

TREATING DEMENTIA WITH SHARED GROUP VISITS



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Seeing patients with dementia in a group setting can streamline visits and help provide support for caregivers and families.

Group medical visits have garnered attention as low-cost, high-impact alternatives to one-on-one appointments for patients with chronic conditions.^{1,2} Alzheimer's disease and related types of dementia are increasingly common in family medicine. Patients with these conditions have higher than average hospitalization rates, and these admissions are often preventable with better outpatient care.^{3,4}

Many primary care physicians view the treatment of dementia as time-consuming and not fitting well into the usual primary care setting.⁵ Previous models of chronic care management often excluded dementia, considering it a heterogeneous condition with vastly different care priorities depending on the stage of the illness. However, all levels of dementia require the same discussions about driving, safety, placement, falls, behavioral symptoms, and establishing ties with community resources.⁶

Our practice decided to explore the feasibility of shared group visits for patients with dementia and their primary caregivers. We were motivated to improve care for these patients because dementia often can lead to poor compliance, inadequate self-care, injury, and family crises.⁷ In addition, the caregivers themselves often end up needing treatment as up to half develop psychiatric symptoms, such as depression.⁵

We learned of a specialty dementia clinic within the Department of Neurology at the University of Washington that had successfully implemented a group visit approach using six monthly sessions, replicating a model that was being used to treat patients with diabetes.⁷ We felt that, similar to other chronic illnesses, successful management of dementia needed a comprehensive approach to managing symptoms, addressing general health and comorbid conditions, considering behavioral and family issues, connecting the patient with community resources, and providing education and support to

the patient's family and caregivers – the kinds of things that can be done well in group visit settings.⁸

We report here how we structured our group visit program and measured its effect on patients, their families, and our practice.

Structure of the group visit

Five patients with a dementia diagnosis and their family caregivers agreed to attend our inaugural program, which consisted of six 90-minute monthly sessions. Dr. Khandelwal and the practice's social worker, Amy Prentice, were present at all sessions. In addition, a pharmacist presented at the second session, and student volunteers assisted each month by taking vital signs and helping with visit logistics. We allocated two hours on our schedules – 90 minutes for the visit itself and 30 minutes to complete administrative issues and medical records.

We held the group visits in a small conference room around a central table. Some aspects of a medical visit (e.g., observation of behavioral status and gait) took place in the group, but the physician held private consultations in an adjacent examination room. We structured the visits so the members could support each other while receiving knowledge in a common setting. (See "Dementia group visit schedule," page 19.)

Key components of the group visit included the following:

Introduction and group social period. The first meeting began with introductions led by the physician and social worker, followed by an overview of the process, goals, and expectations for the group appointments. Subsequent meetings began with brief informal social periods with refreshments; over time, as the group members became more comfortable with each other, patients and caregivers used this time to share experiences in managing everyday life. ➤

About the Authors

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Educational component. Each session included 20 to 30 minutes of education. Topics included an overview of caregiving, treatment of memory loss, coping with stress, brain health, home safety, and end-of-life planning.

Social work component. The social worker met with the group to discuss stresses, adequacy of support and services, specific concerns about managing any aspect of patient care, and goals for management. She also discussed available community resources and encouraged their use. (See “Recommended dementia resources,” page 20.) Group interaction was encouraged, as this session fulfilled a support group function as well as an educational one. Patients were included in the sessions. At first, the social worker met alone with the caregivers, but that was soon discontinued because caregivers and patients preferred to remain as one large group.

Physician visit. During the social work component, individual patients were invited out for one-on-one physician visits. Their caregivers joined them in most instances. The physician would ask about changes in cognitive and behavioral health and functional abilities, as well as caregiver strain and resource needs. The physician would assess how the patient had responded to the previous care plan, help the patient set new goals as appropriate, and make any changes to the care plan

necessary to meet those goals. If needed, the physician also helped manage family conflicts and made referrals for physical therapy, adult day care, and respite care.

Management of urgent problems. The physician and social worker would have private discussions with patients and caregivers before or after the group visit to address urgent or highly sensitive problems.

Confidentiality issues

Although HIPAA (the Health Information Portability and Accountability Act) does not specifically address group visits, we had considered patient confidentiality prior to implementing these visits. All participants were asked to sign a group visit consent form, agreeing in writing that all health information shared in the group was private and had to be safeguarded. The consent form we used was originally published in *FPM* in 2003 and is available online at <http://bit.ly/1CKfpoc>. In addition, because we gathered research data during our groups, we also obtained institutional review board (IRB) approval and asked participants to sign the IRB forms.

Physician experience and payment

We prepared for the group visits like any other visit, reviewing the record to see who needed

Poorly controlled dementia can exacerbate other health conditions and strain caregivers.

Group visits can address common challenges of dementia as well as connect patients and caregivers with community resources.

Visits should include educational and social work opportunities to free up time for one-on-one physician visits.

FINANCIAL ANALYSIS OF DEMENTIA GROUP VISIT PROGRAM

Group visit billing scenario	Minimum number of patients needed	
	To cover all group visit costs	To equal revenue generated by two hours of standard clinic time
Physician and social worker, billing for physician only	3.6	7.1
Physician and social worker, billing for both	2.8	5.4

DEMENTIA GROUP VISIT SCHEDULE

- 10:30 a.m. - 11 a.m.** Arrival and check-in.
Introductions and overview (first visit only).
Refreshments/social period as vital signs are collected.
- 11 a.m. - 12 p.m.** Educational presentation (20-30 minutes).
Group discussion (30-40 minutes) as one-on-one physician visits take place.
- 12 p.m. - 12:30 p.m.** Private discussions, administrative tasks, and records completion.

TOPICS:

- Week 1:** Solutions for caregiving challenges.
- Week 2:** Prevention and treatment of memory loss through drugs and supplements.
- Week 3:** Coping with family stress, holidays, and travel.
- Week 4:** Lifestyle changes to promote brain health and home safety.
- Week 5:** Advance care directives and end-of-life planning.
- Week 6:** Summary of previous discussions (e.g., safety, falls, and advanced care planning).
Revisiting group goals and community-based memory care resources.

a refill of their medication, a blood pressure check, lab tests, etc., and addressed those needs during the visit. If a major health issue was identified, such as a health status change, we suggested scheduling a separate individual visit.

Dr. Khandelwal developed a progress note template in our electronic health record to support visit coding. We billed each one-on-one patient encounter as a level 3 or 4 established patient visit (99213 or 99214), based on complexity of care, as has been recommended for group visits.¹

We found that group visits provided the physician more time with patients. Patients and caregivers could give updates on disease status, general life changes, and family news during and after the educational session. Furthermore, depending on the topic discussed that day, we could perform typical office visit screening tests, including gait assessments and depression screening, as well as medication reconciliation during the group portion. We could also use the group setting to observe patients and visualize disease characteristics such as eating difficulties, daytime sleepiness, or interpersonal interactions. Subsequently, during the individualized patient care portion, the physician could review any screening

questionnaires, order any necessary tests, and follow up with referral information, such as for physical therapy.

Clinical outcomes

We surveyed the patients and caregivers following the program's completion and found that they universally were highly satisfied. Many stated that the chance to share experiences and elicit advice from people in similar circumstances made them feel less isolated and better prepared to deal with the challenges of dementia. Patients and caregivers were also consistent in stating that the group setting did not create issues of privacy or deter them from raising concerns. When asked whether they preferred the group visits to regular one-on-one appointments, however, they tended to view group visits as supplemental to their regular relationship with their physician – describing the group visit more as a supervised support group meeting than a medical appointment.

An added benefit of group visits for Dr. Khandelwal as the primary care physician was that this in-depth setting allowed her to better identify emerging medical and behavioral issues. For example, after observing a patient

■ Participants should sign consent forms to protect patient confidentiality during group visits.

■ Group visits can give physicians more time to observe patients and correct problems early.

■ Patients and caregivers may feel less isolated by comparing their experiences with those of others in similar circumstances.

RECOMMENDED DEMENTIA RESOURCES

ADVANCE CARE PLANNING

- **Caring Conversations Workbook.** Published by the Center for Practical Bioethics, this free guide helps individuals and their families share meaningful conversations regarding end-of-life decisions. <http://bit.ly/1CVdct1>
- **Five Wishes.** Published by Aging With Dignity, this guide on advance care planning is available in 26 languages. <http://www.agingwithdignity.org/five-wishes.php>
- **Consumer's Tool Kit for Health Care Advance Planning.** Developed by the American Bar Association Commission on Law and Aging, these worksheets are designed to help individuals develop advance directives and discuss them with family. <http://bit.ly/1Joy7ad>

CAREGIVER RESOURCES

- **Family Caregiver Alliance.** This organization addresses needs of family members and others providing long-term care at home and offers programs at the national, state, and local levels to support and sustain caregivers. <http://www.caregiver.org>
- **Caregiver Action Network.** This organization, formerly the National Family Caregivers Association, educates and supports more than 65 million Americans who care for loved ones with a chronic illness, disability, or the frailties of old age. <http://www.caregiveraction.org>
- **AARP Caregiving Resource Center.** The center offers helpful tools, worksheets, and tips on how to plan, prepare, and succeed as a caregiver. <http://bit.ly/1FIUKbm>
- **Alzheimer's Facts and Figures.** This annual report by the Alzheimer's Association details the burden of Alzheimer's disease and dementia on individuals, families, state and local governments, and the health care system. <http://bit.ly/1O9xnZd>

PALLIATIVE CARE AND HOSPICE CARE

- **National Association of Home Care and Hospice.** This is the nation's largest trade association representing the interests and concerns of home care agencies, hospices, and home care aid organizations. <http://www.nahc.org>
- **National Hospice and Palliative Care Organization.** This organization represents hospice and palliative care programs and professionals in the United States and works to expand access to hospice care and improve end-of-life. <http://www.nhpco.org>

with dementia being aggressive toward his spouse, she discussed the situation with the couple, which led them to try respite care and eventually move to a retirement community. In another instance, she was able to better understand the degree of a patient's functional impairment, resulting in a recommendation to give up driving. During another discussion, our social worker became concerned about a caregiver's depression. An evaluation confirmed significant burnout, so we started the caregiver on an antidepressant and connected her with additional in-home help. After another patient missed a visit, we called the home and discovered the patient had become bedridden, leading to the initiation of home-based care.

Financial analysis

To determine how our group visit model compared financially with traditional office visits, our administrative intern, Robbie Parrott, looked at the costs and revenues of each type of visit. The analysis showed that our group dementia visits covered the salaries of the physician, the social worker, and other associated costs but were not as profitable as spending the same amount of time seeing patients individually.

We analyzed a variety of scenarios to determine how our group dementia visits could be more profitable. For group visits, we assumed the following:

- Each group visit would consume two hours of staff time, including a physician and a social worker at \$77.56 an hour and \$33.56 per hour, respectively,
- Physician reimbursement would be \$85.04 per patient, the average for visits billed during the study,
- Social worker reimbursement, when necessary or allowed, would average \$23, based on the billing of code 90853 (psychotherapy administered in a group setting),
- Refreshment expenses would total \$49 per group visit.

For traditional office visits, we assumed the following:

- Four individual patient visits would consume two hours of staff time, including a physician and a medical assistant at \$77.56 an hour and \$23.50 per hour, respectively,
- Physician reimbursement would average \$119.65 per patient, the fiscal year 2013

Having a physician and social worker (or nurse specialist) see between six and seven patient-caregiver dyads in a group visit program is likely the most cost-effective model.

average for our physician faculty.

We also assumed a cost of \$10.20 per patient in drug and supply expenses (clinic average) for all visit types.

Our results are displayed on page 18 in “Financial analysis of dementia group visit program.” We found that when we bill for physician services only, we need 3.6 patients per group visit session to cover our costs. The number shrinks to 2.8 patients if we can also bill for the social worker’s services. However, we would need an average of 7.1 patients per group visit session (physician billing only) to generate the same amount of revenue as the equivalent clinic time. Adding the social worker’s billing, when allowed, reduces the number of patients to 5.4.

Discussion

Practices can provide medical care, patient and family education, and caregiver support during a group visit. Because the average medical problem takes only a few minutes to address, we found that the physician can visit with one patient-caregiver pair at a time after allowing ample time for the group session without exceeding the 90-minute time allotment. The physician can maximize his or her time for individual visits by educating the group collectively about common issues rather than repeating the same information to several individuals and by allowing patients and caregivers to learn from one another and solve some of their challenges themselves. We also found that the group setting can accommodate patients at varying levels of dementia without difficulty; in fact, the availability of different perspectives seemed useful to all participants.

We feel that the group visit format helps us perform our jobs better and more efficiently than one-on-one appointments alone. The group sessions provide more frequent reassessment of our patients’ mental and physical status as well as caregiver stress and offer a

much longer period of interaction with each patient and caregiver than would be available in a standard office visit. As a result, the group visits make it easier to identify medical or psychosocial changes at an early stage and take steps to avoid the health crises and comorbidities often associated with a dementia diagnosis.

Having a physician and social worker (or nurse specialist) see between six and seven patient-caregiver dyads in a group visit program is likely the most cost-effective model. The model’s ability to enhance physician satisfaction is further reason to consider providing a group visit program at least annually. **FPM**

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These visits can help physicians diagnose and treat burnout and other problems that caregivers experience.

The authors’ model covered the costs of providing the group visits but did not generate the full amount of revenue they would have earned from traditional office visits.

Group visits can accommodate patients with varying degrees of dementia.

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