The most difficult patients have one thing in common: They need to change their health habits. Group visits can help them.

A NEW APPROACH TO GROUP VISITS: Helping High-Need Patients Make Behavioral Change

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The American poet and essayist James Russell Lowell said, "Human nature has a much greater genius for sameness than for originality."[1]

Family physicians know this. Not only do we see the same diseases repeatedly, but we also see common ways of coping and common reasons for failure. We see patients who struggle with healthy eating and exercise. We see patients who cannot comply with our orders because of low income, lack of support at home, trouble with pain or depression.

As a way of providing additional support to struggling patients, the idea of treating patients who have the same diseases in group visits appeared in the literature several years ago,[2] but it has not gained traction.[3] This article presents a different approach: Focusing group visits not on a single disease state but on behavior change.

The tipping point

The heart of every change is something called the "tipping point."[4] It is the point at which a concept we have previously heard about, but not acted on, tips over into relevance. This applies not only to our patients but also to our own approach to patient care.

I reached the tipping point for group visits in the fall of 2006. The idea became personally relevant because I desperately needed a new way to improve outcomes for my most difficult patients. Using a patient assessment tool called HowsYourHealth.org, which was developed at Dartmouth Medical School, I was able to analyze these patients. They were high utilizers of services, were least likely to be at goal for various clinical outcomes and had multiple comorbidities. But their diseases weren't their only problems. They also had pain, limited support at home, poverty and depression.

I stratified this group and invited them to replace an individual visit with a group visit. In other words, I took a group of overweight, depressed, smoking, sleep apneic, diabetic patients with pain, little money and little support, and I offered to see them all at once.

How it works

As a solo physician with no staff, my goal was to implement group visits in an uncomplicated way so they wouldn't seem like a chore. Unlike previous group visit models,[5] my approach does not require sending out invitation letters, developing a curriculum, lining up staff, etc. I have also kept my costs minimal: a $22 easel, some pens,

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two pads of paper and, occasionally, some healthy snacks.

I hold a 90-minute group visit on the third Thursday of every month and invite my high-need patients to attend. The group averages four to six participants. The visits are structured to have the members support each other while receiving knowledge in a common setting. We discuss basic nutrition, exercise, assertiveness and communication skills, but the two main thrusts are goal setting and problem solving.

I teach my patients that goal setting begins with selecting an achievable goal. A common goal for these patients is losing weight; however, "weight loss" looms large and unattainable and can perpetuate the cycle of failure, discouragement and poor health outcomes. In contrast, the goal of "losing two pounds" is achievable and can usher in a cycle of success, confidence and control over one's health. To achieve their health-related goals, patients also need to confront the perceived risks and benefits of their behavior (for example, a risk of smoking is lung cancer but a perceived benefit might be stress relief), create an action plan, monitor their condition and learn how to deal with failures along the way.[6]

Problem solving is also a critical skill. Teaching patients how to break down problems and find possible solutions enhances confidence and compliance. It is not sufficient for a person to feel confident that they are working on the right problem (e.g., "losing two pounds"); they must be able to identify the specific steps required to solve the problem (e.g., "stop drinking soda" or "take the stairs at work"). We frequently use the problem-solving worksheet shown on page A8.

Each visit draws from one of these areas, but the work is repetitive as we reinforce and build on skills and achievements and tackle setbacks. I plan the content of each visit based on the needs I have perceived in the group or the direction I have seen them taking.

My preparation for the group visit is similar to what I do for any visit. I check to see who needs a refill, blood pressure check, foot exam, lab test, etc., so I can address these issues during the visit. Each patient in the group gets a brief visit with me privately during the group session. I may suggest a separate visit if I see that a patient has many issues to work on.

My billing is based on the content of each individual visit conducted during the group visit, and I generate SOAP notes to support my coding, as with any visit.

Small successes

My patients' response to group visits has been overwhelmingly positive. The group looks forward to coming and comes in all weather, which is significant given the fact that I practice in the western foothills of Maine.

At six months, I asked all members of the group what they had accomplished with regard to their health since we began our group visits:

- One patient cites her biggest achievement as learning to say no. Her difficulties in dealing with pain, controlling her diabetes, exercising regularly and coping with issues at home were all related to her inability to be assertive and communicate effectively. The safety of the group, combined with its problem-solving approach, has enabled her to begin to move forward.
- Another patient has quit smoking. He has stayed smoke-free despite unemployment and marital stress. Interestingly, his decision to quit tobacco came at a time when I was focusing on his morbid obesity and out-of-control diabetes. This underscores the value of focusing on "what matters to the patient" versus "what is the matter with the patient."
- Two patients have begun to lose small amounts of weight consistently and have learned what triggers their weight gains and losses.
- Another patient has gotten her lipids at goal for the first time.
- Another patient has come to terms with depression after years. She credits the group with finally getting her to take medicine for her condition.

There is much more work to be done of

IMP SERIES OVERVIEW

IMP Ideal Medical Practice Series

This article continues our series on the "ideal medical practice" model, which is focused on high-quality, patient-centered, collaborative care; unfettered access and continuity; and extreme efficiency. The articles share learnings from practices involved in a national research project to demonstrate that the model results in high-quality care and vital and sustainable practices. Previous articles in the series include the following:

Practice Measurement: A New Approach for Demonstrating the Worth of Your Work. Guinn N and Moore LG. February 2008:19-22.

Virtual Office Visits: A Reachable and Reimbursable Innovation. Eads M. October 2007:20-22.

Seven Strategies for Creating a More Efficient Practice. Ho L. September 2007:27-30.

The Ideal Medical Practice Model: Improving Efficiency, Quality and the Doctor-Patient Relationship. Moore LG and Wasson JH. September 2007:20-24.

course. I have plans to track these patients' medical outcomes long term, and I expect to see improvement in their A1Cs, lipids, ED visit rates, etc.

Why I do it

I did not initiate group visits to make a profit or to be cost efficient. The original work at Kaiser showed a minimal financial difference between traditional and group visits,[7] which has also been my experience.

I began group visits because I saw so many of my patients failing to make progress toward important clinical goals. My inability to help them using traditional visits was the tipping point that moved me to try a new approach. Group visits can provide support to patients with varying diagnoses but common underlying issues. As the number of elderly and chronically ill patients in our practices grows, group visits based on need rather than disease process are worth exploring. FPM

Send comments to **fpmedit@aafp.org.**

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Group visits can be an effective forum for helping high-need patients address behavioral change.

The visits focus on goal setting and problem solving.

Small successes should not be discounted, as they help build patient confidence.

PROBLEM-SOLVING WORKSHEET

1. Problem:										
2. Achievable goal:										
3. How convinced are you that this is the right goal for you? ☹ ☺										
0	1	2	3	4	5	6	7	8	9	10
	Totally unconvinced		Unsure		Somewhat convinced		Very convinced		Extremely convinced	
4. Solutions:				Pros (+)			Cons (-)			
a)										
b)										
c)										
5. Choice of solution:										
6. Steps to achieve solution:										
a)										
b)										
c)										
Confidence ruler: How confident are you that you can reach your goal? ☹ ☺										
0	1	2	3	4	5	6	7	8	9	10
	Totally unconvinced		Unsure		Somewhat convinced		Very convinced		Extremely convinced	

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