

Q: So you think there needs to be a critical mass at least among a given doctor?

A: There definitely needs to be a critical mass of high utilizing patients. If you just offer this to everyone all you do is increase your utilization. You don't want to invite the people who come in once or twice a year. Go to your database, find your high utilizers, train a couple of doctors, and send your utilizers to that doctor. That's a way. I don't know if it is realistic way.

Q: What if there were three doctors who were family practice or internal

medicine and who worked in the same group in the same clinic? Amongst them there would be 20 patients, so they would have the numbers. Then maybe the three doctors would rotate.

A: That's exactly what I did in the nursing home. I went into the nursing facility, and of the 50 patients in there, only about 20 belonged to me, and half of them were demented. So I just called up the other doctors and asked if I could take over their patients. They were more than happy particularly the family practice doctors. So after making about six phone calls, I got a group. As for the economic impact, the doctors replaced those patients with less complicated patients who pay the same.

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For more information on self-efficacy,
call the NCCC office to order the
September 1999 NCCC publication,
*Self-Efficacy/Self-Health Care Among
Older Adults: A Literature Review.*

Minnesota Senior Health Options

The Minnesota Department of Human Services has developed Minnesota Senior Health Options (MSHO), which combines Medicare and Medicaid financing and acute and long-term care delivery systems. This demonstration facilitates the integration of primary, acute, and long-term care services for people ages 65 and older who are eligible for both Medicare and Medicaid. Minnesota has received federal Medicare 222 and Medicaid 1115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The waivers allow the State of Minnesota to combine the purchase of both Medicare and Medicaid services into one contract managed by the state. Minnesota is the first state ever to be granted such a combination of waivers. This demonstration began serving seniors in the metropolitan area in 1997 and is expected to continue through 2001.

The Robert Wood Johnson Foundation, which supported the planning stages for this demonstration, has provided a grant to cover the initial administration and implementation of the demonstration.

National Chronic Care Consortium National Resource Center on Chronic Care Integration

The NCCC National Resource Center (NRC), a subsidiary of the National Chronic Care Consortium, is the nation's premier resource for obtaining best practice information, consultation, and tools on chronic care integration. NRC products and services are designed to help emerging health networks restructure their primary, acute, and long-term care relationships under risk-based Medicare and Medicaid financing. These practice-based resources enable health networks to move beyond the merger of assets and authority toward integrating the ongoing management of governance, programs, information, financing, and care for people with chronic diseases and disabilities. This service is provided in response to the emergence of people with chronic conditions as the fastest-growing and highest-cost user segment in healthcare and the need to restructure how we finance, administer, and deliver care to contain cost accumulation and maintain quality.

The NRC is sponsored by the NCCC, a strategic alliance of leading nonprofit health systems in the United States and Canada who share a vision of integrated care for individuals with chronic health conditions, from the time of earliest condition awareness until problem resolution or death.

Promoting Self-Efficacy in Older Adults through a Group Visit Model for Primary Care proceedings were written by Mary Almen Goehle, Deborah Paone, and Barbara Vaughan.

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