

Chapter 1

Why Try Group Visits in Your Practice?

Why Group Visits?

Faced with the multiple pressures and harsh economic realities of today's highly competitive healthcare environment (double digit annual increases in the cost of care, ongoing access problems, rapid change, large practices, less time per patient, the expanding medical needs of an aging patient population, decreasing reimbursements, weakening bottom lines, etc.), physicians and healthcare organizations alike are grappling to meet these modern challenges through innovative new approaches to delivering accessible, high-quality, and high-value medical care.

In this challenging environment, a rare combination of benefits makes the Drop-In Group Medical Appointment (DIGMA), Cooperative Health Care Clinic (CHCC), and Physicals Shared Medical Appointment (PSMA) group visit models exciting and unique. It is the remarkable set of benefits that they offer to patients, physicians, and organizations alike (plus the fact that these group visit models work well not only together but also with other healthcare innovations such as Advanced Clinic Access [ACA], Patient Centered Medical Home [PCMH], electronic medical records [EMR], Toyota lean, chronic disease management, etc) that has enabled DIGMAs, CHCCs, and PSMA to consistently work well in a wide variety of applications in actual practice.

Representing a biopsychosocial and multidisciplinary team-based approach to medical care, group visits (interchangeably referred to as shared medical appointments or SMAs, shared visits, shared medical visits, group medical appointments, group medical visits, group appointments, etc.) are meant to enhance quality and outcomes, increase productivity and access to care, improve patient–physician relationships, grow the bottom line, and augment both patient and physician professional satisfaction. Numerous medical centers across the country (Cleveland Clinic, Dartmouth Hitchcock, Harvard Vanguard Medical Associates/Atrius Health, University of Virginia, Palo Alto Medical Foundation, Texas Tech University, Veterans Health Administration, Department of Defense [Air Force, Army, and Navy], Kaiser Permanente, Everett Clinic, etc.) have introduced group visit programs, as have other countries such as Canada and Holland.

The economic imperatives of today’s managed care environment and the fast-paced treadmill of outpatient care have increased the physician’s role as gatekeeper, diagnostician, documenter, and technician fighting disease while decreasing the amount of time he or she can comfort, educate, emotionally support, and get to know patients. Group visits provide a remarkable antidote to this deleterious trend by addressing many of today’s greatest healthcare challenges: closed practices; inadequate attention to performance measures and health maintenance updates; the increasing lack of job doability; growing demands from today’s informed and aging patients; the epidemic explosion of time-consuming diabetes, obesity, and lifestyle issues; decreasing reimbursements and stressed bottom lines; and the rising dissatisfaction of patients and physicians alike.

Confronted by today’s multiple quality mandates, the potential of group visits to both redesign the physician’s office practice and enhance care for geriatric and chronically ill patients (as well as the poor and underserved) is just beginning to emerge. Group visits can also provide a remarkable tool for leveraging existing resources and more efficiently and economically addressing some current concerns surrounding Medicare and Medicaid (and the long-term economic survival of these programs). Though it seems paradoxical, doctors and patients alike maintain that group visits reclaim the closeness of the doctor–patient relationship that many argue has eroded in this era of managed care.

(Please note: The terms *physician* and *provider* are used interchangeably throughout this book, as MDs set up their group visits in exactly the same way as nurse practitioners, podiatrists, pharmacists, physician assistants, etc.)

Carefully designed and properly run group visit programs can offer a multitude of benefits not only to patients, physicians, and healthcare organizations, but also to third-party payers and corporate purchasers by addressing many of the most important healthcare challenges of our time. This book is a step-by-step guide on how to best implement successful group visits in your practice. But before we get started, it is important to understand what group visits can do and why they are such a valuable tool.

Medical Care Plus Support

First and foremost, group visits are medical visits in which multiple patients are seen simultaneously by the physician in a supportive group setting. Medical care is delivered throughout the extended group visit session to meet the unique medical needs of each person individually. It is this singular focus upon actual delivery of quality medical care that differentiates group visits from psychotherapy groups, behavioral medicine programs, 12-step programs, community support groups, health education classes, etc.

In addition to more time and prompt access to quality medical care, shared medical appointments also provide a great deal of patient education and emotional support by integrating other patients and a specially trained multidisciplinary care team into each patient's healthcare experience. This combination of medical care, patient education, and support—plus the presence of the doctor and a multidisciplinary care team throughout the visit—is often preferred by patients when they have a medical need. However, group visits are meant at all times to be voluntary to patients and physicians alike.

Shared Medical Appointments and Individual Visits

Group visits are meant to complement, not to completely replace, the traditional individual visit. Today's three major SMA models (the DIGMA, the CCHC, and the PSMA) work well not only with each other and other types of group programs, but also in combination with traditional individual office visits. It is anticipated that both group and individual office visits will play an important role in the future of healthcare delivery. The challenge facing us now is how to optimize

the use of both types of appointments. As more and more SMAs are implemented, we will undoubtedly find occasions where they work best and where they do not. Once we more fully understand where SMAs do and don't offer substantial benefits over traditional individual office visits, we will be better able to more precisely match the specific type of care that we offer to the exact needs of our patients.

Group Visits Offer More

While many physicians view the individual office visit model as the gold standard of care, it soon may no longer be a viable option for many physicians who might want to maintain the status quo. Simply consider the following: decreasing numbers of primary care and geriatric physicians; growing numbers of closed practices; increasing costs and declining reimbursements; large practice sizes; undoable jobs; increasingly long workweeks; the brief and rushed nature of care; growing backlogs; the inability of patients to secure timely appointments; and dwindling patient as well as physician professional satisfaction.

Given these multifarious stresses, our healthcare system is in dire need of a positive innovation that gives us both an efficient, high-quality alternative to individual office visits and an additional healthcare choice. In addition to medical care, well-run group visits provide better access, greater patient education, one-stop healthcare, a multi-disciplinary team, reduced repetition, a more efficient utilization of physician time, and a venue for efficiently reaching out to the poor and underserved as well as to difficult and information-seeking patients.

Broad Applications

The wide-ranging applications for group visits are much broader than one might at first envision. It's easy to see that, because so much money goes towards the treatment of chronic illnesses, efficient group visits can help to contain the rapidly rising cost of providing care to the chronically ill, to multimorbid geriatric patients, and to patients who are high utilizers of healthcare services. These high-risk patients have the potential for both poor outcomes and high cost to the system—plus often have both lifestyle issues and extensive *mind* as well as *body* needs that are difficult to adequately address during

comparatively rushed individual office visits. Beyond these types of clear applications, I believe that the majority of the medical care we currently provide in outpatient ambulatory care settings (as well as in some inpatient settings) could be as well (or sometimes even better) provided in the group visit paradigm.

Shared Medical Appointments (SMAs) can play an important role in primary care as well as in virtually all medical and surgical specialties, in training residents and fellows in academic settings, and in some inpatient, urgent care, residential, and nursing home settings. They can be employed to meet the medical needs of patients with routine, acute, or chronic issues. They can be used to improve access to both follow-up visits (DIGMAs) and physical examinations (PSMAs), to reduce patient complaints and phone call volume, and to effectively manage difficult patients—such as psychologically needy patients; extreme information seekers; angry, high-utilizing, or non-compliant patients; and those with diagnoses often seen as difficult to treat in the traditional office visit setting (chronic pain, headache, substance abuse, fibromyalgia, irritable bowel, etc.).

Positive SMA results have been achieved in both primary and specialty care in a wide variety of healthcare delivery systems, each of which has its own specific strengths and weaknesses (positive SMA results that interested readers can investigate through either a literature search or by reading the outcomes chapter of Dr. Noffsinger's earlier book, *Running Group Visits In Your Practice*, which was published by Springer in 2009). These include the commercial (fee-for-service, capitated, profit, not-for-profit, PPO, HMO, IPA, etc.), academic, public (public hospitals, community health centers, etc.), and governmental (Department of Defense, Indian Health Services, and Veterans Health Administration) sectors.

Although group visits are still relatively new, they have already been successfully employed in almost all areas of medicine: internal medicine; family practice; allergy; bariatric surgery; cardiology; dermatology; endocrinology; gastroenterology; general surgery; geriatrics; gynecology; hematology; lifestyle medicine; nephrology; neurology; obstetrics; oncology; ophthalmology; orthopedic surgery; pediatrics; physiatry; plastic surgery; podiatry; psychiatry; pulmonology; rheumatology; sports medicine; travel medicine; urgent care; urology; weight management; and women's health—and the number and types of applications continue to grow.

In addition, SMAs have also been used in many ways within each subspecialty. In cardiology, DIGMAs and/or PSMAs have been used

for general cardiology, CHF, arrhythmias, atrial fibrillation, post-MI discharge follow-ups, hypertension, hyperlipidemia, cardiovascular disease, and pacemaker interrogations. In dermatology, these group visit models have been used for general dermatology, acne, skin cancer, cosmetic dermatology, eczema, psoriasis, and sun damage. In nephrology, DIGMAs and PSMAAs have been designed for dialysis patients, predialysis patients, kidney stones, end-stage kidney disease, and hypertension.

Despite the multiple economic and productivity benefits that properly run SMAs are able to offer, it is the service, quality of care, patient education, emotional support, and disease self-management benefits that they can offer to our patients that is the source of greatest satisfaction to me, personally.

Long-Term Benefits

In this country, we too often seem obsessed with profits and have a tendency to focus on immediate benefits and the bottom line—i.e., rather than long-term quality, service, and process improvement benefits. I am very concerned that the same thing could happen to the way we set up, support, run, and evaluate our group visit programs. My hope is that physicians and healthcare organizations will accurately recognize the numerous benefits that SMAs can offer to patients, providers, and healthcare organizations alike—so that they cherish and protect these benefits by providing the necessary personnel, promotional, and facilities supports (and by maintaining a focus on quality care, improved outcomes, and enhanced service). Strive to build quality into your SMA by avoiding the pitfalls of potential abuses, improving processes, measuring results on an ongoing basis, and maintaining a constant focus upon better servicing our patient-customers.

Group Visit Models and Their Benefits

There are three major group visit models currently available—models that are briefly addressed in this chapter but are discussed in greater detail in Chap. 2. They work well together rather than being mutually

exclusive. These major models are: (1) Drop-In Group Medical Appointments (DIGMAs); (2) Cooperative Health Care Clinics (CHCCs); and (3) Physicals Shared Medical Appointments (PSMAs). Table 1.1 depicts the unique features of these models. Additionally, there are other less defined and widespread *hybrid* models that are more educationally or psychosocially (as opposed to medically) oriented, are specialized applications of these major models, or are specifically designed to make use of midlevel providers rather than using the patient's own physician.

While DIGMAs and CHCCs are primarily for follow-up visits, DIGMAs are also sometimes used for new patient intakes and non-private physical exams. The PSMA model, as its name implies, stands alone in that it is used for efficient delivery of private physical examinations in primary care as well as the medical and surgical subspecialties. Because they are run like a series of individual office visits sequentially attending to each patient's unique medical needs, the DIGMA and PSMA models have been widely used in fee-for-service (FFS) settings—where they are typically billed by the level of care delivered and documented (except that they are usually not billed for counseling time). Potential billing challenges with the CHCC and hybrid models are discussed later.

DIGMAs and PSMAs: A Series of Individual Office Visits with Observers

The DIGMA model for return visits (and nonprivate exams) and the PSMA model for private physical examinations have emerged as revolutionary access solutions in primary care as well as the various medical and surgical subspecialties. Increased productivity and improved access at both the individual physician and departmental levels are hallmarks of the DIGMA and PSMA models but not of the CHCC model—which does not improve either physician productivity or access to care (although it has been shown to reduce downstream hospital, ED, and nursing home costs, but only for the 15–20 high utilizing, multimorbid geriatric patients being followed). From the patient's point of view, properly run DIGMAs and PSMAs offer patients what they most want—improved access, more time, greater patient education, better continuity of care, a multidisciplinary care team, and the help and support of others.

Table 1.1 Unique features of today's three major group visit models

Primary focus	DIGMA		CHCC		PSMA	
	Follow-up visits (sometimes intakes and nonprivate physical examinations)		Follow-up visits only		Physical examinations (private exams for new and established patients)	
Target patients	Most patients in provider's practice or chronic illness program needing a follow-up visit (sometimes intakes and nonprivate physicals)		Same 15–20 high-utilizing, multimorbid geriatric patients for monthly follow-ups		Most patients in a provider's practice or chronic illness program needing a private physical examination (as well as new patient intakes)	
Same or different patients	Different		Same		Different	
Formal educational presentation	No		Yes		No	
Run like a series of individual office visits?	Yes		No		Yes	
Medical care from start to finish?	Yes		No		Yes	
When do patients attend?	Only when medically necessary		Regularly (typically monthly) whether medically necessary or not		Only when medically necessary	
Ideal group size	10–16 patients		15–20 patients (though fewer often attend)		<i>Primary care:</i> 7–9 males; 6–8 females <i>Specialties:</i> 10–13 patients	
SMA team members	MD, 1–2 nursing personnel, behaviorist, documenter, and dedicated scheduler		MD, RN, or MA, guest speakers as needed		MD, 2 MAs (possibly a nurse as well), behaviorist, documenter, and dedicated scheduler	

Other personnel (in large systems)	Champion and program coordinator	Program coordinator	Champion and program coordinator
Frequency of sessions	Weekly (or twice weekly, daily, etc.)—can be more or less frequent	Monthly (or per best practice guidelines for Specialty CCHC)	Weekly (sometimes twice a week)— can be more or less frequent
Typical length of sessions	90 min	2.5 h (90 min largely educational group, followed by approx. 1 h of individual care for ~1/3rd of patients)	90 min
Unique benefits	<ul style="list-style-type: none">– Improved productivity, access, and practice as well as disease management– FFS billing	<ul style="list-style-type: none">– Reduced nursing home, ER, and hospitalization costs– Intense patient bonding	<ul style="list-style-type: none">– Improved productivity, access, and practice as well as disease management– FFS billing
Drop-in convenience	Yes	No	No
Subtypes of model	<ul style="list-style-type: none">– Heterogeneous– Homogeneous– Mixed	Specialty CCHC (same format, but for medical subspecialties and meets per best practices)	<ul style="list-style-type: none">– Heterogeneous– Homogeneous– Mixed
Medical care provided in group?	Yes (almost all, except private exams and discussions)	No (care is provided individually and in private)	Yes (during interactive segment but no during private exam segment)
Greatest weaknesses	Maintaining census	Being seen as a class <ul style="list-style-type: none">– FFS billing	Maintaining census



Fig. 1.1 DIGMAs and PSMA s are run as a series of individual office visits with observers in a supportive group setting where all can listen, interact, and learn. The physician and behaviorist typically sit next to each other with a small table upon which to place things between them. The author is shown (right front, with back to camera) serving as behaviorist in a large Oncology DIGMA. (Courtesy of American Medical Group Association and Dr. Lynn Dowdell, the Kaiser Permanente Medical Center, San Jose, CA)

Among all group visit models, DIGMAs and PSMA s most resemble traditional office visits (by providing individualized medical care from start to finish and by being run throughout as a series of individual office visits with observers). In DIGMAs and PSMA s: patients only come in when they have an actual medical need; the physician sequentially attends to the unique medical needs of each patient individually; and the physician remains present throughout the entire session. The same medical services, and often more, are provided (history, examination, risk-assessment and reduction, medical decision-making, counseling, treatment, etc.) and a comprehensive and individualized chart note is documented on each patient. The focus, from start to finish, is on the highly efficient delivery of quality medical care through a series of one doctor–one patient interactions in a supportive group setting where all can listen and learn (Fig. 1.1).

How CCHCs Differ

I will be discussing the original CHCC model as it was initially developed by John C. Scott, MD, although some hybrid iterations and specialized applications have followed. Unlike DIGMAs and PSMAs, CHCCs focus upon the same group of 15–20 high utilizing, multimorbid geriatric patients over time. CHCCs typically focus upon high utilizing patients only, as that is where maximum cost offset exists (but only for the 40% of high utilizing, multimorbid geriatric patients willing to make the necessary commitment to attend regularly). Patients come in on a prescheduled periodic basis (not according to actual medical need) and sessions have a more educational structure than traditional office visits.

Whereas as much medical care as possible is delivered in the group setting with DIGMAs and PSMAs, medical care is still provided one-on-one in CHCCs (although, in the individual care segment that follows the group, it is usually provided for only a third or so of the patients in attendance). Although CHCCs and the related Specialty CHCC subtype for medical specialties do not increase physician productivity or improve access to care in physicians' practices, they do provide great care for those 15–20 patients fortunate enough to receive it.

Better Access to Care

Maintaining desired levels of access to both follow-up appointments and physical examinations through use of existing resources represents a significant and ongoing challenge to many integrated delivery systems in today's healthcare environment. All too often, when efforts are made to improve access to follow-up care, physical examinations get pushed out even further—and vice versa. Many group practices and managed care organizations recognize that there is simply not enough money in the system (nor the number of physicians and professional staff available) to hire the required numbers of physicians and support staff to solve existing access, service, economic, and quality of care problems through traditional office visits alone.

For both return appointments and physical examinations, a tool is needed that will dramatically increase productivity and efficiency,

improve access and quality of care, leverage existing resources, and strengthen the bottom line. The improved productivity, efficiency, and access of DIGMAs and PSMAs provide an answer to this conundrum.

Psychosocial Medicine

These group visit models also provide an effective means of addressing the many lifestyle, informational, and psychosocial issues that affect patients' emotional well-being, disease self-management, and quality of life—benefits that are important given the underdiagnosis of depression, anxiety, and substance abuse known to occur in the primary care setting. This is especially important because a large percentage of all medical visits are driven by behavioral health, informational, and psychosocial issues rather than true medical need. Because of the extensive amount of time that patients are able to spend with the physician, the multidisciplinary care team, and each other, they receive a great deal more information about healthy lifestyles, emotional well-being, and disease self-management strategies during each and every DIGMA, CHCC, and PSMA session than could possibly be worked into a relatively brief individual office visit.

Shifting Duties Off of the Physician

While many physicians initially viewed group medical appointments as just another unwanted change in their routine, most now recognize their multifarious benefits and just want to know how to implement them correctly in their practice—which is precisely the focus of this book. Although the group itself provides some efficiency benefits (as repetition can be avoided and sessions can be overbooked to compensate for no-shows), the primary reason that DIGMAs and PSMAs are so efficient is because they shift as much as appropriate and possible from the physician onto a less costly multidisciplinary team. The presence of both a documenter (to assist the physician with chart notes) and a specially trained behaviorist (typically a psychologist or social worker, but occasionally a nurse, diabetes nurse educator,

Pharm.D., nurse practitioner, or other specially trained professional) are hallmarks of the DIGMA and PSMA models.

DIGMAs and PSMAs reverse the trend over recent years of adding evermore responsibilities onto the physician, and instead reduce physician tasks to an absolute minimum by instead placing those duties onto the less costly and specifically trained multidisciplinary team whenever possible and appropriate. Besides the documenter and behaviorist, the SMA team includes nursing personnel, a care coordinator, and often a dedicated scheduler. These personnel leverage the physician's time by enabling the physician to focus on patients and on that which the physician alone can do: to deliver high-quality, high-value, and individualized medical care to each and every patient in the room.

Patient Benefits

As depicted in Table 1.2, DIGMAs and PSMAs offer numerous benefits to patients. DIGMAs and PSMAs are designed to enhance the patient's care experience by providing the benefits of prompt access, more time, *max-packed* visits, and a *one-stop shopping* healthcare experience. The unique healthcare needs of each patient are individually addressed, injections and routine health maintenance are brought current, greater patient education and attention to psychosocial issues are provided, and the helpful support of other patients is built into the care experience—and all this is accomplished by maximizing use of the multidisciplinary team and limiting the use of physician time to that which the physician alone can do.

Despite being a more expensive form of medical care to deliver (due to their additional personnel, promotional, and facilities requirements), these DIGMA and PSMA costs are more than offset by the remarkable productivity gains that these models offer when properly run—as is discussed in the *financial analysis* section of the next chapter. DIGMAs and PSMAs are the right thing to do for our patients because of the multiple benefits they offer. SMAs give patients an additional healthcare choice, one that not only enhances quality, outcomes, and performance measures, but also integrates the help and support of other patients and a multidisciplinary care delivery team into each patient's healthcare experience.

Table 1.2 Patient benefits of DIGMAs and PSMA

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- Prompt access to care
 - Extra time with their own physician and a more relaxed pace of care
 - Max-packed visits, a one-stop healthcare experience, and quality of care benefits
 - They integrate help and support of other patients and a multidisciplinary care team (CCHCs also)
 - Greater information, disease self-management skills, and patient education provided (CHCCs also)
 - More consistent attention to routine health maintenance and HEDIS as well as performance measures
 - Each patient's unique medical needs are addressed individually (commonly in the group setting)
 - Closer follow-up care and enhanced physician–patient relationships (also true for CCHCs)
 - Drop-in convenience (for DIGMAs)
 - Appropriate privacy is maintained at all times, as private time with physician is available as needed (also true for CCHCs)
 - Patients have physician's full attention, as documenter does real-time charting
 - Answers provided to key questions patients might not have thought to ask (because others ask)
 - SMAs provide patients with an additional health care choice
 - Extra services are provided (such as max-packed visits, healthy snacks, after visit summaries, follow-up appointments scheduled, and Patient Packets)
 - Professional skills of a behaviorist to better address psychosocial needs
 - Holistic care—*mind* and *body* needs are met (CCHCs also)
 - Helpful information provided to family members and caregivers
 - More access for poor and underserved patients, and those currently *falling through the cracks*
 - Excellent venue for Medicaid and Medicare patients
 - High patient satisfaction (CCHCs also)
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Physician Benefits

When establishing a new group visit program, great attention must be directed towards extracting every possible benefit from the SMA, especially those most important to patients and the individual physician for whom the DIGMA or PSMA is being customized. By so doing, even initially reluctant physicians will become aware of the multiple physician benefits that the customized DIGMA or PSMA offers—which can range from better managing busy, backlogged practices (and having the opportunity of doing something interesting

and different) to seeing dramatically more patients in the same amount of time and experiencing greater professional satisfaction. Physicians must clearly understand the multiple benefits of running group visits if they are to be expected to fully embrace these models.

Physicians can be reluctant to embrace SMAs at first due to: a variety of personal concerns; a comfort level with the status quo; and sometimes the belief that they have already undergone too much change in their practice. Naturally, such concerns must be balanced against the many real benefits that properly run DIGMAs, CHCCs, and PSMA can offer.

The following are some examples of the benefits of SMAs. Unlike individual office visits, where physicians must do almost everything themselves, DIGMAs and PSMA offer physicians real and meaningful help from other patients and the entire SMA treatment team. Unlike rushed individual visits, SMAs offer a more informative and relaxed pace of care due to the greater amount of time available and their inherent efficiencies. The same information does not need to be repeated to different patients individually, and it can often be presented in greater detail. Sessions can be overbooked in order to nullify potential physician downtime from no-shows and late-cancels. Table 1.3 outlines the many physician benefits that a customized DIGMA or PSMA can offer.

Organization Benefits

Through well-run DIGMAs and PSMA, a healthcare organization can achieve the benefits of increased productivity, improved access, reopened practices, enhanced job doability, the leveraging of existing resources, a stronger bottom line, and more satisfied patients and providers (Table 1.4). Furthermore, happier patients and providers should ultimately translate into retained patients and providers.

The increased productivity and efficiency provided by DIGMAs and PSMA can be used to solve access problems, to enable physicians to better manage their large practices, to better address the needs of the elderly and chronically ill, to reach out to the poor and underserved, and to improve the customer focus of the organization. In addition to the competitive advantage of offering a positive new service, SMAs can also improve the quality of care offered by the organization through greater attention to: routine health maintenance; HEDIS and performance measures; disease self-management skills; psychosocial and lifestyle issues; and prevention.

Table 1.3 Physician benefits of DIGMAs and PSMAAs

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- Effective tool for better managing busy practices and *working smarter, not harder*
 - Dramatic increase in productivity and efficiency
 - Improve access to backlogged practices and chronic illness treatment programs
 - Leverage existing resources to increase productivity by 200–300% or more
 - Improved RVUs, revenues, income, and bottom line
 - Work down and eventually eliminate patient wait lists (without working extra hours)
 - Open previously closed practices
 - Open up more time for surgeries and procedures
 - Eliminate physician downtime by overbooking sessions to compensate for no-shows
 - More time with patients, a more relaxed pace of care, and a reprieve from clinic demands
 - A regular *oasis* in busy workweeks away from normal clinic duties and distractions
 - Real help from the entire multidisciplinary team and other patients (plus team collegiality)
 - Documentation support
 - Follow patients more closely and provide enhanced continuity of care
 - Reduces the repetition of information
 - Efficiently intake new patients, grow a practice, and increase patient panel size (if desired)
 - Reduce clinic time by an hour or so (for desktop medicine or to go home earlier)
 - Get off the fast-paced treadmill of individual office visits
 - Decrease need to work-in or double book patients
 - Reduce patients' phone call volume and complaints about poor access
 - Enhance quality, outcomes, service, and the patient's healing experience
 - Increase attention to patient education and psychosocial needs
 - Better chronic disease management
 - Each group visit is customized to the physician's particular needs and practice
 - Help in optimizing the physician's master schedule
 - Get to know patients better, increase compliance, and improve doctor–patient relationships
 - Effective venue for treating difficult, information seeking, noncompliant, demanding patients
 - A means of efficiently reaching out to the poor, underserved, and Medicaid patients
 - Decrease defect rates (build HEDIS measures and updated health maintenance into SMA workflow)
 - An opportunity to do something different, interesting, and fun
 - High levels of patient and personal satisfaction
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Table 1.4 Organizational benefits of DIGMAs and PSMA

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- Improved access at both individual physician and departmental levels
 - Dramatically increased physician productivity (200–300% or more)
 - Better provider management of busy, backlogged practices
 - Enhanced efficiency, largely through the use of existing resources
 - Potential for containing costs while increasing revenues, RVUs, and the bottom line
 - Quality medical care offering max-packed visits and a one-stop healthcare experience
 - Improved outcomes, health maintenance, and HEDIS/performance measures (CCHCs also)
 - Increased patient education, prevention, and disease self-management (CCHCs also)
 - Important tool for chronic illness population management programs (CHCCs also, but only to a limited degree)
 - Important tool for efficiently and cost-effectively reaching out to poor, underserved, and disenfranchised patients
 - Improved customer focus for the organization
 - Fewer patient complaints about access and reduced phone call volume
 - Greater attention to informational and psychosocial issues that drive many office visits (CCHCs too)
 - The competitive advantage of a new service and an additional healthcare choice (CCHCs also)
 - Ability to reopen some closed practices
 - Often receive important PR from positive mass media reports regarding SMA program
 - High levels of patient and physician professional satisfaction (CCHCs also)
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Interestingly, my experience has been that patients do not abuse the improved access that DIGMAs and PSMA provide. If anything, prompt access appears to reduce utilization, as patients stop making those “*just in case I need it*” appointments they have learned to make because their doctor is typically booked weeks or months in advance.

While they provide a rare combination of benefits that can be extremely beneficial to patients, physicians, and organizations alike, these SMA models clearly cannot solve all of the challenges facing medical groups today (which holds true for other healthcare innovations as well). On the other hand, group visits can be an integral component to new healthcare innovations such as advanced clinic access (ACA), Toyota lean, and the Patient-Centered Medical Home (PCMH)—in which group visits could not only be an access, quality, and satisfaction enhancer, but also an efficiency and economic driver helping to improve productivity and the bottom line.

Group Visit Literature

Because of this multitude of potential patient, physician, and organizational benefits, many articles have already been published on group visits—and this body of literature continues to grow. While this book specifically focuses upon how to best implement group visits in your practice, readers interested in learning more about all aspects of group visits are referred to: the existing published literature (where there are a plethora of articles on group visits, including numerous articles by the author); my 2009 comprehensive medical textbook on the subject, *Running Group Visits In Your Practice*; and to <http://www.GroupVisits.com>.

Topics discussed in depth in the author's earlier textbook include: outcome studies; a more detailed discussion of the major group visit models; potential abuses of group visits; an extensive literature review; and a comprehensive chronic disease management paradigm that makes full use of group visits. This paradigm can be used with equal benefit for virtually any chronic disease, and excels when there are large volumes of patients whose illness needs to be successfully and cost-effectively managed—such as for thousands of diabetic patients.

The author's earlier textbook also contains an attached DVD with not only a medical grand rounds presentation and behaviorist training video by the author, but also examples of all forms and promotional materials necessary to launch a successful group visit program. Interested readers will find this text and attached DVD to be invaluable for implementing a successful group visit program.

Reception in the Popular Press

Group visit programs have created quite a stir in the popular press because of the many patient benefits they can offer. Positive stories have appeared in *Time Magazine*, *U.S. News & World Report*, *WebMD*, *Good Housekeeping*, *AARP's Modern Maturity*, *The Washington Times*, *San Jose Mercury News*, *The Boston Globe*, *Minneapolis Star Tribune*, *The Wall Street Journal*, etc. (to name just a few). In addition, they have been featured both locally and nationally on CNN, PBS, National Public Radio, and numerous other radio and television stations. I believe that this overall positive reception is due

to the consistent emphasis on group visits always being for the benefit of our patients.

There are many reasons that group visits are so patient centered—especially because of the enhanced quality, access, time, education, support, follow-up care, and satisfaction benefits that they offer to patients. I originally developed my two group visit models as a seriously ill patient out of personal frustration with traditional medical care as it was being delivered, and this despite having the best doctors that one could possibly hope to have. I found our healthcare system to be broken, especially in terms of being service oriented and patient centered. It is important that the focus of SMAs always remain on our patients, and that extreme caution be taken to ensure that group visits are never perceived as a means for physicians to extract more money out of patients or to spend less time at work and more time on the golf course—which is how one newspaper editor put it to me.

Creating a Culture of Excellence

Always strive to create a culture of excellence surrounding whatever group visit program you might choose to initiate. I personally feel that sometime in the future, when used to the greatest possible extent, group visits could eventually account for as much as 40–70% of all outpatient ambulatory care—plus make significant contributions to other forms of medical care as well. But this remarkable potential can only be achieved if we do things correctly, design and run our group visits properly, consistently maintain full groups, avoid any potential for abuse, and build excellence into all group visit programs.

To ensure excellence, there are four critical factors one must be certain to design into any group visit program: (1) *maximize quality* through max-packed visits, fully expanded nursing and behaviorist roles, educational handouts, Patient Packets, etc.; (2) *consistently meet census targets* by optimally promoting your DIGMA or PSMA program and inviting all appropriate patients; (3) *contain overhead costs* of the SMA program by using appropriate facilities and trained personnel; and (4) *periodically measure results* on an ongoing basis.

For example, contain overhead costs by not having two providers in the SMA at the same time, lest the productivity gain be cut in half. Avoid having a nurse practitioner as a behaviorist, unless the cost of the NP is clearly assessed to the SMA program by hourly wage and

not by revenues that could have been generated by the NP instead seeing patients in the clinic (which would prove to be an onerous overhead expense).

Try not to settle for less than what is optimal and to do the best you can with available resources. SMAs represent a major paradigm shift from traditional office visits and are something that patients and physicians are as yet largely unfamiliar with. Therefore, many beginners' mistakes can very easily be made when setting them up, especially because they are so counterintuitive. When group visits do fail, inadequate census is almost always at fault (i.e., to ensure economic viability and sufficient group interaction). Therefore, take particular care when designing and promoting your SMA to ensure that you will be able to consistently fill sessions over time. Also, successful SMAs pose a multitude of operational challenges, tend to stress the system and exacerbate any preexisting problems, and have many support requirements (personnel, facilities, promotional, and budgetary) that must be met for full success to be achieved.

Constantly evaluate what you are doing so that you can strive to improve the product that you are delivering. It has never been my intention to convince others to do group visits, especially those who do not have any desire to run them in their practice. I do, however, want to provide the information needed in order to make this decision as to whether or not to run a group visit program. Rather, my intent has always been to convince those who have chosen to start a group visit program to do so correctly—and to show them how to do so.

Because so much good can come out of a well-run SMA program, be certain that your group visits are carefully designed, adequately supported, appropriately promoted, properly run, and thoroughly evaluated on an ongoing basis. Do not: cut corners or fall short on promoting your SMA program; fail to provide the necessary personnel and facilities; launch prematurely without proper training for all involved; or fail to take the necessary precautions to prevent any potential for abuse.

Some Concluding Comments

Although the traditional one-on-one office visit has been the bedrock of medical practice for over a century, it is now being eroded by new forms of medical care that are more efficient, less costly, and better

aligned to the specific needs of patients. Increasingly, patients are being offered a menu of options from which they can choose the particular form of medical care they desire.

The following are but some examples of the types of medical care choices now available. Patients are often able to receive prompt medical advice through 24/7 telephone and email availability of their providers and care teams (including boutique practices). This avoids the scheduling of appointments and offers many advantages: immediate access; no drive time or need to come into the office; no waiting in either the lobby or the examination room; and not being exposed to the germs of many other sick people. The convenience of the highly accessible “*doc-in-a-box*” at your local drugstore or superstore is becoming an option for many patients. Internet-based medicine is becoming the preferred source of information, scheduling, and medical care for many patients and conditions.

This list of choices will continue to grow as we move toward a future that increasingly includes telehealth, automated triage, Web-based care, group visits, and an increasing variety of electronic care options. Although traditional office visits will always have a role to play in medical care, that role is certainly changing and its predominance is decreasing.

Whereas the individual office visit model of care was developed during an era when acute medical care needs were predominant (and prior to the introduction of antibiotics and most of today’s modern therapeutic interventions), we are now in an era of chronic care. The majority of patient demands upon our medical services, as well as healthcare dollars spent, are in the area of chronic disease management. It is with chronic illnesses that group visits truly excel. While the individual office visit model has heretofore predominated in acute care settings, my experience has been that properly run DIGMAs and PSMAAs are equally capable of addressing many acute care needs—and that they are often much better at addressing the multitudinous, complex mind and body needs of our burgeoning geriatric, obese, and chronically ill patient populations.

During this historic focus on acute care, patients were well yesterday, sick today, and dead tomorrow. In today’s era of chronic care, patients were often sick yesterday, are sick today, and will be sick for the rest of their lives. For chronically ill patients, the issue becomes how they can live their lives as fully as possible despite having chronic illnesses. Why would we think that the same model of healthcare delivery would be best in both acute and chronic care situations?

As will be seen in this book, group visits—especially properly run DIGMAs, CHCCs, and PSMAAs (as well as other SMA models yet to come)—offer a practical and refreshing solution to many of today’s healthcare woes, including challenges surrounding treatment of the chronically ill.

Although many view the traditional office visit as the *gold standard* of care and would simply like to maintain the status quo, the unfortunate consequence of this sole focus on individual office visits has been high costs, rushed visits, backlogged practices, beleaguered physicians, increasingly large panel sizes, patient and physician dissatisfaction, and a level of accessibility that is not commensurate with good care—problems that cannot simply be solved by throwing evermore physicians and support staff at them. Group visits provide a refreshing alternative to the individual office visit.

Because they delegate so much to the multidisciplinary SMA team and need to personally do less in the DIGMA and PSMA settings, providers can efficiently see many more patients in the same amount of time—yet emerge after the group session feeling energized rather than depleted. The group interaction they foster enables patients to help patients and reduces the sense of isolation that patients so often feel. Medical patients leave the group visit session recognizing that: they are not alone; their situation could be worse; there is still much they can do which others cannot; and they can build on their strengths rather than perseverating on the limitations imposed by their illnesses.

In SMAs, patients teach each other by exchanging helpful information, sharing personal experiences, discussing successful coping strategies, and providing one another with emotional support. Patients appreciate the extra time with their own doctor, enjoy the opportunity to talk with others dealing with similar issues, and frequently comment upon how they no longer feel alone. Far from ending when the group is over, it is not uncommon to see patients lingering in the hallways, lobby, and even the parking lot as they continue talking with one another.

As you read this book, I would encourage you to think about how you might use group visits as your primary care delivery modality—i.e., rather than as some sort of add-on or extra service that is secondary to individual office visits. All too often, physicians and healthcare organizations alike approach group visits in a very limited way. In so doing, they miss just how broad the application of group visits could be both in their own practices and throughout all areas of the organization.

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