

# **Group Medical Appointments**

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# Learning Objectives

- Understand why you should consider adding group medical appointments to your practice.
- Explain the two basic models: CHCC & DIGMA.
- Identify variations: physicals & disease-specific.
- Discuss implementation, including Health Insurance Portability and Accountability Act (HIPAA) and billing issues.
- Understand why group visits work.

# Why Consider Groups?

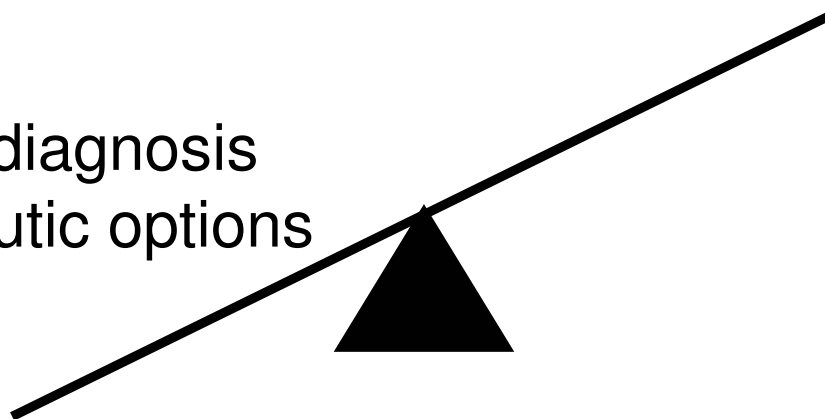
- Institute of Medicine's report *Crossing the Quality Chasm: A New Health System for the 21st Century*
- Pay-for-performance plans
- Better outcomes, lower costs, higher patient satisfaction
- Option to drop medicine may go away
- Time constraints

## Growing Care Needs

- Quality-of-life issues
- Aging population with complex needs
- Empowered patients with questions
- Need for patient education
- Increased diagnosis and therapeutic options

## Ways to Meet Patient Care Needs

- Traditional office visits: Average length is 14-18 minutes; only half of this time is face-to-face with MD



# New Models of Care

- There are more than 20 models.
- Build your own.
- Pick elements that might fit your practice.
- Key: Patients are a resource in care delivery.

# **New Care-Delivery Model: Group Medical Appointments**

- Voluntary
- Interactive
- Medical care – not classes or support groups
- Efficient
- Effective fun

# Typical Cooperative Health Care Clinic (CHCC) Structure

**“What would my mother want?”**

- 2- to 2½-hour monthly visits
- 15 to 20 patients and caregivers
- Same patients typically attend every group visit – the continuity model
- Long-term commitment to regularly scheduled visits

# Components of CHCC

<b>Component:</b>	<b>Minutes:</b>	<b>Percentage of total time:</b>
Warm-up	10 to 15	11 to 17
Education	30	33
Nurse/Doctor time	30 to 40	33 to 45
Question & Answers	10	11
Plan next meeting	6	6
<b>Total:</b>	<b>90</b>	<b>100</b>

**\*Private time following group = 60 minutes**

# CHCC Multidisciplinary Team

- Physician
- Nurse
- Health educator, physical therapist, pharmacist and/or dietician as needed

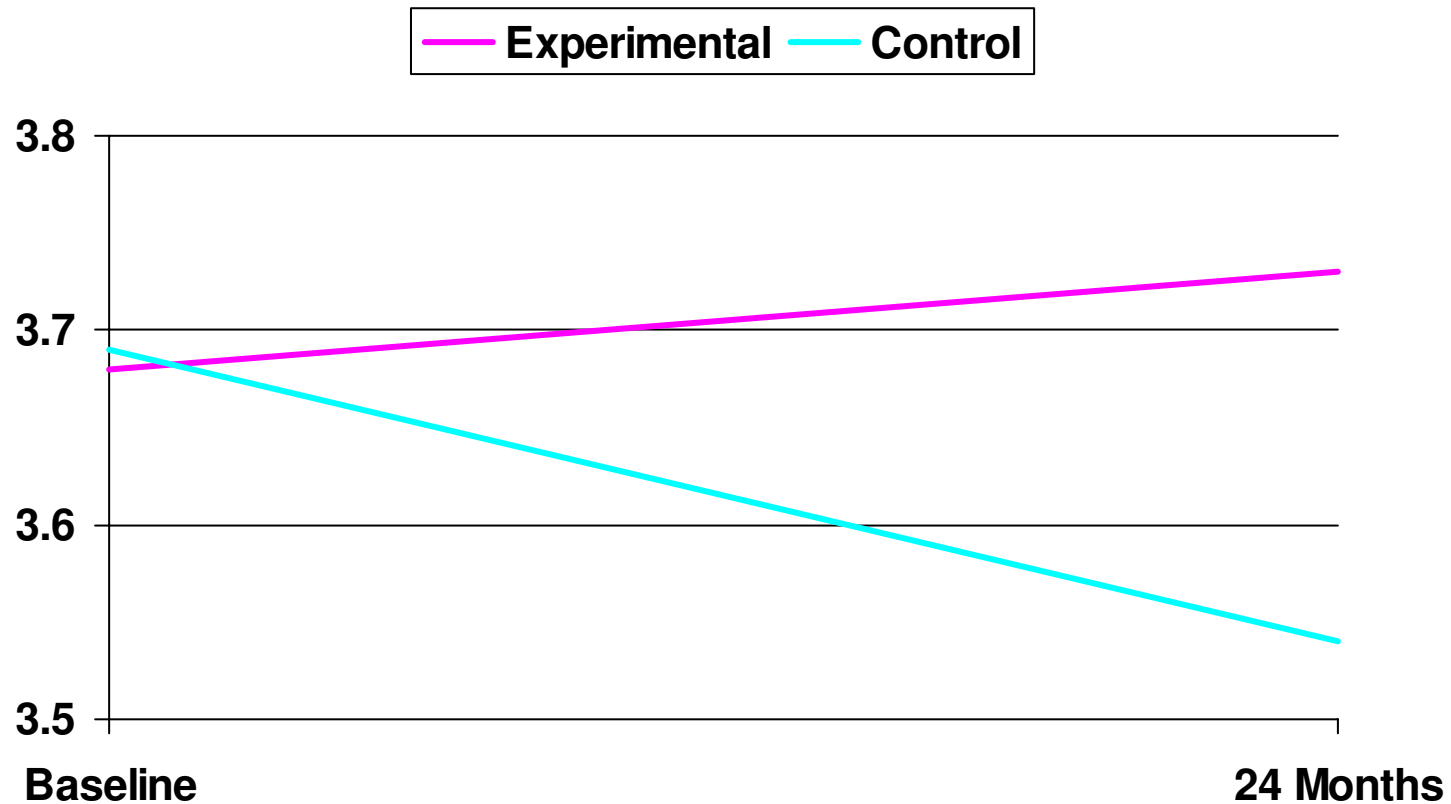
# CHCC Personal Care Notebook

- Medical problem list
- Medication list
- Last electrocardiogram (EKG)
- Disease management guidelines
- Advance directives

# Results: CHCC Health Care Utilization

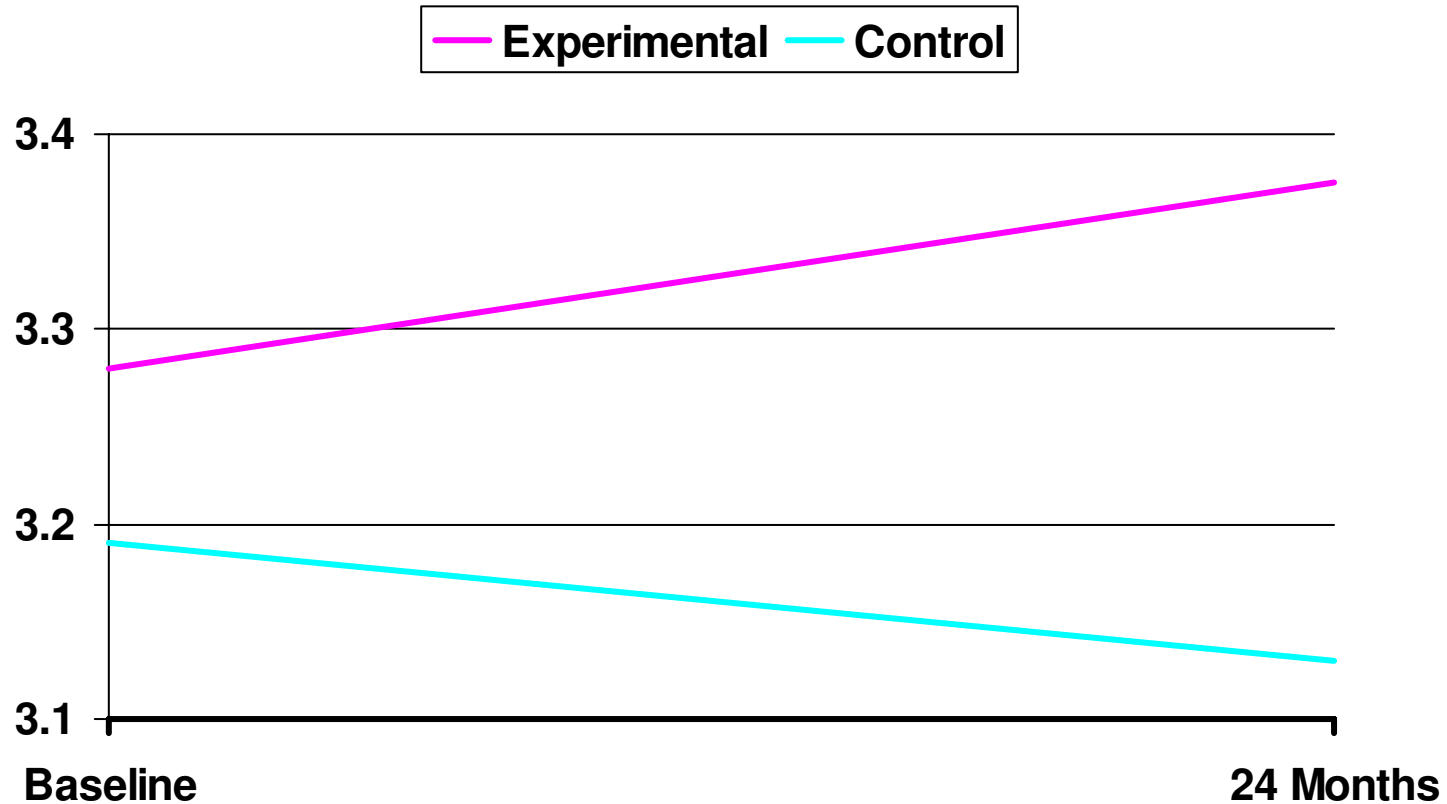
- No difference in outpatient visits
- Significantly fewer hospital admissions per patient ( $p=.012$ )
- Significantly fewer emergency department visits ( $p=.008$ )
- Fewer professional services ( $p=.005$ )

# Change in Patient Satisfaction with Primary Care Physician



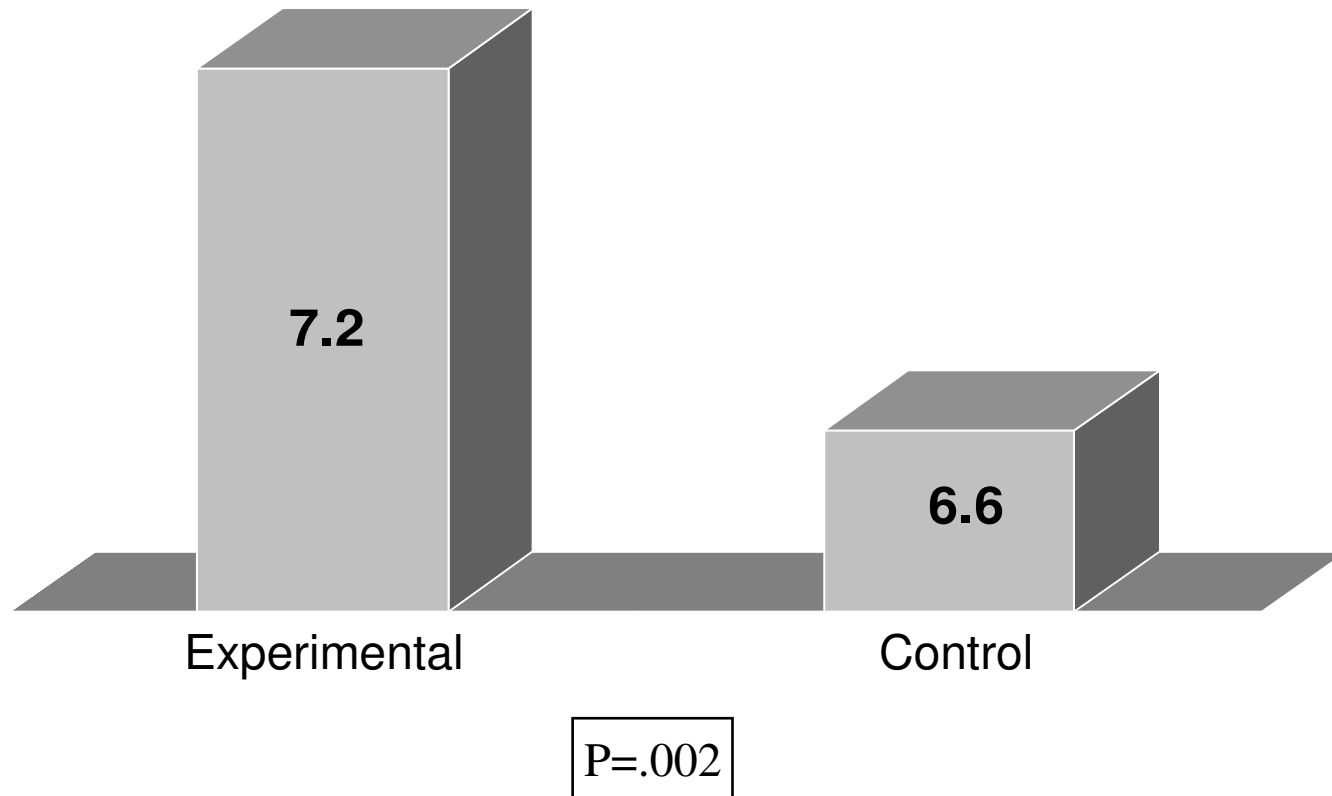
Scale: 1 to 5. Higher Score = Greater Satisfaction.  $p = .003$

# Change in Patient Satisfaction with Overall Quality of Care



Scale: 1 to 5. Higher Score = Greater Satisfaction.  $p = .004$

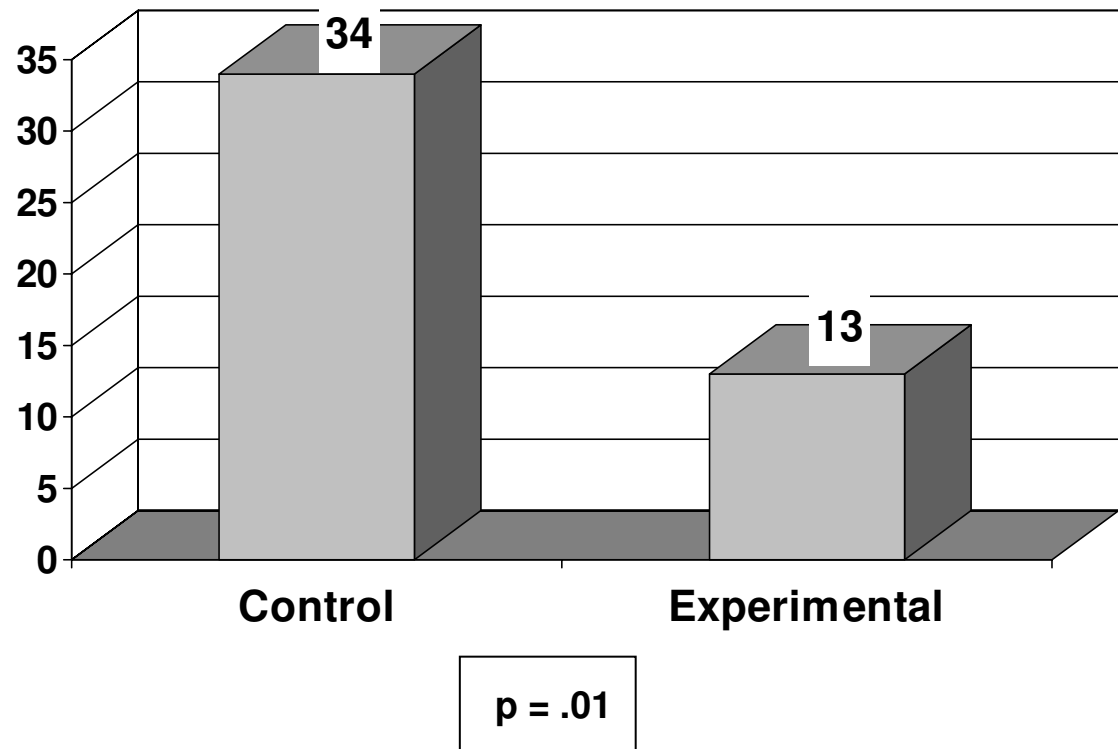
# Quality of Life



**How would you rate your quality of life, with “0” being the worst and “10” being the best?**

# Disenrollment

- Significantly fewer terminations from the health plan
- \$33,600 savings in costs associated with termination from the health plan



# Drop-In Group Medical Appointment (DIGMA)

- Developed in 1996 by psychologist Edward Noffsinger at the Kaiser Permanente San Jose Medical Center
- Primary purpose is to improve access
- Useful in most primary and specialty care settings

# DIGMA Multidisciplinary Team

- Physician
- Co-facilitator needed: behavioral health specialist or psychologist
- Medical assistant
- Scheduler

# Typical DIGMA Structure

- 1½-hour weekly visit
- 10 to 16 patients and 2 to 6 caregivers
- The most common model includes a heterogeneous population.
- Different patients with different conditions attend each group only when they have medical need.
- Some patients attend by appointment and some as drop-ins.
- Visits are facilitated by a physician with the assistance of a behaviorist.

# DIGMA Process

- Patient recruitment:
  - Patient self-referral
  - Physician invitation
  - Staff referral
  - Invitation from scheduler
- Patients and accompanying friends/family are asked to sign a confidentiality agreement and waiver.
- Pre-visit vital signs are taken and brief introductions are made, followed by medical care and individual appointments, as needed.
- Circular seating: The physician and behaviorist sit next to each other with medical charts on a table between them.

# DIGMA Target Patient Population

- Open to most patients on a physician's panel – both high and low utilizers alike.
- Not appropriate for:
  - Patients who have dementia
  - Patients who have severe hearing loss
  - First-time visits

# DIGMA: Kaiser Pilot Study (2001)

- 4 primary care doctors (FP, IM, GER),  
700 patients
- 6-month pilot
- Cost-effective if more than 5.2 patients attend
- High patient and physician satisfaction
- 60 percent said they would **prefer** a group visit to a private office visit
- 8 to 12 patients is ideal

# Dartmouth Groups

- 2003
  - Breast reconstruction group
  - Full-time employee (FTE): 1.0 to 0.8 reduction
- 2005
  - Carpal tunnel group
  - SBITR (Surgeon booked in two rooms)

# Dartmouth Revenues

- Breast reconstruction
  - \$843 vs \$2,580
  - 206 percent increase in revenue with groups
- Carpal tunnel
  - \$1,124 vs \$3,091
  - 175 percent increase in revenue with groups

# Dartmouth Billings

<b>FISCAL YEAR / FTE</b>	<b>APPOINTMENTS</b>	<b>VISITS</b>	<b>OR CASES</b>	<b>MNS CASES</b>	<b>GROSS BILLINGS</b>
2002 / 1.0	1434	1740	156	163	\$1,475,885
2003 / .90	1686	2002	184	176	\$1,673,292
2004 / .80	1604	2185	211	180	\$2,273,206
2005 / .80	1657	2126	209	214	\$2,578,396
<b>2002 vs 2005 % change</b>	<b>16.8% ↑</b>	<b>22.2% ↑</b>	<b>34.0% ↑</b>	<b>31.3% ↑</b>	<b>74.7% ↑</b>

# Dartmouth Return On Investment

- **Group visits require support**
  - Reorganization/training, space, marketing
  - Is it justified?
- **Estimated Annual Net Revenue**
  - \$710,400\* maximizing groups (\*Excludes increased revenue from previous slides)
  - \$113,280 without groups

# Additional Group Visit Models

- Diabetes multi-station
- Hypertension
- Well-baby exams
- Fibromyalgia
- Functional bowel

# Diabetes Multi-station Group Visits

- **Purpose:** To provide diabetes care to a target population within a physician practice.
- **Multidisciplinary team:**
  - MD
  - Clinical pharmacist
  - Diabetes care manager
  - Foot care nurse
- **Target population:** Patients with type II diabetes with A1C greater than 6.9

# Diabetes Multi-station Group Visits (cont'd)

- **Group structure**
  - 2 to 3 hours in length
  - 15 to 25 patients
  - Return every 3 months/continuity
- **Planning process**
  - Patients identified by physician.
  - Patients invited to attend with RSVP.
  - Patients who respond are sent reminder to complete lab work in advance of group visit.
  - Make reminder call one week prior to visit.

# Diabetes Multi-station Group Visits (cont'd)

## Typical meeting – 2½ hours

- Welcome and introduction
- Review purpose
- 30 to 45 minutes of education and Q&A
- Patients cycle through stations:
  - MD (BP – renal)
  - Diabetes education (eye, diet, lifestyle)
  - Clinical pharmacist (lipid management)
  - RN (monofilament and foot care)
- Documentation at each station

# Kaiser Permanente 2005 Dr. S

<b>Variable</b>	<b>2/05</b>	<b>12/05</b>
BP < 130/80	18%	50%
A1C < 7	20%	50%
LDL < 100	56%	76%
Current statin	74%	84%
Current ASA	0%	92%

*BP=blood pressure; LDL=low-density lipoprotein; ASA = acetylsalicylic acid*

# Kaiser Permanente 2005 Dr. B

<b>Variable</b>	<b>2/05</b>	<b>12/05</b>
BP < 130/80	37%	47%
A1C < 7	5%	26%
LDL < 100	89%	89%
Current statin	85%	89%
Current ASA	Unknown	89%

*BP=blood pressure; LDL=low-density lipoprotein; ASA = acetylsalicylic acid*

# Kaiser Permanente: Family practice department 3/05-1/06

(90 patients in group vs 755 patients in dept.)

<b>Variable</b>	<b>FP Dept</b>	<b>DM Group</b>
BP < 130/80	44%	58%
Foot exam < 12 months	6%	30%
A1C < 7	42%	33%
LDL <100	50%	73%
ASA use	43%	72%

*FP=family practice; DM=diabetes mellitus; BP=blood pressure; LDL=low-density lipoprotein; ASA = acetylsalicylic acid* 32

# Diabetes Group Visit Findings

- University of South Carolina: 6-month randomized controlled trial (RCT) with 120 participants
- Tested feasibility and acceptability of group visits for care of uninsured or inadequately insured diabetics.
  - Improved trust
  - Better coordination of care
  - Better community orientation
  - More culturally competent care

Clancy DE, Cope DW, Magruder KM, Huang P, Salter KH, Fields AW. Evaluating group visits in an uninsured or inadequately insured patient population with uncontrolled type 2 diabetes. *Diabetes Educ.* 2003;29(2):292-302.

# Diabetes Group Visit Findings

- Turin, Italy: 2-year RCT, 112 patients
- **Objective:** To evaluate whether group visits, delivered as routine diabetes care and structured according to a systemic education approach, are more effective than individual consultations in improving metabolic control in non-insulin dependent type 2 diabetics.
- **Findings:**
  - Group patients showed:
    - Lower levels of A1C ( $p < .002$ ),
    - Improved knowledge of diabetes ( $p < .001$ )
    - Improved quality of life ( $p < .001$ ).
  - Physicians spent less time seeing 9 to 10 patients as a group than individually, but patients had longer interaction with health care providers.

Trento M, Passera P, Tomalino M, Baiardi M, Pomero F, Allione A, et al. Group visits improve metabolic control in type 2 diabetes: a 2-year follow-up. *Diabetes Care*. 2001;24(6):995-1000.

# Well-Baby: 6-month or 9-month Visits

- **Purpose:** To provide education, consultation and care for well-baby visits.
- **Multidisciplinary team:**
  - Pediatrician
  - Child development specialist
- **Target population:** Parents and babies for 6-month and 9-month well-baby visits

# Well-Baby: 6-month or 9-month Visits (cont'd)

- Group structure:
  - 2 hours long
  - 6 to 10 patients with babies
  - One-time visit
- Planning process:
  - Parents invited to participate via letter
  - RSVP

# Well-Baby: 6-month or 9-month Visits (cont'd)

- Typical meeting
  - Pediatrician welcomes families; babies and parents are on a blanket on the floor.
  - Child development specialist talks about behaviors, safety and what to anticipate and Q&A.
  - Physician sees individual child in a room; shots in a separate room.
- Issues
  - Patient volume/continuity
  - Patient satisfaction vs. physician satisfaction

# PEEC

(Pre-op Education and Evaluation Center)

- **Purpose:** To provide pre-op education, evaluation and consent in a single visit.
- **Multi-disciplinary team:**
  - Nurse practitioner (2)
  - RN educators (2)
  - Consenting staff orthopedics department
- **Target Population:** Patients needing orthopedic surgery

# PEEC (cont'd)

- Group structure:
  - 2-hour meeting
  - 6 patients plus family member or friend
- Planning process:
  - Patients who need surgery are scheduled by phone.

# PEEC (cont'd)

- Typical meeting – 2 hours
  - 45 minutes: History and physical by NP (3 patients)
  - 20 minutes: Group consent
  - 20 minutes: Education by nurse
  - 20 minutes: Follow-up and Q&A
  - 45 minutes: History and physical by NP (3 patients)

# PEEC Findings

- Efficiency
  - Completes 6 pre-op work-ups in 2 hours; it previously took 2 visits and 3 hours for each patient.
- Satisfaction for both providers and patients:
  - 100% of patients said they would prefer a group visit for a future surgery

# PEEC Total Joint

- Expanded team
  - Advance directives nurse
  - Transfusion consent staff
  - Orthopedic surgeon teaching
  - PharmD for anti-coagulation education
  - PT rehabilitation review
  - Home care coordinator
- Visit expanded to 3 hours

# Review of 3 Basic Types of Group Visit

- CHCC
- DIGMA
- Physical exams

# CHCC

- Continuity – same patients
- Age-specific
- Disease-specific
- Purpose: Improved outcomes

# DIGMA

- Discontinuity – different patients
- Primarily used for follow-up
- Disease-specific or mixed
- Purpose: Improved access
- Requires a co-facilitator (medical knowledge)

# Physical Exams

- One-on-one exams first
- Q&A and education in group
- Examples: sports, pre-op, women's health

# Personal Care Notebook

- Medical problem list
- Medication list
- Last EKG
- Disease management guidelines
- Advance directives

# Planning for Success

- Obtain administrative buy-in
- Identify staff:
  - Interested physicians
  - Support staff
  - All stakeholders

# Planning for Success (cont'd)

- Reimbursement criteria
- HIPAA considerations
  - Annual permission
  - Prior to each group
  - Consent by action
- Documentation needs
  - Document as you go

# Planning for Success (cont'd)

- Devise a strategy
  - One-time group visit vs. periodic group visit
  - Same patients vs. different patients
  - Disease-specific vs. multi-diagnosis
- Implementation plan
  - Pilot with evaluation prior to large-scale roll out
  - Wide implementation (“Just do it.”)
  - Research study

# Planning for Success (cont'd)

- Outcome measures and determining success
  - Patient/clinical outcomes
  - Satisfaction of patient and provider
  - Cost savings, utilization and performance outcomes
  - Attendance
- Resource needs
- Roles
- Training needs (those directly involved and those in supporting roles)

# Planning for Success (cont'd)

- Target population
  - Age
  - Diagnostic criteria
  - One physician or more
- Building the group
  - Identifying patients
  - Recruitment strategies
  - Scheduling and reminding

# Planning for Success (cont'd)

- Consider the patients' perspectives: What will their experience be like?
- Accountability for the project:
  - Ensure goals and objectives are being met (process, census).
  - Respond to patient issues and concerns.
  - Ask: Are processes efficient?
  - Evaluate desired outcomes.
- Tell the story: champions and data
- Celebrate success

# Why Group Medical Appointments Work

- Increased contact time for communication
- Enhanced doctor-patient relationship
- Therapeutic factors of groups (Yalom)
  - Instillation of hope
  - Universality
  - Imparting information
  - Altruism
  - Corrective recapitulation of the primary family group

# Therapeutic Factors of Groups

- Development of social techniques
- Imitative behavior
- Interpersonal learning
- Group cohesiveness
- Catharsis
- Existential factors

# Summary

- A group visit is a medical appointment – not a class or support group.
- Group visits require planning and commitment.
- Group visits must be modified and molded to meet your unique needs.
- Group visits offer the potential for improved quality of care, clinical outcomes, access and satisfaction for patients and health care providers.

# References

Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G, et al. *A Randomized Trial of Group Outpatient Visits for Chronically Ill Older HMO Members: The Cooperative Health Care Clinic.* J Am Geriatr Soc. 1997;45: 543-549.

Clancy DE, Cope DW, Magruder KM, Huang P, Salter KH, Fields AW. *Evaluating Group Visits in an Uninsured or Inadequately Insured Patient Population with Uncontrolled Type 2 Diabetes.* Diabetes Educ. 2003;29(2):292-302.

Coleman EA, Eilertsen TB, Kramer AM, Magid DJ, Beck A, Conner D. *Reducing Emergency Visits in Older Adults with Chronic Illness.* Eff Clin Pract. 2001;4(2):49-57.

Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, et al. *Diabetes Management in a Health Maintenance Organization.* Diabetes Care. 1999;22(12):2011-7.

# References

Scott JC, Conner DA, Venohr I, Gade G, McKenzie M, Kramer AM, et al. *Effectiveness of a Group Visit Model for Chronically Ill Older Health Maintenance Organization Members: A 2-year Randomized Trial for the Cooperative HealthCare Clinic*. J Am Geriatr Soc. 2004;52:1463-1470.

Scott J, Gade G, McKenzie M, Venohr I. *Cooperative Health Care Clinics: A Group Approach to Individual Care*. Geriatrics. 1998;53:68-81.

Trento M, Passera P, Tomalino M, Bajardi M, Pomero F, Allione A, et al. *Group Visits Improve Metabolic Control in Type 2 Diabetes*. Diabetes Care. 2001;24(6):995-1000.

Yalom, ID. *The Theory and Practice of Group Psychotherapy*. New York: Basic Books;2005.