### Diabetes Group Visit Flow

Updated 12.28.2010

<table>
<thead>
<tr>
<th># and Type of Employees Needed</th>
<th># of Patients Scheduled for Visit</th>
<th>How Often Visit Occurs</th>
<th>Time Required for Visit</th>
<th># of Slots Blocked in Provider Schedule</th>
<th>Best Time for Provider to be Blocked for GV Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Provider</td>
<td>Max 12</td>
<td>Min. every 3 mos</td>
<td>Provider 100 min</td>
<td>5</td>
<td>Anytime *AM when fasting labs are needed. When all patients are not on the same fasting lab schedule mornings are best.</td>
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<tr>
<td>1 Nurse</td>
<td></td>
<td>120 min</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2 MAs</td>
<td></td>
<td>120 min ea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Case Manager</td>
<td></td>
<td>120 min</td>
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### Which patients should be included in this GV?

Any patient from the provider’s Diabetes panel.

### How does a patient get identified, scheduled and confirmed for this GV?

1) Diabetes Registries are printed and given to the provider.  
2) Provider identifies Diabetes patients from their registry that would be a good group participant.  
3) Case Manager calls the identified patients and invites them to come to the group.  
4) Case Manager confirms and puts the patients into the provider’s schedule 2 weeks before the group.  
5) Front Desk makes confirmation calls 1 day before the GV.  
6) If patient calls to cancel, call center attendant should schedule an individual appointment with the patient’s PCP.  
7) CM follows up with cancellations, make sure they are seen.

### What information should be given to a patient prior to attending this GV?

1) This is not a one-on-one appt with the provider and care will be provided in a group session with other Diabetes patients, but it will be a visit with the provider.  
2) You do NOT need to fast before the appointment. (Unless fasting labs will be done)
3) The location of where the patient will check-in for the appointment  
4) The approximate length of the appointment (2 hrs)  
5) If possible, do not bring kids  
6) Call and cancel appt if you are not going to make the appt  
7) Take morning meds with plain water  
8) Bring all meds with you to the group  
9) Explain that there will be a foot exam, and the patient will need to remove his/her socks and shoes.  
10) It is ok to bring snacks  
11) Spouses are welcome.  

| Medical Record? | If the patient is an established patient and not yet in the EMR all data will be entered into the EMR. If the pt is established and still has paper chart, the chart should be pulled by Med Recs upon provider request or per site protocol. |
| What, where and who enters the data into the EMR? | MA: The day before the group, review patient charts and look at future labs, immunizations, last foot exam, last LDL, etc. and fill out Diabetes GV chart review spreadsheet. Go over the spreadsheet with the provider before the group. At the group open the Diabetes Flow Sheet and enter A1c, vitals, meds, finger stick, foot exam, immunizations and check status of aspirin, ACE inhibitor, and lipid lowering medications on the flow sheet. Enter brief HPI and make sure group visit box is checked.  
Nurse: Open a DM flow sheet and open the diagram of the feet and enter foot exam. The nurse does not document on education because they are piggybacking on what the CM covers.  
Case Manager: Create a separate encounter. Open Master IM (FP, office visit), and open Bh Home. Enter info in HPI note. Do a SOAP note. Open the Self Management IPN template and do a Self Management
goal. If any psychosocial issues are identified, open the PHQ template and complete. Open another self management goal template for the PHQ. Concatenate and sign your note from the Bh Home template. If smoking cessation counseling was done go into the **provider's encounter**, open the Diabetes flow sheet and mark counseled for smoking. Save and close.

| What materials/supplies are needed to prep GV room for GV? | Urine cups  
BP cuffs (Reg and Large)  
Scale  
Glucometer and supplies  
A1c machine and supplies  
Blood work supplies  
Culture tubes  
Thermometer  
Hemostat  
phlebotomy kit  
blood draw station  
sharps containers  
monofilament  
hand sanitizer  
immunizations, syringes and VIS  
Patient shadow charts  
name tags for patients  
Computer to check-in patient  
Printer (Make sure employees going group are set up to use  
Appointment cards  
pens  
clipboards  
tables and chairs  
Projector for presentations  
Retinal Camera and paper forms needed for Retinopathy exams. |

| How does patient get checked in for appointment? | OT checks patients in 20 min before the 1st blocked slot |

| Visit Flow (Describe the flow from the time patient arrives until all post visit work is complete) | 1) Front desk checks patients in and collects co-pay  
2) MAs take vitals and blood work  
3) MAs document in EMR  
4) MA concatenates the master document in the EMR for the provider doing the group  
5) CM facilitates introductions, provides education/facilitates group activities, and assists with self-management goal setting. |
<table>
<thead>
<tr>
<th>Role of the Financial Screener</th>
<th>N/A Established patients only</th>
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</table>
| Role of the OT                  | Works the Diabetes Registry every month  
Makes confirmation calls the day before the group  
Checks patients in before the group  
Collects co-pay  
Prints labels (5) |
| Role of the MA and information covered by the MA | Huddle with Nurse and CM a week prior to the group to prepare.  
Review the charts 1-3 days before the visit, put in future labs (labs, immunizations, foot exam, eye exam) and fill out the chart review spreadsheet. (Review info with provider)  
Prepare shadow charts and nametags before the group visit  
Help set-up the room  
Perform vitals  
Perform UA and blood draw  
Assist patients with their self management records as necessary  
Enter information into the EMR  
Perform Retinal Exams as needed  
Collect shadow charts and put back in file cabinet  
Help clean the group visit room |
| Role of the nurse and information covered by the nurse. | Meet with case manager to decide topic and prepare activities for the group. (At least a week before the group)  
The nurse huddles with the provider at night before morning groups and mid-day for afternoon or evening groups to anticipate the providers needs (confirming medications with patient, possible medication teaching)  
Nurse provides Diabetes education, foot exam, monitors staff, monitors flow of group and assists as needed. |
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<th>Role of the provider and information covered by the provider.</th>
<th>Meet with MA prior to the group to go over what needs to be done for each patient (i.e. lab work, immunizations, foot exam). Meet with CM before the group to discuss topic/activity to be covered. The provider is called down to the group visit when all patients have completed their vitals, blood draw, etc. Provider reviews pt info in EMR, does a basic physical exam addressing each individual pt and deals with concerns/issues as needed.</th>
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<tr>
<td>Role of the Case Manager and information covered by the CM.</td>
<td>Work the Diabetes registry every month, calling patients to remind them of the next group. (To avoid unwarranted individual visit being scheduled) Call and schedule patients two weeks before the group. Huddle with the nurse and MA a week before the group to prepare activities. The Case Manager comes down 20 minutes after patients arrive to welcome the patients and facilitate introductions. The Case Manager presents information and facilitates activities relevant to the topic (Retinopathy, Nutrition, Exercise, etc) Make a note of patients who no show and follow up with them. The case manager assists with the clean up of the room The case manager charts on each of the patients</td>
</tr>
</tbody>
</table>
| What needs to be tracked/measured? | **Diabetic Outcomes**  
- Self Management Goals  
- Smoking Cessation Counseling  
- HbA1c control  
- Blood Pressure Control  
- Cholesterol control  
- Retinal exams  
- Foot exams  
- Nephropathy Screening Assessment |
| Who collects data for tracking/measuring? Who creates report results and how often is it reported? | Data is reported on the Diabetes Registries  
CMs responsible for SM Goal Setting and Tobacco Cessation Counseling |
| **Planning/Admin** | 1) DM Groups are held at minimum every 3 months  
2) The PCP can schedule more often than every 3 months if deemed necessary  
3) The provider is blocked based on the number of pts in their group  
4) If the group has 10 or more pts, consider splitting into 2 groups.  
5) Never block more slots than you have pts in the group  
6) Determine the providers DM GV schedule out permanently (e.g. the 3rd Thursday the first month of the quarter from 2:00-3:30)  
7) Reserve room for group out permanently  
8) Submit permanent blocking request  
9) Inform pts at the first group what the schedule will be for future groups  
10) Call the pt the week prior to the group visit to remind pt of the upcoming group visit  
11) When calling the pt the week before the group, enter the appt into the appropriate appt slots in the providers schedule  
12) When scheduling the pt for the group, remind the pt to fast, bring all meds and wear socks/shoes that are easy to remove.  
13) Do a confirmation call the day before the group visit appt. |

Reviewed and approved:  
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Attached: Group Visit Content Threads