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GROUP MEDICAL APPOINTMENTS
DIGMAs—Physicals SMAs—CHCCs

The Group Medical Appointment Manual First Edition 2007 has been compiled and written by Primary Health Care Resource staff from Northern Health.

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The Group Medical Appointment Manual/resource DVDs/CD are available free of charge to Northern Health staff, physician offices, and associates.

Others may request copies of the resource DVDs/CD for a fee to cover costs of production, shipping and handling. Please use email to request a quotation.

About the Group Medical Appointment Manual

THERE ARE THREE MAJOR Group Medical Appointment (GMA) models developed as options to traditional one to one office visits. The models are—Cooperative Health Care Clinic (CHCC) concept by Dr. John Scott, as well as Drop-In Group Medical Appointments (DIGMAs) and Physicals Shared Medical Appointments (Physicals SMAs) crafted by Dr. Ed Noffsinger. All three models have been used by healthcare systems internationally, to improve access, provide comprehensive chronic disease care, and they receive high satisfaction ratings from patients and providers alike.

This training manual provides information on all three models. Included are three DVDs, specific information on launching each of the Group Medical Appointments types, relevant articles, question—answer sections, and a CD with resource files. Please contact any of the names below for timely permission to reproduce this material.

Before offering Group Medical Appointments, please read this manual, and, if possible, observe a Group Medical Appointment. The DVDs are formatted into chapters/sections for your personal viewing convenience. Training and coaching is available for interested teams.

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Group Medical Appointments — Executive Summary

- **Definition**

  Group Medical Appointments provide usual 1 to 1 medical appointment care but in front of other patients. Other staff participate in roles that ensure the efficiency and success of the group appointments. Group visits have shown to increase patient and physician satisfaction, deliver integrated care that enhances quality, improve access, and leverage physician time and productivity.

- **GMA Models**

  There are 2 major types—CHCCs and DIGMAs, and a sub type of the latter—Physicals SMAs. CHCCs are best suited for up to 20 high utilizer patients (eg. frail elderly). The same group meets monthly for 90 to 120 minutes. DIGMAs last 90 minutes and ideally have a census of 12-16 patients who have routine health issues (eg. chronic diseases) to address. Although it is possible to 'Drop In' to the DIGMA, patients are usually booked in. There are different patients each time. DIGMAs can focus on a single health issue (homogeneous) or any routine reason to see a physician (heterogeneous).

  Physicals SMAs allow for 6-13 specialized and private medical examinations to be carried out one after another at the beginning, with discussion of results taking place within the group setting.

- **What's in it for patients?**

  Patients feel that they have actually spent 90 minutes with their doctor. They never have to wait, they get answers to questions they never even thought to ask, and are supported by others who may have similar health issues. Group visits have been likened to a 'one-stop shopping' healthcare visit. Preference for group appointment visits is routinely higher than 80% by participants.

  All GMAs include a confidentiality commitment. After this, the discussion of most medical issues in front of others is not an issue for patients.

- **What's in it for a physician?**

  For 90 minutes, physicians can focus on being physicians. Other members of the team take care of administrative duties, group dynamics, and other interventions that make for a 'one-stop shopping' experience. Meeting best practice guidelines is relatively easy within this context. Constant repetition of medical advice is rare in group visits..

  It is a serendipitous side-effect that physicians see a 2 to 4 fold increase in productivity for the same amount of time. Access is dramatically improved.

Summary (Continued)

- **What's in it for the support team?**

  Group visits are a practical way to provide integrated health care. Although GMAs are designed to deliver primary medical care, opportunistic input into patients health issues by team members occurs naturally. Many times, program services that require patients to attend another appointment somewhere else can be incorporated into this model.

  Regarding professional satisfaction, GMAs are known to expand the scope of some vocations and encourage the full expression of others.

- **What's in it for Northern Health?**

  Given that integration is a component of sustainable health care, Northern Health is supportive of these models of group visits in terms of sharing staff and in some locations, space.

- **Suggested Reading**

  Understanding Today's Group Visit Models—See Articles Part 1

Group Visit Models at a Glance

	Cooperative Health Care Clinic	Drop In Group Medical Appointment	Physicals Shared Medical Appointment
Acronym	CHCC	DIGMA	Physicals SMA
Developer	John Scott 1993	Ed Noffsinger 1996	Ed Noffsinger 2001
Min/Session	90+60 for private appts	60-90	60-90
Ideal Census	<20	12-16	6-13
Target Patients	High utilizers	Routine follow-ups	Specialty/physical exams
Formal Learning	Yes	Opportunistic	Opportunistic
Support Staff	2-3	3-4	3-5
Support Roles	MOA Nurse Guest Speaker	MOA Behaviorist Nurse Documenter	MOA Behaviorist Nurse (1-2) Documenter
Billable Patients	Most	All	All

GMAs at a Glance (Continued)

	CHCC	DIGMA	Physicals SMA
Frequency	Same patients meet monthly, ranging from several times to long-term	Different patients each time, offered daily to monthly	Different patients each time, offered weekly to monthly
Diagnostic Groupings	Homogeneous	Heterogeneous Homogeneous	Homogeneous
Limitations	▪ Pt preference ▪ Hearing impaired ▪ Dementia	▪ Initial assessm'ts ▪ Pt preference ▪ Complex pro-cedures/exams ▪ Hearing impaired ▪ Dementia	▪ Pt preference ▪ Highly complex procedures & exams ▪ Hearing impaired ▪ Dementia
Improve Access	+	++	++
Pt Satisfaction	++	++	++
⇑ Clinical Outcomes	Yes	Emerging evidence	Emerging evidence
Provider Satisfaction	++	++	++
Basic Format	▪ Social time 10m* ▪ Interactive learning 30m ▪ Group 1:1 routine care 25m ▪ Q/A 20m ▪ Planning next session/close 5m ▪ 1:1 private appts prn 60m *minutes	▪ Pre: V/S, record health concerns ▪ Behaviorist introduction 5m* ▪ Sequential 1:1 appts in front of group 70m ▪ V/S, health maintenance continues by nurse ▪ Behaviorist manages group, documenter records ▪ Wrap-up 5m ▪ Private 1:1 appts prn 10m	▪ Pre: V/S, record health concerns ▪ Behaviorist introduction 5m* ▪ Sequential & private 1:1 exams 40m ▪ During this time, behaviorist engages group in discussion ▪ 1:1 discussion of results/plans in front of group 40m ▪ Behaviorist manages group, documenter records ▪ Wrap-up 5m

How to use the resource manual

Part I

Group Medical Appointments

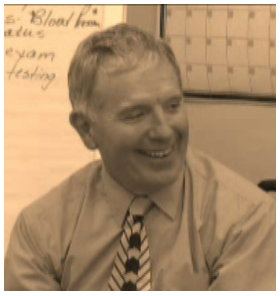
DIGMA and Physicals SMA

DIGMAs

"The efficient delivery of quality medical care to a group of patients in a supportive environment addressing each patient's unique medical needs individually."

Dr. Ed Noffsinger

What are DIGMAs?



DIGMAs (Drop-In Group Medical Appointments) are medical appointments with a patient's physician that take place in a supportive group setting. The model, developed in 1996 by Kaiser Permanente psychologist Dr. Ed Noffsinger, is a combination of an extended medical appointment with the patient's own physician and effective group learning and support. The group consists of the physician, a behavioral health professional, and patients from the physician's panel. **See articles and DVD #1**

DIGMAs are best suited for routine appointments.

Types

There are three types of DIGMAs—

- **Homogeneous:** Patients with the same medical diagnosis (eg. diabetes) attend the group.
- **Heterogeneous:** Patients attend the group for any reason.
- **Mixed:** Physician practice is divided into four large groups (eg. cardiac, diabetes, GI problems, women's' health). Each week of the month a DIGMA is held for one of the groups.

Benefits

There are several potential benefits of DIGMAs—

- Improved access and productivity
- Increased patient satisfaction
- Increased professional satisfaction
- Efficient way to meet clinical guidelines
- Greater attention to psychosocial issues
- Support from other patients

DIGMAs (Continued)

Limitations

There are some limitations to DIGMAs—

- Patients who need detailed examinations are better seen individually.
- 10 to 20% of patients who have experienced a group medical visit prefer individual office visits
- DIGMAs might be suitable for initial consultations or initial evaluations **(See Physicals SMAs pg. 1-5)**

Team

There are some key roles that make up the ideal DIGMA team. (**See Team Roles pg. 1-9** for more information on each of the team members.)

- Physician
- Behaviorist
- Nurse
- Documenter
- Office 'Champion'

Equipment

The equipment that is necessary to conduct a DIGMA—

- Room large enough to hold 12-20 patients with exam rooms close by
- Patient package **(See Part IV for Resources, etc.)** that includes a 'welcome' letter from the physician, confidentiality agreement, session evaluation, patient education material, DIGMA/GMA pamphlet, blank paper for making notes, and anything else the team may want to include
- Flip Chart/felt pens/pens or pencils
- Coffee/tea/water/sugar/milk/napkins/cups/plates
- Snacks
- Small table
- Clock
- Hand sanitizer
- Nursing equipment (BP cuff, vaccines, syringes, weigh scale, tape measure)
- Computer for electronic medical recording
- Foot check kit (10G monofilament, alcohol swabs, sanitizer wipes, gloves, long shoe horn, screening form, patient handouts **See Resource CD**)
- Other physician specific examination equipment

DIGMAs (Continued)

Census

TIME Nov 10, 2003
The Semi-Private Checkup

The VA medical center in Bay Pines, Florida introduced group appointments in 2002 as a way to combat a backlog of 17000 patients waiting to be inducted into its primary care system. Today that list hovers about 100…and the model is being extended to VHA centers across the country.

DIGMAs are designed for 12 to 16 patients seen over a 90 minute period of time. Overbook the groups by at least 1 to 2 patients to account for no-shows.

***Note**: It is important to maintain a minimum census for economic and group dynamic reasons.*

Patients to include

The types of patients that would benefit from DIGMAs are—

- Routine follow-up care
- Relatively stable chronically ill patients
- Difficult or problematic patients
- Patients willing to attend

Patients to exclude

The patients who may not benefit from DIGMAs are—

- Patients requiring a translator
- First time consultations
- Patients with dementia
- Severely hearing impaired
- Acute infectious diseases
- Medical emergencies
- Complex medical procedures
- Patients refusing to attend

DIGMA session

The group session characteristics are—

- The sessions are scheduled for 90 minutes.
- Medical care is given as in individual office visits. Most exams are done in the group.
- No formal education class is held in the group. Education is opportunistic, done in the context of the doctor working with the patient.

DIGMA Flow

- Patients register in the physician's office.
- Patients are given the 'patient package' and are asked to sign the confidentiality agreement.
- Before the group begins, the nurse begins to take patients one at a time to take vitals, immunize, and do other required nursing functions. The nurse continues to see the patients once the group starts, until they are all seen.
- Before the group begins, the behaviorist writes down on flip chart paper next to the patient's name, the 1 or 2 concerns he/she would like the doctor to address.
- The flip chart with the patients' concerns is posted on the wall opposite the doctor. The doctor uses the information on the flip chart as a cue to a patient's presenting problem.

Dr. Jones did a DIGMA, not because he wanted to, but to stop Ed Noffsinger from constantly asking…

We had 16 patients for the first time and they were pouring out their hearts. But Dr. Jones was twiddling his thumbs, looking at the ceiling, as if he couldn't be less interested.

This was not going well.

But then we got to the 3rd women from the end and she looks at him and says, "Dr. Jones, I just want you to know every night I pray for you...I pray that God will give you the courage, strength, and wisdom to help the many people whose lives you affect every day, that you can help them as much as you have helped my husband and I."

When she was done he had a tear coming down his cheek…you could tell there was something about this process that he liked…now it's 8 years later and he still does it and loves it.

From These Things Change You
DVD #1 A Model For Our Time

- Patients are seated in a circle.
- The behaviorist begins the group with an introduction.
  See DVD #2 *'The Speech'*
- The physician enters the room and sits next to the behaviorist.
- The physician starts by seeing the patients who need to leave early.
- Medical exams, history taking, and medical decisions are mostly done in the group.
- The documenter charts during patient care delivery.
- The physician checks the chart note after each patient.
- The behaviorist facilitates group discussion when the physician is either checking the documentation or is out of the room.

What are Physicals SMAs?

"The Physicals SMAs can be viewed as a series of doctor/one patient physical examinations that occur one after the other (ie. in both the exam and the group room), with the added benefits of the behaviorist and the group itself."

Dr. Noffsinger

What are Physicals SMAs?

The Physicals Shared Medicals represent a series of doctor/one patient encounters within a group setting. This model, developed in 2001 by Dr. Ed Noffsinger, refined the original shared appointment concept to include physical examinations of all types.

During the first half of a Physicals SMA, all physical exams are performed in private. Typically, the actual examination takes just a few minutes per patient. During the second half, all the discussion is brought to the group setting so that all may listen and learn from what is being said. Excepted are findings that appear ominous or may make the physician or patient uncomfortable (**See *Ominous Finding* DVD #1**). This format significantly reduces the need for repetition by the physician.

Types

There are different types of Physicals SMAs—

- **Homogeneous**: Patients with similar diagnoses.
- **Heterogeneous**: Patients requiring **physicals** for a variety of reasons (eg. new patients).
- **Mixed**: Physician/specialist practice is divided into four large groups (eg. cardiac, diabetes, GI problems, women's health). Each week of the month the team has a SMA with one of the groups.

Team

The ideal Physicals SMA team consists of—

- Physician
- Office 'Champion'
- Documenter
- 1 or 2 (preferable) Nurses
- Behaviorist

Physicals SMAs (Continued)

Benefits

The benefits of Physicals SMAs include—

- Improved access to physical examinations in primary and specialty care through the use of existing resources
- Support from other patients
- Increased patient self-management
- Increased provider and patient satisfaction

Patients to Exclude

There are some patients who would best be seen for an individual physical exam appointment.

- Patients requiring a translator
- Patients with dementia
- Severely hearing impaired
- Acute infectious diseases
- Medical emergencies
- Complex medical procedures
- Patients refusing to attend

Equipment

The equipment needed for a Physicals SMA includes—

- Space to hold 6 to13 patients with 2 to 4 examination rooms nearby
- Patient packages which may include a program pamphlet, confidentiality agreement, session evaluation, a list of resources, educational material, a cover letter from the physician, a detailed health questionnaire, required lab requisitions
- Flip chart/felt pens/pens or pencils
- Coffee/tea/water/sugar/milk/napkins
- Cups/plates
- Snacks
- Hand sanitizer
- Nursing equipment (BP cuff, vaccines, syringes, weigh scale, tape measure, foot check kit **See pg. 1-2**)
- Computer for electronic medical recording
- Other physician specific examination equipment

Physicals SMAs (Continued)

Census

The census in a Physicals SMA depends on the type of group.

- Gender specific examinations usually have from 6 to 9 patients.
- The census in medical subtypes (eg. prenatal patients, patients requiring hip replacement) is often larger, usually between 9 and 13 patients.
- Patients can either be new or existing patients.

Key Points

- All private components of the physical exam are completed in the exam room.
- The verbal dialogue in the private exam is limited to what is needed to complete the exam.
- The rest of the discussion is conducted in the group setting where everyone in the group can listen and learn from what is being said.
- The physician addresses the needs of each patient but with the added help of the behaviorist and the other patients.

Physicals SMA Flow

Pre-Registration

- Patients register in advance with the office.
- Clerical staff mail out patient packages 2 to 4 weeks prior to the group visit. Patients are instructed to complete the enclosed forms as soon as possible and return them to the office. They are also asked to have the required lab work done prior to the group visit.

"In Physicals SMAs, the physician only needs to say things once, but often in greater detail, to all patients, rather than repeating the same information to different patients in the exam rooms. Patients benefit even further by talking to one another and hearing the answers to questions that may not have occurred to them or that they may be reluctant to ask."

Dr. Ed Noffsinger DVD #1

Physicals SMA Flow (Continued)

The Physical Exam Component
■ Patients are roomed in all the examination rooms one after another. ■ The nurse takes the vitals, performs special exams (such as immunizations and foot exams), makes entries in the patients chart, and prepares the patient for the examination. ■ The physician examines the patient and limits the conversation to what is needed to complete the exam. ■ The physician and/or nurse, etc., documents on the patient chart after each exam. ■ Other patients remain in the group with the behaviorist. ■ The entire physical exam component is expected to take between 30-45 minutes.
The Interactive Component
■ This segment lasts 45 to 60 minutes. ■ The physician and behaviorist are in the group with the patient. ■ The physician works with each patient individually, reviewing the examination, addressing medical/health concerns, and providing health information. ■ Group discussions are stimulated by patients' questions, health concerns, and suggestions from other patients. ■ The documenter records on the patients' charts. ■ The visit ends on time. The physician leaves while the behaviorist stays until all the patients have left.

Team Roles

All Shared Medical Appointment models utilize a team to perform certain roles. Generally speaking (physician excepting), these roles are not necessarily dependent on a providers professional background.

Office 'Champion'

This role is assumed by one or several individuals who enthusiastically promote group visits with patients and coordinate the details that ensure successful group visits. MOAs, office assistants, or office nurses can function in this role.

Prior to the GMA, the 'Champion'—

- Invites patients to the group, registers patients for the SMAs, helps with putting together patient packages, mails patient packages (for Physicals SMAs), gets name tags ready, pulls patient charts, monitors the group census.

The day of the GMA the 'Champion'—

- Along with the team, ensures the room is ready (eg. the chairs are set up, coffee, tea, water, and snacks are available, flip chart is the room, and patient charts/EMR summaries or flow sheets are ready).
- May be involved in registering patients and handing out patient packages.
- Helps with clean up after the group.
- Participates in a short debriefing after the group.

Documenter

MOAs, office assistants, or other health care providers (eg. pharmacist, medical student, nursing student) can function in this role. The documenter—

- Checks that the computer is functioning and is familiar with the EMR being used.
- Along with the team, may ensure the room is ready (eg. the chairs are set up, coffee, tea, water, and snacks are available, flip chart is the room, and patient charts or flow sheets are ready).
- Documents notes on each patient for the physician.
- Participates in a short debriefing after the group.

Team Roles (Continued)

Nurse

Nurses, nursing students, or medical students can function in this role. Duties include—

- Taking vital signs, immunizing, doing foot exams, rooming patients, and any other functions the physician would like the 'nurse' to perform.
- Arriving 15 to 20 minutes before the group is to begin.
- Taking patients one at a time as they arrive and measuring their vital signs, etc. until all are seen.
- Recording on the patient chart, the flow sheet, or reporting information to the documenter to record.

Physician*

*Group Medical Appointment models can be used by any provider who can independently deliver patient care.

Mackenzie's MasterCard Moment

We managed to get a fellow to our DIGMA who had difficulty making doctor appointments due to working out of town. He did get his lab work done and it turned out his numbers were the highest in the group. The group pointed this out and the man admitted that he ran out of his medications 3 months ago. Before the nurse or doctor could address this the group started to talk about how important it is to take the medications and how much better they feel when they take their medications and how good their blood sugar results are when they take their medications.

These comments were well received by the fellow and he asked lots of his own questions to the group. After the group visit the fellow went to the pharmacy to have his medications filled. He returned to the doctor's office later in the day to show us how he had his medications blister packed to help him to remember to take them and when to get refills. He was quite pleased that he had made that change and positive that this would be the tool to help him get his numbers down.

DIGMA folders $1.00—Coffee and Snacks $20—Visit time 90 minutes—Mr. D understanding he needs to take his diabetes medication regularly—P R I C E L E S S ! Deb Lewis RN

The models are designed to allow the main provider to focus on the kind of care he/she is uniquely qualified to do.

Physician duties for the GMA include—

- Arriving on time or several minutes after the session begins.
- Delivering usual medical care but in front of other patients.
- Using the delivery of care time to educate and inform.
- Reviewing chart notes beforehand.
- Addressing concerns or examinations that should be dealt with in private near the end of the SMA.
- Leaving on time.
- Participating in a short debriefing after the group.
- Participates in choosing educational materials.

Team Roles (Continued)

Behaviorist

Please see *The Behaviorist Role* DVD #2 and Part II about this role. Highlights are included here.

Many different providers can function as behaviorists—

- MOAs
- NPs, RNs, LPNs
- Social workers
- Mental health workers
- Medical students
- Nursing students
- Clinical educators

The behaviorist role is very active—

- Manages the group dynamics
- Keeps the physician on time
- Deals with psychosocial issues
- Facilitates group discussion

Behaviorist duties during the group visit include—

- Arriving 15 to 20 minutes early and meets patients as they arrive.
- Recording each patient's 1 or 2 concerns on flip chart paper.
- Beginning the group on time with an introduction speech
- Staying after the session ends to deal with any minor patient concerns.
- Participating in a short debriefing after the group.

Question—Answer

What are GMAs?

GMA is an acronym for Group Medical Appointment. There are three types of group appointments—

- Drop-In Group Medical Appointments (DIGMAs)
- Physicals Shared Medical Appointments
- Cooperative Health Care Clinics (CHCCs)

What are some of the benefits of GMAs?

Some of the benefits of group visits are—

- Increased productivity and reduced access times
- Increased patient satisfaction
- Increased professional satisfaction
- Improved ability to meet clinical guidelines (influenza vaccines, foot checks, lab tests, etc.)
- Greater attention to psychosocial issues
- Support from other patients in the group, often with similar concerns

Is confidentiality an issue?

Contrary to intuition, confidentiality has not been an issue whether in **urban** or **rural**, even military settings! Patients are made aware in advance that they will be participating in a Group Medical Appointment. Promotional material is clear that routine, individual medical care will be given in front of others. Further, all participants sign confidentiality agreements prior to the GMA. The behaviorist discusses the agreement at the beginning of each group appointment.

What do you need to consider when designing group appointments?

When designing GMAs one should—

- Use professional looking patient education/ promotional material
- Improve quality by fully utilizing the role of the nurse and behaviorist, thereby, “max-packing” the visits
- Ensure there are adequate numbers to fill the groups
- Decide on what results to measure **See Part 4 *Evaluating…***

QA (Continued)

How long are group appointments?	GMAs should start and end on time and usually last 90 minutes.
Do patients find it acceptable to receive their medical care in a group?	80% or more of the patients who have attended a GMA rate it very high and will return as a preference. Approximately 1 in 20 patients do not like the group appointment experience and choose only individual office visits.
Do group appointments take the place of individual office visits?	GMAs are complementary to traditional office visits. Patients who require lengthy physical examinations or procedures, patients facing ominous diagnoses, etc, and patients not willing to attend a GMA are best seen in an individual visit
What if a patient has an issue he/she feels uncomfortable discussing in the group?	If there is an issue that either the patient or physician is uncomfortable discussing in the group, time is left at the end of the group visit to see the patient in private.
How are group appointments different from group support or education sessions?	GMAs are not to be confused with support groups or educational sessions. During a GMA, the focus is on the patient receiving his/her medical care as they would in a one-to-one visit, but in front of a group.
How does education occur in Dr. Noffsinger's group visit models?	There are no pre-planned education presentations for DIGMAs or Physicals SMAs. Rather, the education is done in sound bites in the context of working with an individual patient. It seems that, in the end, everything gets covered that would have been covered in an education session.
Is there a way to include guest speakers in GMAs?	Guest speakers can be invited to give 20 to 30 minute presentations either before, but preferably after the medical care has been delivered. It is not recommended that they give their presentation during the 90 minute appointment because it takes away from the time the doctor has with his/her patients.
How do you account for the no-shows?	Always overbook the GMA by 1 to 2 patients to account for the no-shows.
What if a patient needs to leave early?	Let the patient know that he/she will be one of the first patients to be seen.

QA (Continued)

What happens if the physician receives an emergency call during an group visit?

In case of an emergency call—

- The physician leaves to address the emergency and the behaviorist takes over. The group resumes when the doctor returns.
- In the unlikely event that the physician needs to leave for an extended period of time, the behaviorist can notify the group and re-schedule.

What happens in a typical Physicals SMA?

In a typical 90 minute Physicals SMA—

- Patient packages are sent out 2 weeks prior
- Patients return the completed forms and have their lab tests done
- Exams are done in the first half of the visit while the behaviorist manages the group
- The second half is a group visit where all the discussion occurs

What kind of exam is done in the Physicals SMA?

The patient receives the same exam he/she would in an individual office visit except for the discussion, which is done in the group setting. Conversation in the exam room is limited only to what is needed to perform the physical exam.

Group census is dependent on the type of physical exam being conducted.

How do you match a behaviorist with a physician?

Suggestions to match a behaviorist with a physician—

- A physician who is organized and has good time management skills can have a behaviorist that is “warm and fuzzy”.
- A physician, who has difficulty with time management, needs a behaviorist that manages time well.

Do patients introduce themselves at the beginning of the session?

No. Having each person introduce themselves takes too much time from the visit.

QA (Continued)

Does the behaviorist review the rules of group discussion?

In DIGMAs and Physicals SMAs, the behaviorist does not spend time discussing these. Group dynamic issues are handled as they arise.

How do you deal with the patient who likes to dominate the group?

The doctor begins with the patient next to the one who tends to dominate, then proceeds in the opposite direction so that patient is seen last. Should that patient feel that he/she needs more time, the behaviorist can suggest returning to another session so more of the concerns can be addressed.

How do you deal with the quiet, shy patient?

Ask the patient if it is okay to go to the next patient and come back to him/her later. Sometimes having others speak first make him/her feel more at ease.

How do you deal with too much interaction in the group?

The behaviorist steps in and directs the interaction to the critical areas that need to be addressed in the group. Often too much interaction is driven by a dominating patient.

How do you address depression?

Normalize it as much as possible. Talk about it being a normal part of dealing with a chronic illness but that there are things that can help.

How do you promote Group Medical Appointments?

There are things you can do to promote GMAs—

- Send out a letter of invitation signed by the doctor.
- Hang a large plaque in the waiting room and wall posters in each of the exam rooms.
- Have patient fliers available for patients in the waiting room.
- Personal invitations from all office personnel and from the physician.
- Mention that it will be fun, an opportunity to spend 90 minutes with the doctor, and a chance to meet other patients with similar problems or concerns.

What is W.I.I.F.M.?

This is an acronym for **W**hat's **I**n **I**t **F**or **M**e. Pronounced *WIH-fem.* To increase patient acceptance of an unfamiliar office visit paradigm, Dr. Noffsinger suggests promoting the benefits of GMAs, especially as part of the behaviorist's introduction.

QA (Continued)

How far can you deviate from the GMA models described in this guide?

Following a model that ensures a consistent product or outcome is commonplace in business and healthcare. Regarding the former, it is the basis for all fast food establishments, big box stores, and many franchises. As for healthcare, it is called following protocols. This principle seems to apply to a subjective 'product' such as delivering health care to groups.

Over the past several years, groups have been tried where physician and other health care professionals were co-located. Patient interest was usually high initially, then waned. Teams found it onerous. Only group visits that closely resemble the GMA models described herein have come close to sustainability.

Following might be considered key attributes of successful Group Medical Appointments—

- Statement of purpose or goal
- Adequate support team
- Behaviorist or equivalent
- Main focus—the delivery of quality medical care
- Adequate census
- Opportunity for peer learning and support
- Enthusiastic staff and organized marketing effort
- Structured agenda

GMAs can be customized in the following areas—

- Patient group type and maximum census
- Team composition and duty limits
- Duration of visit and frequency of sessions
- Parameters selected for evaluation
- Contents of patient binder
- Limits on what is shared, shown, or examined
- Handling of group dynamics
- Minor changes to agenda

What advice would you give a physician considering offering a GMA?

- ***G****et* excited about having fun and being compensated at the same time.
- ***M****ove* as much care as possible to the group setting.
- ***A****ttract* enough patients to make the group visit efficient and fun.

Understanding Today's Group Visit Models

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Today's rapidly changing and highly competitive health care environment, with increasing patient demands for expanded services at reduced rates, requires health care organizations to look for innovative ways to improve service and quality of care while reducing costs. Different group visit models have been developed as an effective means of simultaneously achieving these complex objectives through the use of existing resources. Unfortunately, this has resulted in some confusion as to what the various group visit models are and how they differ. Nonetheless, experience with group visits to date, as well as the data that has been collected, are both exciting and encouraging. This article discusses the multiple advantages that group visits offer; how they can best work together with individual office visits; the different basic models of group medical visits that currently exist, how they differ, and what their respective strengths and weaknesses are; what the future looks like for group visits; and how these group visit models might best work together to produce even greater efficiencies than any one model alone could provide.

We invite physicians, administrators, and health care organizations to take a closer look at group medical visits and see what they can do for you. Many physicians and administrators are coming to the conclusion that the current paradigm of individual office visits alone is economically unsustainable. There simply isn't enough money in the system to throw enough physicians at the current access, service, and quality of care problems to solve them through traditional means. What is needed is a tool for leveraging physician time and increasing both efficiency and production while improving service and quality of care. The authors feel strongly that properly run group medical visits can provide this much needed tool.

DIFFERENT GROUP VISIT MODELS HAVE BEEN DEVELOPED AS AN EFFECTIVE MEANS OF SIMULTANEOUSLY ACHIEVING COMPLEX OBJECTIVES THROUGH THE USE OF EXISTING RESOURCES.

There are currently two major group visit models that have been developed—one that is patient focused and another that is physician focused. The first was the result of pioneering work that was begun in 1990 in the Cooperative Health Care Clinic (CHCC) at the Kaiser Permanente Medical Group in Colorado,[1] a model that focuses on patient populations. Although the CHCC model initially focused on patient populations by utilization behavior (i.e., high utilizing geriatric patients), it was later extended to various specific patient populations by diagnosis (i.e., Specialty CHCC groups). The Specialty CHCC model serves as the foundation upon which to base high-risk patient population management programs (i.e., diabetes, asthma, hypertension, hyperlipidemia, congestive heart failure, depression, anxiety, irritable bowel, chronic fatigue syndrome, fibromyalgia, headache, etc.). The CHCC model was designed to provide adequate time to deliver the quality of care that all physicians know they should deliver. The therapeutic benefit of the group dynamic; enhanced physician and patient satisfaction; better patient outcomes; reduced hospital, emergency room, and nursing facility utilization; and lower costs were happy consequences of adequate time for well-trained physicians to practice their art.

The second major group visit model, the Drop-In Group Medical Appointment (DIGMA) model was originated by Dr. Noffsinger in 1996 at the Kaiser Permanente San Jose Medical Center.[2] The DIGMA model has an entirely different focus. Rather than focusing on patient populations either by utilization behavior or by diagnosis, the DIGMA model focuses upon the entire patient panel of the individual physician and is open only to patients from the physician's own panel. The DIGMA model was designed to accomplish the following: to improve access for patients on the physician's panel; to leverage the physician's time and increase productivity so that the physician is better able to manage his or her increasingly large patient panel; to improve quality of care by providing closer follow-up care and by better attending to the mind as well as body needs that patients bring to their medical visits; and to increase both patient satisfaction and physician professional satisfaction.

Advantages of Group Visits

Many physicians feel that the traditional office visit model is the best form of care and would therefore like to maintain the status quo. Unfortunately, their patient panel sizes are now so large that schedules are backlogged, waiting lists are common, patients are unable to get timely appointments, and there is a poor level of accessibility that is not commensurate with good care.

Group visits can offer a tool that will enable physicians to leverage their time and to "work smarter, not harder."

Group visits can offer many benefits for physicians and their patients. For example, group visits reduce the sense of isolation that medical patients often feel by integrating into their medical care the encouragement and support of other patients. Patients also gain a more balanced perspective because they realize that, in comparison with others in the group, things could be worse, there is sill much that they can do which others cannot, and they can build on their strengths rather than just dwelling on their illness and disability.

For many, group visits reduce the stigma of illness through the emotional support of others, including those who are similarly afflicted. Often, patients will state how much they have been wanting to talk to someone else who is experiencing the same health problems, but never knew anybody until they attended the group. They comment on how much they appreciated the group for providing the opportunity to finally meet and talk to such a person.

Unlike individual office visits, where physicians have to do everything themselves, in group visits they have the help of other patients as well as of support staff (e.g., the behavioral health professional in the DIGMA model, and the nurse, pharmacist, health educator, etc. in the CHCC model). In group visits, patients teach patients by discussing successful coping strategies, sharing personal experiences, and providing much helpful information. Unlike rushed individual visits, the pace of group visits is generally more relaxed due to the great amount of time allotted for each session.

It is important to note that group visits are meant to work in conjunction with the judicious use of individual office visits and not to completely replace them. Both group and individual appointments have their respective advantages and disadvantages, and neither is best for all situations and circumstances. In this article, we will discuss the advantages and disadvantages of the different major group visit models, and how they can work together and with individual office visits to provide optimal value through reduced cost and improved, integrated care.

These alternate delivery modes use group doctor office visits of various types for specific patient populations as well as for the physician's entire patient panel. There is evidence not only that it works, but that it actually works better for a large percentage of patients than the current one-on-one office visit paradigm. We will present three group visit models of care that have been demonstrated to increase patient and physician satisfaction, deliver enhanced quality of care, improve access, and cost less than the current individual office visit model. These are (1) Cooperative Health Care Clinics (CHCCs) in geriatrics, (2) Specialty CHCCs, and (3) Drop-In Group Medical Appointments (DIGMAs).

CONFIDENTIALITY, ALTHOUGH AVAILABLE IN THE ONE-ON-ONE TIME, IS A NON-ISSUE, AS PATIENTS FEEL THE SUPPORT GROUP FUNCTION OF CHCC IS "STRONGER THAN FAMILY."

Each model, though directly concerned with patient care, has a slightly different philosophical underpinning. The CHCC is primarily for the benefit of the patient. The DIGMA's primary goal is to improve access and help the physician better mange his or her large panel of patients. The Specialty CHCC groups are for the primary benefit of the organization as a whole.

CHCC Model

This model is targeted at high-utilizing seniors who either come in or contact the system twice a month or more. They are over age 65 and therefore usually multimorbid. Patients are identified by administrative data and are grouped by physician. If the physician is willing to undertake a CHCC, invitations explaining the CHCC concept and process are sent to the target population.

Nine years of consistent experience has taught us that 40 percent will accept enthusiastically, 20 percent will demure, and 40 percent will decline to participate. A recent two-year, randomized, controlled clinical trial sponsored by the Robert Wood Johnson Foundation clearly shows that the target population is that 40 percent who unequivocally accept. Group size is set at 20 to 25. Participating physicians were surveyed on the issue of group size and the consensus was that groups larger that 25 lose the group dynamic and personal interaction which are key to their success, and groups smaller than 15 require too much energy from the physician and nurse to keep discussions lively. In addition, groups smaller than 15 start to lose the up-front cost benefit to the organization. Groups meet once a month on a regular basis—same time, same place. The same group of patients is invited to attend each month, although new patients are added as group members move, change health plans, or die. Daylight hours are essential for geriatric patients due to nearly universal problems with driving in the dark. Two-and-one-half hours are set aside for each CHCC session. Group time comprises 90 minutes, followed by an hour for one-on-one patient-physician visits as needed. This involves an average of six to seven patients seen after each group session.

A Typical CHCC Session

The group session has five key components:

Socialization Time: Each session begins with 10-15 minutes of organized or spontaneous socialization.

In the first few sessions, reminiscence therapy techniques are used to help build cohesiveness of the groups. Questions like, "What was Christmas Day like when you were 10 years old?" or "What was your most memorable trip?" are passed around the U-shaped seating arrangement for optional responses. The communality of experiences that this process elicits helps build the foundation for communications around specific diseases, coping skills, and emotional support that evolves quickly in every group. As time goes on, the socialization time becomes more informal, e.g., vacation stories or even jokes. Formal or informal, the focused group interviews done after seven years of CHCC experience tell how important this process is. Patients describe the group as a stronger support system than even family.

PATIENT SATISFACTION AND COMMITMENT TO CHCC TRANSLATES INTO MEMBERSHIP RETENTION THAT IS MORE THAN DOUBLED WHEN COMPARED TO SENIORS NOT ATTENDING CHCCS.

Education Time: Roughly the next half hour of group time is given over to education. During the first year, there are certain core topics that are delivered to every group. These are advanced directives, health maintenance requirements, use of the emergency system, Medicare coverage, and long-term care. Later the topics are selected by the groups and range from safety in the home to cardiovascular signs and symptoms in the elderly. Educational sessions are interactive rather than didactic. For example, the physician might ask, "Has anyone in the group ever had a heart pain?" Usually three or four hands go up and those folks are asked, "What was it like?" or "What did you do?" Following several descriptions, the physician elaborates on key points or fills in the blanks. Not only is information conveyed, but also the patients are validated as reliable sources of information for each other.

The Break: Next comes the most active and most essential part of the group session, inappropriately referred to as "the break." During this 15-20 minute segment, the physician and nurse position themselves at opposite sides of the U-shaped seating arrangement and address multiple issues presented by members of the group. Blood pressure levels are monitored, prescriptions are refilled, forms are filled our for everything from durable medical equipment to parking stickers, immunizations are given as needed, and "oh, by the way, doc" issues are addressed. Everyone gets the opportunity for one-on-one contact with both health care professionals. Those who do not actively engage with the provider interact with each other while enjoying snacks, which designated group members provide for each session.

Questions and Answers: This working break is followed by a question and answer period that again is very interactive and subjects may rage from topics presented that day to the latest media medical stories. Often one question will trigger a series of questions and multiple facets of complex issues are addressed.

One-on-one Physician-Patient Time: It is critical in describing the CHCC model to include the one-on-one physician-patient time that occurs after the group visit time. Six to seven patients are seen after each session, about half for intercurrent illnesses or flares in chronic conditions, and about half for health maintenance (e.g., physical exams, routine checks on diabetes or heart disease, etc.). On average, each patient is seen about four times a year in this individual setting.

Strengths of CHCCs

CHCC is a care delivery system that is entirely voluntary for both patients and staff. It is both efficient and effective, while at the same time it enhances quality of care and the satisfaction of all participants. In focus group interviews, patients tell us that this format improves the doctor-patient relationship, is far superior to the usual patient education formats, gives them an opportunity to get all their questions and issues addressed, and makes them feel that they are capable of coping with their various medical issues. Confidentiality, although available in the one-on-one time, is a non-issue, as patients feel the support group function of CHCC is " stronger than family." This patient satisfaction and commitment to CHCC translates into membership retention that is more than doubled when compared to seniors not attending CHCCs. This format is not just good medicine, it is good business.

Perhaps the greatest strength of the CHCC model is that it is evidence-based. The outcomes of improved independence and functional ability, improved perception of quality of life, fewer hospital days, and less ambulance and emergency room use are significant and reproducible. In these days of cost-conscious medical care, the cost-effectiveness of CHCCs cannot be overemphasized.

Weaknesses of CHCCs

The financial success of the CHCC model depends upon major savings in "big ticket" items such as hospitalization and ER use. It is only dramatically economically successful in an integrated system of care—at least as the world of medicine is currently constituted.

The CHCC model requires constant monitoring and coaching to be sure that it remains an interactive care deliver process and does not become a "class," i.e., purely educational. We have found that even well-intentioned physicians left to their own devices often slip into the role of authority figure and professor, roles that are much more comfortable for many than the role of facilitator in an interactive process.

To do a CHCC group well probably requires more up-front skill building in the area of group process than we have been able to provide. As mentioned above, it also requires coaching and monitoring. One person could provide these services for a minimum of 40 groups (our experience) and perhaps up to 100.

A major hurdle for the CHCC model is the fact that its benefits are invisible to the staff in the clinic providing the care. Nursing staffs are stretched to the breaking point providing same-day access for a myriad of minor complaints that must be addressed in the service-quality imperatives of managed care. Frontline nursing supervisors are faced with the here and now issues of same-day access, unscheduled walk-in patients, and emergency care. Although aware of the long-term favorable results of the CHCC model, staff is frequently diverted to more visible demands. High level administrative support for CHCCs, even when present, is not enough. Dedicated nurse support is a necessity.

The Future of the CHCC Model

The future of the CHCC model looks bright. Reflect at first only on the geriatric population. This population, currently about 12 percent of the whole, will double in the next 20 to 30 years. It does and will control the majority of wealth in the country and thus, for better or worse, will influence health care policy in Washington. Medicare will not be allowed to languish and seven-and-a-half-minute doctor visits—long predicted, currently not uncommon, and surely the scourge of the future—will not be tolerated even under the flags of "computer-assisted quality time" or "institutional memory." People want to talk to doctors about aging, death, and dying. *www.death.com* will not suffice for the aged of today, or for their children and grandchildren.

The same is true for virtually every chronic disease, regardless of the age group. People have thoughts, beliefs, fears, and expectations about their medical issues that cannot be bundled into simple guidelines and checklists. These human reactions to illness are often the major determinants of outcomes, regardless of "prescribed" interventions. It takes time to deal with these issues. CHCC provides both the time and the environment. The current one-on-one, doctor-patient paradigm is not only economically unsustainable as a sole delivery system, but it lacks the power of the "therapeutic benefit" of the group dynamic.

Two challenges loom for CHCC. The first is data entry and retrieval in the computer age. The current CHCC model features patients sitting with their medical charts in front of them. Notations are made in the chart both during and after the group session. The transition to the all-computerized medical record will require new formats for the transfer of information. The second challenge for CHCC is securing a CPT code. The process can be long and arduous and must include safeguards against abuse.

Specialty CHCC Groups

The CHCC model of care is adaptable to a large number of diseases and patient populations. In some instances, the emotional support provided is less important than the educational component. Thus, hypertension groups for working age adults meet only twice a year, while diabetic groups might meet for four to six intense education sessions followed by two to three meetings a year for routine maintenance diabetic care. Although the frequency, content, and duration may vary considerably from the original CHCC geriatric model to the subsequent Specialty CHCC groups(e.g., for attention deficit disorder and well-baby groups), the basic elements remain the same—sufficient time for interactive care delivery with multidisciplinary assistance as needed. The Specialty CHCC model can be used as a foundation for all population management programs for high risk patient populations.

Specialists find the Specialty CHCC model useful for addressing diseases where there is a need to deal with significant psychosocial issues. The list of such diseases is long but successful pilots have been done by rheumatology with fibromyalgia, gastroenterology with functional bowel disorder, cardiology with congestive heart failure, and pulmonology with COPD. The emphasis for the specialists is on efficiency in caring for time-consuming but non-procedure requiring patients. This same focus has recently been brought to bear in orthopedics, where pre-op and post-op group visits are viewed as potentially freeing up more operating room time. From the administration's point of view, the cost-benefit is obvious, and for surgeons the operating room is their raison d'être.

Quality assurance is another mandatory consideration for health plan administrators. Guidelines for management of specific diseases and patient populations are proliferating faster than the providers can read them, let alone implement the details. Reporting requirements are likewise proliferating, with HEDIS being the most prominent to date. The Specialty CHCC model, either run by or including the specialists as guest speakers, is the ideal forum for implementing guidelines and enlisting the patients in monitoring their own compliance.

The DIGMA Model

The DIGMA model was originated in 1996 to improve access and enable physicians to better manage their large patient panels by seeing dramatically more patients in the same amount of time, but to do so in such a manner that both patient satisfaction and physician professional satisfaction are increased while access, service, and quality of care improve. DIGMAs enable physicians to "work smarter, not harder" while simultaneously providing patients with more integrated and holistic care that also addresses their

psychological and behavioral health needs—needs that typically cannot be addressed adequately during the brief time span of an individual office visit.

DIGMAs are customized to the needs, goals, practice style, and patient panel constituency of the individual physician. Open only to the physician's own patients (i.e., they are not drawn from elsewhere in the medical center), DIGMAs are designed to encompass the majority or entirety of the physician's own panel. DIGMAs are a combination of an extended medical appointment with the patient's own physician and an effective support group consisting of the physician, a behavioral health professional, and other patients from the physician's panel. Surveys have consistently shown patient satisfaction with DIGMAs to be extremely high. This is because DIGMAs provide what patients want most: better access, high quality health care in which both mind and body needs are addressed, and more time with their own doctor.

Co-led by the physician and a behavioral health professional (such as a health psychologist, social worker, marriage and family therapist, nurse, health educator, etc.) who are both present throughout each DIGMA session, the sessions are typically held for 60, 90, or 120 minutes weekly or biweekly. Daily, biweekly, and monthly DIGMAs are also possible. Most DIGMAs run to date have been 90 minutes long, held weekly, and supported by a medical assistant and a scheduler. They are typically attended by 10 to 16 patients and 2 to 6 support persons (most frequently the spouse, family members, friends, or caregivers) for a total DIGMA size between 12 and 22 members. Different patients attend each week, whenever they have a question or medical need. Patients help others in the group by sharing information, encouragement, support, effective coping strategies, and disease self-management skills.

The behavioral health provider plays a very active role throughout each DIGMA. He or she introduces the DIGMA concept and discusses procedural items at the beginning of each session; handles group dynamic issues; keeps the group running smoothly and on time; addresses emotional and psychological issues; deals with psychiatric emergencies; provides behavioral health evaluations and interventions; sees that each patient's mind and body needs are met during the session; does whatever necessary both during and outside the group to assist the physician; and runs the group alone if the physician is late or steps out of the room to conduct a brief private examination. This frees the physician up to focus on delivering high-quality, high-value medical care in the warm and supportive group setting. Patients often remark that the increased time with their own doctor, the warm and comfortable atmosphere, and the relaxed pace of the DIGMA are like "Dr. Welby care" and helps put the "care" back in health care.

Patients enter DIGMAs either by being directly booked into them in lieu of an individual appointment or by simply dropping in whenever they have a question or medical need. Patients can be directly booked into DIGMAs in two ways: (1) by physician invitation during routine office visits, where a physician invites appropriate patients to have their next visit be at a DIGMA in lieu of an individual appointment, or (2) by a scheduler who telephones patients approved by the physician from the physician's panel or waiting list who are either due or past due for a return visit, inviting them through a scripted message and follow-up letter to have their next visit at a DIGMA. Allowing patients to drop in avoids the need to schedule in individual visit, improves accessibility, increases efficiency, and provides a warm and compassionate side of medical care.

Kaiser Permanente San Jose Medical Center has hosted more than 8,000 DIGMA patient visits to date in the groups co-led by Dr. Noffsinger and 11 specialty and primary care physicians. DIGMAs have consistently been demonstrated to work in actual practice during the past three years in oncology, nephrology, endocrinology, rheumatology, neurology, and primary care. The results have demonstrated that DIGMAs work well in both primary care and specialty care settings.

Extensive medical care is provided during every DIGMA session. Charts are reviewed. Visits are documented through a progress note on each patient, which is largely preprinted and partially in check-off form to minimize charting time. Vital signs are taken, referrals made, tests and procedures are ordered, and test results discussed. Prescriptions are changed or refilled, and medications and side-effects are discussed. Medical questions are answered and treatment options explained. In addition to the medical needs that initiated the DIGMA visit, routine health maintenance issues are addressed and some examinations are conducted. When appropriate, brief private examinations and discussions are provided by the physician towards the end of the group session. Medical care is the central focus of DIGMA visits and the physician plays an active role throughout the session.

DIGMAs are not meant to completely replace individual appointments, but to complement the judicious use of traditional office visits in order to achieve maximum value. In this manner, patients such as the relatively stable chronically ill and "worried well" who can be appropriately seen in a group visit, will be seen in a cost-effective and highly accessible DIGMA visit. Conversely, patients needing individual visits can be seen in a traditional office visit. Always be certain to let patients know that participation in DIGMAs is completely voluntary and that the groups are meant to offer them freedom of choice. They are still welcome to have individual appointment as before, even though they may have attended a DIGMA session.

A Typical DIGMA Session

If you were to compare a typical CHCC visit and a typical DIGMA session, you would immediately notice substantial differences. Although the DIGMA session usually begins with some brief introductory comments by the behavioral health professional regarding the purpose of the group, its intended benefits to patients, and the importance of telephoning and pre-registering a day or two before dropping into the group, the focus immediately shifts to the delivery of medical care—a focus that is then maintained throughout the remainder of the session. Although there could be an initial socialization or education piece, typically there is not.

DIGMAs typically meet weekly and are only 90 minutes long, with a few minutes spent on introductions and 10 to 15 minutes spent at the end of each session on individual examinations. The focus of the remainder of the group is on the delivery of comprehensive mind-body medical care to all patients present. For this reason and because the physician is present throughout each group session, DIGMAs resemble a traditional office visit, rather than a health education class, behavioral medicine program, or psychiatry group. Patients never confuse a DIGMA with a class or group therapy.

Upon entering a typical DIGMA session, you will see a group of 12 to 22 members seated in a circular arrangement. The physician and the behavior health profession typically sit together with a small table between them where medical charts, forms, and any handouts are stacked. The nurse or medical assistant calls patients out of the group one at a time at the beginning of the session in order to take vital signs and perform other important duties, such as partially completing the patient information section of lab slips and referral forms for preventative tests and medical services that are due or past due. This minimizes the amount of physician time required during group to complete forms and referrals. Although there are different types of DIGMA models (homogeneous, heterogeneous, and mixed), patients in the room typically represent a heterogeneous mix in terms of age, sex, diagnosis, marital status, race, utilization behavior, and so on, although in the homogenous DIGMA model they would be relatively homogeneous as to diagnosis.

Introductory comments are followed by a request for patients to introduce themselves one at a time. Although they can choose how they describe themselves, they are asked to state what their medical condition is and what specifically they would like from their doctor today. It is explained that the doctor will answer everybody's medical questions and deliver most of the same medical services normally provided during routine office visits—only at a more relaxed pace because of the greater amount of time available. All are invited to be active participants in the highly interactive group. A patient who volunteers starts the group, and the focus gradually shifts sequentially from one patient to the next in a clockwise or counterclockwise direction. Sometimes physicians prefer to address patients in clusters according to diagnosis—for instance, the neurologist has Parkinson's disease patients go first, followed by patients with headaches, seizure disorder, stroke, etc. After going around the entire room, the physician spends the remainder of the group—usually the last 10 to 15 minutes—providing brief private examinations to patients who need or want them.

DIGMAs consistently provide a highly interactive experience, with everyone present playing active roles. The physician spends much of the time answering patients' medical questions, occasionally getting up to hand patients a prescription refill, provide a referral, or perform a brief examination that can be appropriately conducted in the group. Meanwhile, other patients offer encouragement and support, provide gentle confrontation when needed for non-compliant patients, and share relevant information and personal experiences—all of which can be very helpful to the patient who is the focus at the time.

In short, this highly interactive quality with a focus on comprehensive mind-body health care is a characteristic feature of the DIGMA model. Everything that can be appropriately conducted in the group is provided during the DIGMA, where all can listen, learn, and respond. Patients rarely bring up confidentiality issues, but physicians concerned about this may want to consider having patients sign a full disclosure consent form encompassing confidentiality at the beginning of each DIGMA session.

Patients and staff consistently report that they find DIGMAs a lively, interesting, helpful learning opportunity. Physicians report learning things about their patients they never knew, even after having seen them for years during individual office visits. Patients learn from the physician, the behavioral health professional, and other patients—often stating that they even learned answers to relevant questions they did not know to ask until somebody else did.

The number of patients actually requiring an individual examination at the end of DIGMA sessions is surprisingly small—typically one or two, occasionally three or four. This finding supports the claim of various authors that most medical visits are driven by psychosocial and behavioral health issues rather than by medical need.[3] The reason only a small number require individual examinations is that once their questions are answered and mind and body needs addressed, few patients find they need an individual examination.

Occasionally the physician will spot a medical condition during the DIGMA that requires a traditional office visit and schedules one. In this instance, the office visit should be more readily accessible because

DIGMAs permit many appropriate individual visits to be off-loaded to DIGMA visits, so office visits become more available to those who truly need them.

One note: It is the goal of every DIGMA to end on time, with all of the physician's duties completed. This includes the progress note for each patient present, which is typically written in group as each patient is being focused upon. Accomplishing this end requires discipline, coordination between the physician and the behavioral health provider, and a certain amount of experience running DIGMAs. When this goal is achieved, the physician leaves the session back on schedule, even if he or she enters the group late.

THE FINANCIAL BENEFITS OF THE DIGMA MODEL CAN BE MEASURED DIRECTLY BY EVALUATING THE DEGREE TO WHICH IT LEVERAGES EXISTING STAFFING RESOURCES, WHICH SOLVES ACCESS PROBLEMS WITHOUT HIRING EXTRA STAFF.

Strengths of DIGMAs

Cost Savings

The financial benefits of the DIGMA model can be measured directly by evaluating the degree to which it leverages existing staffing resources, which solves access problems without hiring extra staff. The model has been shown to dramatically leverage physician time and can be converted to cost savings based on lower staffing levels required to provide good service and care. By addressing behavioral health and psychosocial issues (which are known to drive a large percentage of office visits), as well as body needs, DIGMAs also decrease utilization.

Because DIGMAs are readily accessible, patients will often drop into a DIGMA any week that they have a question or medical need rather than scheduling an individual office visit, demanding an urgent work-in appointment, complaining about poor access, or telephoning. This saves money through both reduced office visits and decreased phone volume. In addition, patients can be taught during DIGMAs by the physician, the behavioral health professional, and other patients to more appropriately use the emergency room and other inpatient and outpatient services. Because they are specifically designed to handle many of the most difficult, time-consuming, psychologically needy, and inappropriately high utilizing patients in the physician's practice, DIGMAs provide a format where these patients can be better treated with less cost.

DIGMAs represent the best use of staff and budget. They increase physician productivity and efficiency, provide many economic and patient care benefits, offer the competitive advantage of a new service that is much appreciated by patient customers, and reduce costs by leveraging staffing. A properly run and adequately supported DIGMA program can substantially and positively impact a health care organization's bottom line while simultaneously creating happier patients and physicians. Happier patients and physicians translate into better retention of both patients and staff. DIGMAs increase value by providing high-quality medical care with excellent access and service at reasonable cost in a warm, supportive group atmosphere that is enjoyed by patients and physicians alike. Because they optimally balance the needs of patients, physicians, and health care organizations, DIGMAs provide a "win-win-win" situation and are expected to play an increasingly important role in the future of health care delivery.

Increased Access

DIGMAs are specifically focused upon improving primary and specialty care access through the use of existing resources and upon enabling physicians to better manage their large patient panels. Access has become a national problem. Physicians are already working as hard and efficiently as possible, so that this access problem cannot be solved by simply having physician work longer and harder—any fat that existed here has long since been removed. The DIGMA model provides a tool that enables physicians to substantially leverage their time so that they can see dramatically more patients in the same amount of time, while providing excellent service and high-quality medical care. DIGMAs have been shown to utilize existing resources to improve access by rapidly reducing return appointment backlogs at both the individual physician and departmental levels.

Patient Satisfaction

Because they provide patients with prompt access, quality health care, and increased time with their own doctor, DIGMAs increase patient satisfaction and improve their perceptions of the quality of care they are receiving. Patients appreciate the fact that DIGMA sessions comprehensively address the totality of mind-body needs they bring to the medical visit. This contrasts with individual office visits, where patients often feel rushed with barely enough time to address physical needs, let alone psychosocial needs. One indication of the degree to which DIGMAs have been meeting patient needs was found when both rheumatologists at The Kaiser Permanente San Jose Medical Center started their successful Rheumatology DIGMAs. Shortly after the Rheumatology DIGMAs started, a previously successful fibromyalgia and chronic fatigue syndrome program in the Division of Behavioral Medicine failed due to lack of census. The reason given by patients is that they preferred attending their rheumatologist's DIGMA whenever they had a question or medical need.

Improved Compliance

Consider the non-compliant patient, a situation that is often poorly handled during traditional office visits. The information, encouragement, support, and gentle confrontation provided by members of the group and the behavioral health professional increases patient compliance with recommended treatment regimens. It amazing how influential another patient who has already undergone the treatment or lifestyle change with benefit (e.g., dietary compliance, initiating insulin, undergoing chemotherapy, starting dialysis, smoking cessation, etc.) can be in relieving a non-compliant patient's anxiety and in persuading the resistant patient to comply with recommended treatment by confronting them with the long-term consequences of non-compliance.

Physician Satisfaction

Improved access as well as increased patient and physician professional satisfaction are certainly among the great strengths of the DIGMA model consistently demonstrated in actual practice. Carefully designed, properly run, and adequately supported DIGMAs result in high levels of patient satisfaction and increased physician professional satisfaction. Each DIGMA is customized to the particular needs, goals, practice style, and patient panel constituency of the individual physician. Physicians appreciate being able to better manage their burgeoning panel sizes and to regain control over their practices while simultaneously delivering a more satisfying level of care and enjoying improved relationships with patients. They like the more relaxed pace of DIGMAs, the reduction in repetitive information, the opportunity to try something interesting and different, and the collegial interaction with the behavioral health colleague. Physicians also appreciate the increased ability to respond effectively to angry or demanding patients and to secure increased patient compliance. Because of the many benefits they offer, DIGMAs are already beginning to gain national acceptance and recognition for the role they can play in health care delivery.[4]

With the DIGMA model, it is the physician and his or her entire panel of patients who directly benefit from the increased efficiencies and quality of care. Because they enable physicians to better manage their large panels and offer many other benefits, DIGMAs are "owned" by the physician running them. With DIGMAs, there is never an invisible or orphan program without strong physician ownership and support, as could be the case for some group programs such as for hypertension, diabetes, asthma, etc., where only a comparatively small percentage of the physician's panel is covered.

There are other advantages that DIGMAs offer to physicians. Instead of repeating the same information over and over as is the case with individual office visits, the physician can address and entire group at once and offer information in greater detail. They can also address issues of common interest such as information or misinformation patients have gleaned from the media, the Internet, friends, and pharmaceutical advertisements. Also patients get to see their physicians more relaxed and they get to know each other better as people. This can only lead to improve physician-patient relationships.

Patients will often open up more in a group because of the relaxed pace and the support of group members. Sometimes physicians can detect some serious or life-threatening conditions that might otherwise have gone unnoticed, especially if patients are denying or minimizing their symptoms. For instance, one patient dropped by an Endrocrinology DIGMA requesting a prescription for glasses, stating he would not have bothered to come in except for the fact he could simply drop by without an appointment. Because fingerstick blood glucose levels are routinely taken for all diabetics in the Endrocrinology DIGMA, it was discovered that his blood sugar level was over 900, and he was immediately provided with emergency care. At another DIGMA, a patient who had been quiet most of the session spoke up when other patients were complaining about fatigue, stating that he needed a pep pill. When asked why, he explained that he become extremely fatigued with even minor exertion and that when he laid down to rest, he felt like an elephant was stepping on his chest. What he received was an urgent cardiac work-up, not a pep pill!

Weaknesses of DIGMAs

DIGMAs have some minor support needs that must be met if they are to be successful. For larger medical groups and managed care organizations, there needs to be a highly skilled champion who is knowledgeable about the DIGMA model to move the entire program forward throughout each facility. Also, a behavioral health profession needs to be trained by the champion to take over each of the DIGMAs that are established. The behavioral health professional must be well matched with both the physician and the patients attending the DIGMA.

Most DIGMAs will also require a medical assistant and a scheduler. The primary requirement for the medical assistant is a willingness to work hard both in terms of seeing the larger volume of patients and in terms of the expanded responsibilities that need to be assumed. Similarly, a scheduler trained by the champion must be provided for most DIGMAs with adequate dedicated time each week (up to four hours, typically with less time required as the sessions gain acceptance) to maintain the desired census level by telephoning enough patients selected by the physician each week with a scripted message and then sending them follow-up letters containing details.

Clearly, any innovative health care delivery program that differs as much

as the DIGMA model does from the traditional office visit format requires a high level of administrative commitment and support. Also, as is the case for all group programs, there are certain necessary facilities. DIGMAs require a comfortable group room of sufficient size with an examination room located nearby. In addition, the model requires that each physician running a DIGMA for his or her practice take approximately 15 to 30 seconds during routine office visits to invite all their appropriate patients to have their next visit be at a DIGMA. A small one-time expense must be budgeted at the introduction of each new DIGMA for professional-appearing posters and program description flier holders mounted on the walls of the physician's lobby and examination rooms. These marketing materials must be of high quality to reflect the quality of care the groups will offer and to ensure patient buy-in.

DIGMAS PROVIDE WHAT PATIENTS WANT MOST: BETTER ACCESS, HIGH QUALITY HEALTH CARE IN WHICH BOTH MIND AND BODY NEEDS ARE ADDRESSED, AND MORE TIME WITH THEIR OWN DOCTOR.

Because different patients attend each DIGMA session, establishing and maintaining a minimum census level based on medical economics is critical. Census is achieved through marketing materials, personal invitations from the physician, and telephone calls from the scheduler.

DIGMAs work best for routine return visits. They are not meant for initial evaluations, one-time consults, inpatients, most medical procedures, highly contagious illnesses, medical emergencies, rapidly evolving medical conditions, lengthy individual examinations, acute illnesses, or patients who refuse to attend group visits. Interestingly, experience has shown that as patients become more familiar with the model and hear favorable reports from other patients, the number refusing a group visit tends to decrease.

How Group Visit Models Can Work Together

While the CHCC, Specialty CHCC, and DIGMA models work individually and offer distinct advantages in terms of reduced costs and increased efficiency, productivity, service, quality of care, and patient and physician satisfaction, the models can operate together to provide even greater benefits. Optimal value will only be achieved in the future of health care delivery when the best possible mix of efficient, effective group visits and traditional individual visits is offered. Then, patients who can appropriately be treated cost-effectively in group visits will be seen in group, and individual visits will be used judiciously for patients who truly need them.

To fully capture their potential economic and patient care benefits, it is important that all group visit programs be carefully designed, properly run, and adequately supported. If, in a rush to roll out a group visit program, medical groups and managed care organizations hurriedly launch a poorly planned, inadequately supported CHCC or DIGMA program, their multiple potential benefits will never be fully realized.

As a means to achieve the benefits these models can co-jointly offer, consider the following illustrative example of fully integrated care. First, every primary and specialty care provider who wants one would have a DIGMA for their practice as a means of better managing their patient panel, leveraging their time, solving their access problem, and providing comprehensive mind-body care. In addition, there would be numerous CHCC and Specialty CHCC group visit programs at the facility for managing high-risk patient populations both in terms of utilization behavior (e.g., CHCC programs for high utilizing geriatric patients) and by diagnosis (e.g., population management programs based on the Specialty CHCC model for diabetes, hypertension, asthma, etc.). Any patient seen in a physician's DIGMA who needs further help for a particular health problem could be then efficiently referred to the appropriate CHCC or Specialty CHCC group. Conversely, patients seen in CHCC or Specialty CHCC groups could be encouraged to have their next medical visit be at their doctor's DIGMA, if appropriate. In this manner, all patients who could best be seen in a group visit would be. Individual office visits would be reserved for those who really need them.

This vision for optimizing value in health care delivery through the integration of various group visit models with individual office visits would involve substantial alterations in various areas: the long-range business plan; allocations of funding; staffing resources; facilities planning; and the manner in which mainstream medical care will be delivered. This is achievable and can result in improve access, dramatic cost savings, more efficient utilization of existing staffing resources, and most importantly, substantially improved service, quality of care, and patient and physician satisfaction.

Continuity of care is a recurring theme for most managed care organizations.[5] Its benefits need no elaboration. Continuity presupposes physician and member retention. Primary care physicians today as a whole are not a happy group and turnover rates in some organizations are alarming. The professional satisfaction derived from a job well done is a major part of physician satisfaction with the CHCC and DIGMA models, yet control issues loom large for physicians in managed care. DIGMAs provide some degree of control in the management of large patient panels, and that in and of itself is a positive development for the physicians. In addition, both group models provide some variety in an often tedious work day. This is espe-

cially true in an environment where hospital and emergency room duties have been assumed by dedicated teams of hospitalists and emergentologists. Satisfied physicians create satisfied patients. Satisfied physicians and patients stay with the organization. Continuity is enhanced and costs reduced because of decreased turnover of patients and staff.

Next, consider practice management. Roughly 50 percent of a panel of patients will be candidates for group visits of some type, and this percentage is expected to grow in the future as patients become more familiar with the benefits of group visits. Experience shows that the other 50 percent prefer the tradition physician-patient dyad, even though satisfaction with that model is in decline. This presents the individual physicians with some potentially wonderful options for better managing their practice through the use of group visits. We say "potentially" for a reason. In a fully capitated system, a physician's panel size must be fixed before he or she can even consider the benefits of group visits. If the reward for efficiency is a larger panel and no commensurate increase in reimbursement (time or dollars), then innovation is doomed from the outset. If, however, everyone in the organization participates in some way, then group appointments will increase access and efficiency, improve service and quality of care, enhance patient and physician satisfaction, and more efficiently use existing resources while providing more time for effective and fulfilling physician-patient relationships.

An effectively integrated system of CHCCs, Specialty CHCCs, DIGMAs, and traditional individual office visits can provide and "win-win-win" for patients, physicians, and managers of health care. Furthermore, CHCCs and DIGMAs can provide useful tools in helping to manage the ever-increasing demand for specialty and primary care services through the use of existing resources. We offer them for consideration as a package to medical groups and managed care organizations as exceptionally helpful tools for confronting the access, service, quality of care, and economic challenges facing them in today's rapidly evolving and highly competitive health care environment.

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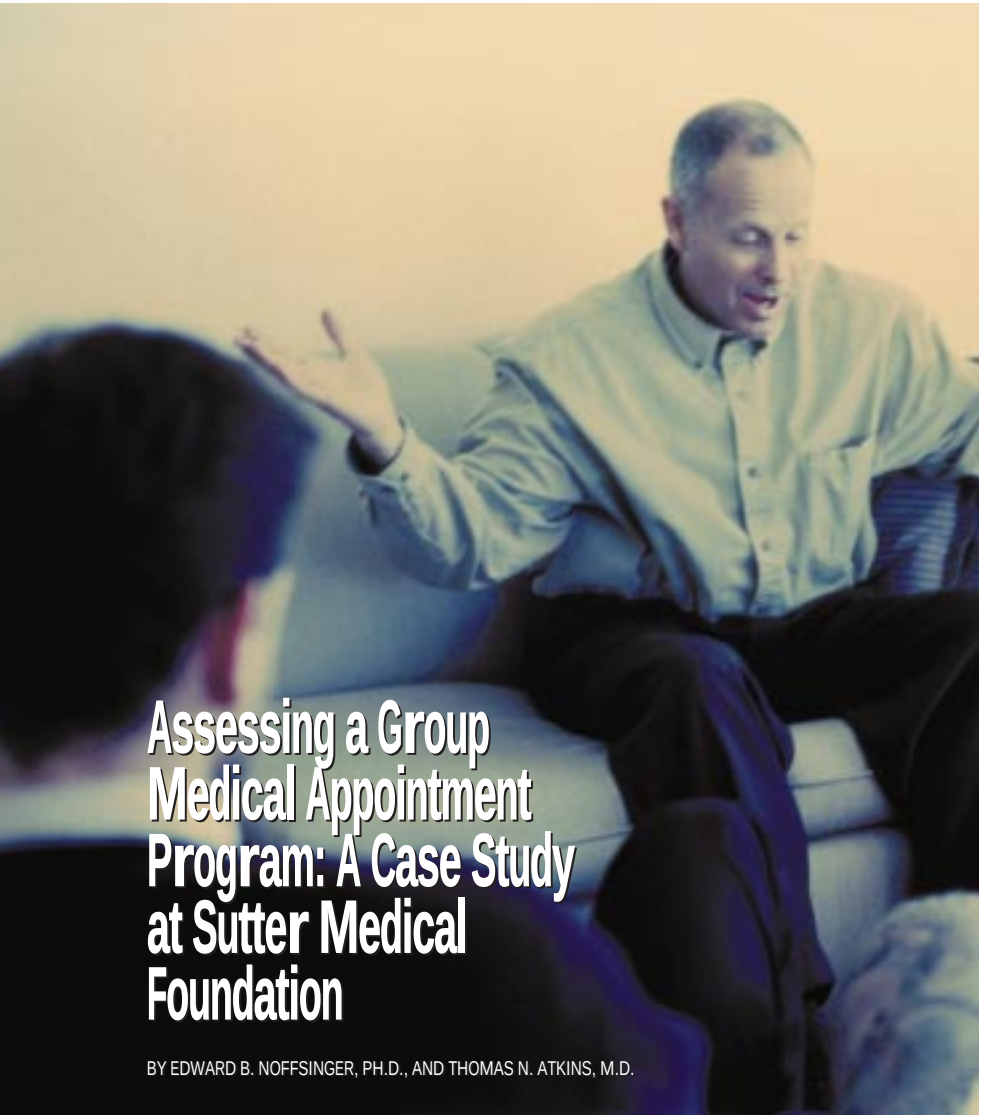
The authors will be speaking about group visit models at AMGA's National Conference on Physician Directed Health Care, March 5-8, in Las Vegas, Nevada. **For details, see page 59.**



Assessing a Group Medical Appointment Program: A Case Study at Sutter Medical Foundation

BY EDWARD B. NOFFSINGER, PH.D., AND THOMAS N. ATKINS, M.D.

Editor's Note: Over the past few years, the Group Practice Journal *has published numerous article on the DIGMA model of group medical appointments. These programs were originally developed at Kaiser Permanente. Last month's article focused on the implementation of a DIGMA program at a different kind of health care organization and the challenges the medical group had to overcome to design and implement the program. This article assesses the impact of the model on operations, using patient satisfaction and physician productivity data.*

This article summarizes the experiences gained during the early stages of implementing a pilot DIGMA project at two different medical center sites (one urban, the other rural) of the Sutter Medical Foundation, a large multispecialty health care organization in northern California that is partially capitated and partially fee-for-service in nature. This article reviews the data generated from the pilot project and examines the degree to which physician productivity was increased; how satisfied patients were with the pilot; and how pilot physicians felt about their DIGMAs.

IN TOTAL, THE FOUR PILOT DIGMAS COMBINED OCCUPIED ONLY 5.5 HOURS PER WEEK OF PHYSICIAN TIME.

Early Results from the Pilot DIGMA Program

Data was collected on the four pilot DIGMAs during the six weeks that the consultant (Dr. Noffsinger) participated in these programs. Although he initially acted as DIGMA champion and behaviorist during the first three sessions, he progressively delegated more and more of these responsibilities to the behavioral health professional who was being trained to take over these roles.

Increased Physician Productivity

The data collected during the six weeks of the pilot DIGMAs are presented in Figure 1. These tables depict the following numbers:

- Patients who were pre-registered for each of the various pilot DIGMA sessions
- Pre-registered patients who actually attended
- Patients who simply dropped in without pre-registering
- Support persons who accompanied the patient (spouses, family members, friends, and caregivers)

The final table in Figure 1 depicts the total number of patients seen in all pilot DIGMAs combined. Also depicted is the total number of support persons who attended all pilots combined each week. As can be seen from these numbers, an estimated 81.2 percent of all patients who pre-registered actually attended.

Similar to the airlines, "no shows" can be compensated for by overbooking all DIGMAs. To insure the desired level of attendance, this data indicates that DIGMAs at these two Sutter sites should be overbooked by approximately 25 percent in order to compensate for the expected number of "no shows." However, when planning to consistently meet targeted census levels, take into account that in addition to the number of pre-registered patients who are expected to actually attend there will also be a number of patients who simply "drop in" without pre-registering.

The number of drop-ins is expected to gradually increase over time as more and more patients become familiar with the DIGMA program, give it a try with success, and then return. This is precisely what is depicted in the cumulative data of Figure 1, where the total number of patients who simply dropped in on the four pilot DIGMAs each week steadily increased.

Aggregate Data on Increased Physician Productivity

Figure 2 consolidates the data from Figure 1 into a simpler and more readily understandable form. It shows the total number of patients attending each of the six initial pilot DIGMA sessions that the consultant attended, regardless of whether they pre-registered or simply dropped in. Unlike Figure 1, it does not show the number of patients who pre-registered or the number of support people attending. As can be observed in Figure 2, the average number of patients seen per week in each pilot DIGMA ranged from 8.7 to 14.0, with the average weekly total for all four pilot DIGMAs combined being 41.8 patients. In total, the four pilot DIGMAs combined occupied only 5.5 hours per week of physician time, although they did involve additional facilities and support personnel requirements.

Figure 2 also compares data gathered during the pilot DIGMAs to the pre-DIGMA physician productivity data for individual office visits. For the entire month prior to starting the pilot DIGMA program, the 4 pilot physicians saw during clinic hours an average of between 2.9 patients per 90 minutes (Dr. Scalapino) and 4.7 patients per hour (Dr. Fields) during routine office visits. Figure 2 compares physician productivity between traditional office visits and DIGMA group visits during the length of time that each physician's DIGMA took (i.e., 90 minutes in all cases except for Dr. Fields, for whom it was 60 minutes).

During the 5.5 hours of physician time that the 4 pilot DIGMAs occupied each week, these same physicians would on average have only been able to see 16.3 (4.5+2.9+4.2+4.7) patients during individual office visits. Compare this level of productivity to the 41.8 patients seen during a comparable amount of time in the initial sessions of the pilot DIGMA program. For the four pilot physicians combined, this corresponds to an average increase in efficiency of 256.4 percent (41.8/16.3 x 100%) during the time spent running their DIGMAs.

FOR THE FOUR PILOT PHYSICIANS COMBINED, THIS CORRESPONDS TO AN AVERAGE INCREASE IN EFFICIENCY OF 256.4 PERCENT.

Instead of seeing 4.5 patients individually, Dr. Hopkins saw an average of 14 in his 90-minute DIGMA, which corresponds to a 311.1 percent increase in his productivity. Instead of seeing 2.9 patients individually, Dr. Scalapino saw 8.7 in her 90-minute DIGMA, corresponding to a 300 percent increase in her productivity. Similarly, Dr. Abate saw an average of 9.6 patients per week in her 90-minute DIGMA rather than the 4.2 she would have seen on average individually during the same amount of time, which is a 228.6 percent increase in her productivity. Finally, Dr. Fields leveraged his time by 202.1 percent by seeing an average of 9.5 patients per week in his 60-minute DIGMA versus the 4.7 patients he otherwise would have seen individually. Overall, even at this early stage of implementation, the average increase in physician productivity demonstrated through this DIGMA pilot study was 256.4 percent. Even during this early phase of implementation, three of the four physicians met their originally targeted increases in productivity.

Dr. Abate's situation is particularly informative and certainly warrants a closer examination. She initially started her pilot DIGMA with a mixed DIGMA model for her practice, but later shifted to a heterogeneous model after her first two sessions due to poor attendance. As is the case for many physicians considering a DIGMA for their practice, Dr. Abate only worked half time; therefore, she had a correspondingly smaller pool of patients from which to draw attendees for her DIGMA. Achieving targeted census levels, while possible, simply requires more effort from half-time physicians such as Dr. Abate. For this reason, it is imperative that half-time physicians adequately market their program and consistently invite enough patients to attend their DIGMA whenever they have a future medical need in order to ensure that group census requirements are consistently met during every session.

Dr. Abate's percentage increase in productivity during the DIGMA was only 228.6 percent compared to the target increase for primary care of 300 percent. However, a closer examination of the data reveals that the mixed DIGMA model was initially not viable for Dr. Abate; however, the heterogeneous model (which is more inclusive, because all patients qualify to attend, regardless of diagnosis) was quite successful. During her first two sessions, when she employed a mixed DIGMA model, she only saw an average of 7.5 patients per DIGMA session—which corresponded to a 179.6 percent increase in her productivity. In dramatic comparison, during the following three sessions (after she changed to the heterogeneous model) she saw an average of 11.0 patients per DIGMA session—corresponding to a 261.9 percent increase in her productivity, which is approaching the targeted level of 300 percent. Because the pilot program was still quite new, further increases in census and therefore productivity can be reasonably anticipated over time.

The lesson to be learned here is that half-time physicians can successfully run DIGMAs to achieve

FIGURE 1

Attendance Data for 4 Pilot DIGMAs

Dr. Hopkins' Internal Medicine DIGMA

Number of Patients per 90 minutes seen prior to DIGMA: 4.5
Minimum Census: 13.5
Target Census: 15

	Pre-registered Patients	Pre-registered Attendees	Non-pre-registered Attendees (Drop-Ins)	Support Person Attendees
Week 1	17	12	0	3
Week 2	12	8	4	3
Week 3	17	14	0	2
Week 4	14	11	5	4
Week 5	7	5	0	1
Week 6	20	20	5	0

Average Number of DIGMA Patients per Week: 14
Percent Increase in Productivity: **311.1%**

Dr. Abate's Family Practice DIGMA

Number of Patients per 90 minutes seen prior to DIGMA: 4.2
Minimum Census: 12.6
Target Census: 15

	Pre-registered Patients	Pre-registered Attendees	Non-pre-registered Attendees (Drop-Ins)	Support Person Attendees
Week 1	7	8	0	0
Week 2	Cancelled Due to Illness			
Week 3	5	6	1	0
Week 4	11	11	0	2
Week 5	7	4	4	0
Week 6	14	12	2	0

Average Number of DIGMA Patients per Week: 9.6
Percent Increase in Productivity: **228.6%**

Dr. Scalapino's Rheumatology DIGMA

Number of Patients per 90 minutes seen prior to DIGMA: 2.9
Minimum Census: 8.7
Target Census: 12

	Pre-registered Patients	Pre-registered Attendees	Non-pre-registered Attendees (Drop-Ins)	Support Person Attendees
Week 1	9	5	0	0
Week 2	12	6	0	1
Week 3	13	7	2	2
Week 4	9	8	0	1
Week 5	7	6	1	1
Week 6	15	14	3	3

Average Number of DIGMA Patients per Week: 8.7
Percent Increase in Productivity: **300%**

Dr. Fields' Family Practice DIGMA

Number of Patients per 60 minutes seen prior to DIGMA: 4.7
Minimum Census: 9.4
Target Census: 13

	Pre-registered Patients	Pre-registered Attendees	Non-pre-registered Attendees (Drop-Ins)	Support Person Attendees
Week 1	13	10	0	0
Week 2	17	13	0	1
Week 3	5	5	1	0
Week 4	7	6	0	2
Week 5	15	13	0	2
Week 6	8	8	1	1

Average Number of DIGMA Patients per Week: 9.5
Percent Increase in Productivity: **202.1%**

Totals For All Pilot DIGMAs Combined

	Pre-registered Patients	Pre-registered Attendees	Non-pre-registered Attendees (Drop-Ins)	Support Person Attendees
Week 1	46	35	0	3
Week 2	41	27	4	5
Week 3	40	32	4	4
Week 4	41	36	5	9
Week 5	36	28	5	4
Week 6	57	54	11	4

Overall Average Number of DIGMA Patients per Week in Pilot: 41.8
Overall Percent Increase in Productivity during Pilot: **260.5%**

targeted levels of increased productivity; however, succeeding might require the employment of the more all-inclusive heterogeneous model.

Drs. Abate and Fields lag behind Drs. Hopkins and Scalapino in terms of effectively utilizing their DIGMA program to leverage their time and meet targeted objectives regarding increased productivity. Experience gained through this pilot project reveals that the Laguna site clearly needs some additional help, especially in terms of support staff, in order to optimize benefits from their pilot DIGMAs.

In addition, because Dr. Fields is normally such a highly productive physician, he places singular challenges upon any model that attempts to further increase efficiency and productivity for a physician who is already so productive. With a baseline productivity of 4.7 patients per hour, it would prove very difficult for any model to further leverage Dr. Fields' time. Certainly, it is very unlikely that he will be able to further increase his productivity in any meaningful way through individual appointments alone. An additional complicating factor was the small size of the group room, with its maximum capacity of only 15 people, which severely limited the group size and necessitated that Dr. Field's DIGMA be limited to just 60-minutes in length. It was a remarkable accomplishment that in spite of these difficulties and challenges, the DIGMA model was nonetheless able to leverage his time and further increase his already amazing productivity by 202.1 percent.

Even during the pilot phase of her DIGMA program, Dr. Scalopino's Rheumatology DIGMA had already increased her productivity by a respectable 300 percent—her targeted goal. Nonetheless, the targeted increase of 400 percent for a specialist has not yet occurred—although it could well be achieved in the future as experience is gained and as more patients find out about the program and are willing to attend. Because experience has repeatedly shown that the ideal group census for DIGMAs is between 10 and 16 patients in both primary and specialty care, Dr. Scalapino should be able to achieve this goal of 400 percent in the near future by increasing (and maintaining) her group census to 12.

PATIENT SATISFACTION WITH THESE PILOT DIGMAS WAS VERY HIGH.

While the DIGMA model was able to substantially increase the productivity of all pilot physicians, even in the early stages of implementation, it is important to note that Dr. Hopkins was especially adept at achieving the minimum census goal for his DIGMA. This is because he had mastered the process for referring patients into his DIGMA from the outset.

During individual office visits, Dr. Hopkins was careful to personally invite to his DIGMA every patient who could appropriately be seen in a group visit. He recommended his DIGMA to appropriate patients whenever they had a future medical need or required a follow-up appointment. His office staff was also enthused, well trained, and supportive of his DIGMA program. His medical assistant routinely informed every patient she roomed about Dr. Hopkins' DIGMA, pointing to the poster on the exam room wall and giving patients a program description flier to read while waiting for Dr. Hopkins to see them. Reception staff was also trained to tell all of Dr. Hopkins' patients about the program when they registered for an office visit. When appropriate, patients telephoning the doctor's office were told about the DIGMA program when they called to talk to the doctor or to schedule an individual appointment. By off-loading patients who could appropriately be seen in a group visit onto the DIGMA program, Dr. Hopkins freed up many individual office visits.

Patient Satisfaction

Ever since the DIGMA model was developed in 1996, both patient satisfaction and physician professional satisfaction have been of primary importance. Increased physician productivity and improved access are not enough; enhanced patient satisfaction and physician professional satisfaction are also required of the DIGMA model for it to be successful.

Patient satisfaction with these pilot DIGMAs was very high, which is consistent with findings in DIGMA programs that have been implemented elsewhere. At the end of every pilot DIGMA session, patients attending were asked to anonymously complete a DIGMA Patient Satisfaction Survey. Patients were asked to rate their level of satisfaction with the pilot DIGMA program by responding to seven questions on the following 5-point Likert scale: Excellent (5), Very Good (4), Good (3), Fair (2), and Poor (1).

The questions were as follows:

1. The length of time I had to wait between making an appointment and to see the doctor today was: ____
2. The length of time I had to wait at the office to see the doctor was: ____
3. I felt today's visit with the doctor was: ____
4. I felt the explanations of medical procedures, tests, and drugs was: ____
5. I felt the amount of time I had with doctors and staff during today's visit was: ____
6. I felt the personal interest in myself and my medical problems by doctors and staff was: ____
7. Overall, I felt the quality of care and services I received today was: ____

FIGURE 2

Productivity Data by Physician for Pilot DIGMAs

Name of DIGMA	Number of Patients per Week						Average Number of Patients Per Week	% Increase in Physician Productivity
	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6		
Dr. Hopkins' Internal Medicine DIGMA Sutter Fort Site Initial Avg. #Pts/ 90 mins: 4.5 **Minimum Census: 13.5** Target Census: 15	12	12	14	16	5	25	**14**	**311.1%**
Dr. Scalapino's Rheumatology DIGMA Sutter Fort Site Initial Avg. #Pts/ 90 mins: 2.9 **Minimum Census: 8.7** Target Census: 12	5	6	9	8	7	17	**8.7**	**300%**
Dr. Abate's Family Practice DIGMA Laguna Site Initial Avg. #Pts/ 90 mins: 4.2 **Minimum Census: 12.6** Target Census: 15	8	Cancelled Due to Illness	7	11	8	14	**9.6**	**228.6%**
Dr. Fields' Family Practice DIGMA Laguna Site Initial Avg. #Pts/ 60 mins: 4.7 **Minimum Census: 9.4** Target Census: 13	10	13	6	6	13	9	**9.5**	**202.1%**
Total	**35**	**31**	**36**	**41**	**33**	**65**	**41.8**	**256.4%**

Number of Patients per Week: Actual number of patients (not counting support persons) who attended each weekly DIGMA session (i.e., regardless of whether they were pre-registered or simply dropped in).

Average Number of Patients per Week: Average number of patients actually seen per week by each physician during the six pilot DIGMA sessions that the consultant attended (not counting support persons).

Percentage Increase in Physician Productivity: Percentage increase in physician productivity during their pilot DIGMA. The average number of patients that the physician saw during the pilot DIGMA sessions compared to baseline productivity (averaged over a month prior to starting the DIGMA) for individual visits during the 90 minutes (60 minutes for Dr. Fields).

Figure 3 depicts the patient satisfaction data that was compiled for all four pilot DIGMAs during the six weeks that the consultant participated in them.

These scores reveal a high level of patient satisfaction with the pilot DIGMA program. The overall average score in this pilot project (i.e., for all seven survey questions and all four pilot physicians) was a remarkable 4.67 out of 5. Although not measured in this pilot project, it would have been interesting to compare these patient satisfaction scores for DIGMA visits with similar scores for individual office visits with the same pilot physicians obtained by using the same measurement instrument. Because these patient satisfaction scores for the pilot DIGMA visits are so high, it is unlikely that similar patient satisfaction data for individual office visits with the same physicians would have been significantly higher or even as high.

Pilot Physicians Evaluate Their DIGMAs

A structured telephone interview was conducted with each of the pilot physicians upon completion of the pilot phase of this program. Pilot physicians were asked to evaluate their level of satisfaction with their DIGMA program. Some representative physician comments during these telephone interviews are included in the excerpts below.

One thing was abundantly clear throughout these telephone interviews: all four physicians were highly satisfied with their DIGMA program. Therefore, the results of this pilot DIGMA program have demonstrated not only dramatically increased physician productivity, but also high levels of both patient satisfaction and physician professional satisfaction.

Dr. Thomas Hopkins

"Drop-In Group Medical Appointments or DIGMAs are a unique way to deliver health care and provide an interaction between physician and patient that would not ordinarily occur. My DIGMA has primarily provided three things to my practice of internal medicine. It has allowed my patients greater access. It has allowed me to spend more time with my patients in an appointment setting where a wide range of issues can be discussed. My patients are given the opportunity to share their health issues in a group setting and receive information that may come from experiences of others sharing in the appointment. The Drop-In Group Medical Appointment allows me to educate my patients, identify and address their psychosocial issues, and provide support in a group setting. Thus far, my patients have enjoyed this appointment setting. The majority seem to like the easier access to my practice afforded by the DIGMA, and the opportunity to spend 90 minutes with their physician!

> IT IS ALSO CLEAR THAT DIGMAS ARE POTENTIALLY BEST ABLE TO DRAMATICALLY INCREASE THE PRODUCTIVITY OF PHYSICIANS WHOSE PRE-DIGMA PRODUCTIVITY DURING INDIVIDUAL OFFICE VISITS IS RELATIVELY LOW.

"Professionally, the DIGMA has created more time in my schedule. It has increased the number of longer appointments available in my schedule where I can do physical exams or consultations. This has been made possible because I can schedule shorter appointments such as routine follow-up appointments, medication refills, blood pressure checkups, and straightforward medical issues into the DIGMA. Personally, this approach to delivering health care has relieved some of the burdens of juggling time between a busy internal medicine practice and time spent with my most cherished possession, my family.

"Drop-In Group Medical Appointments are not for everyone. The concept may sound interesting but be vague to both physician and patient. Some patients and physicians may prefer individual, one-on-one appointments. DIGMAs don't take away this opportunity. They are not meant to be a substitute, but an alternative. My initial skepticism about DIGMAs dissipated quickly when I reviewed the high patient satisfaction scores obtained and the impact it has made on patient access in my practice. I now feel that I have a greater command over my time and schedule in my practice. I no longer feel under the gun to see 25-30 patients a day in order to be productive and meet my compensation standards. I feel that this appointment format allows me to deliver the highest quality health care while improving patient satisfaction and enhancing my efficiency.

"As we move into the next century, health care systems must explore a variety of health delivery mechanisms that will foster quality, efficiency, and patient satisfaction. The Drop-In Group Medical Group Appointment is one way that this has been accomplished in my practice."

Dr. JaNahn Scalapino

"There are some definite advantages and some disadvantages to the group. For chronic illnesses, for patients with rheumatoid arthritis or fibromyalgia, and for chronic pain and disability issues it works very well. It doesn't work as well for acutely ill or sicker patients because I'm afraid that I'll miss or overlook something important for patients who drop in but actually require a thorough examination and an individual visit. I still have to learn how to best use my group and individual visits: How to have patients who need to be seen individually not drop into group and patients who can best be seen in group not be seen individually.

"Overall, the experience has been a very good one for me, and the patients absolutely love it. It seems like every day I have patients who

have seen the poster or have heard about the group who tell me that it's a good idea and that they would like to attend. Over time, this should help keep the group filled with less effort on my part. In general, I would say that I like it, that patients really like it, and that what I need now is to learn how to best use it."

Dr. Lorraine Abate

"My overall feeling is that it has expanded my horizons about my interactions with patients and different ways that I can interact with them. I've also gotten a lot out of the group dynamics that I've liked. It's heartwarming to see patients open up, share, and help each other. It warms my heart to see that. I also like the fact that I don't have to do any notes afterwards—that I can get them all done during the group.

"I don't feel that I've gotten far enough off the ground yet to see as much from my group as I'm sure it will eventually provide, mostly because I only work half-time. Even if I only broke even as a result of having the group, it would still be worth doing the group because it's so enjoyable, different, and helpful to patients. I expect to see even more benefit with time as my patients and I get more used to using it. As schedulers and patients become more familiar with the group, and as I see and invite more patients, I expect that it will succeed exponentially—which is the key to increasing census.

"The biggest challenges to me are: (1) getting the census up; (2) learning how to best manage my time in the group; and (3) figuring out how to best do it as it's so different from what I'm used to. I don't know of any negatives that have occurred as a result of the program. One thing I can say is that I didn't anticipate how draining it would be to see such a large number of patients at once in the group. On the other hand, the group concept takes advantage of one of the greatest untapped resources we have: the patients themselves—both in managing their own disease and in helping each other. Also, I've appreciated all the help that I've received in group from the behaviorist."

Dr. Daniel Fields

"Challenges for me: Let the behaviorist be more active in it. Give up some control. As physicians, we have a long history of always having to be in control, so this is new to me. Use it more for follow-up—that is where it will be most valuable to me. Also, it's a good place to put follow-up care—to save time and improve quality of care. Many patients' issues only take two or three minutes of appropriate care, so why give them a 15-minute appointment if it can be handled better in just a couple of minutes in group? This will free up my office visits so that I can have more time available for patients who need them. Also, it reduces the need for my having to repeat the same information over and over, because I can say it one time in the group to many patients at once. Plus, patients are more likely to follow a lot more of the advice because other people in the group agree with what I'm saying. Also, I can spend more time in the group on lifestyle and non-compliance issues (like weight loss, stopping smoking, and better diabetes control) and get a better result. People will listen to and learn more from other people than from me.

"I'm glad that I'm doing it, although it still causes me some anxiety because it's still a new thing and I'm not quite used to it. It's an effort to invite people and that's the key to success—I simply have to do a better job at making that effort. I think the schedulers are starting to get more enthused about the program, which should help. I think that it's a good idea to have them sit in on the group to see what it's like. Although it's hard to free them up from other duties in the clinic, perhaps we could have them each come in one time for 15 or 30 minutes.

"Do I enjoy it? Absolutely! I really like the fact that I get almost all of my notes written there so that when the group is over, it's over. Plus it's better for the patients too because there are things that happen there that are better care. We can follow some things closer and there's less chance of missing something or having it fall through the cracks because we can watch for it each time they come in."

FIGURE 3

Patient Satisfaction Data for Four Pilot DIGMAs

RANGE OF AVERAGE SCORES BY PILOT PHYSICIAN FOR ALL SEVEN QUESTIONS

Physician	Average Score (out of 5)
Dr. Hopkins (75 Surveys)	4.3 - 4.7
Dr. Scalapino (42 surveys)	4.7 - 4.9
Dr. Abate (33 surveys)	4.5 - 4.8
Dr. Fields (62 surveys)	4.4 - 4.8
Overall Average Score	**4.67 / 5**

Conclusion

This pilot project has clearly demonstrated several benefits of the DIGMA model: Even in the earliest stages of the implementation process, carefully planned, adequately supported, and properly run DIGMAs can enable physicians to be more productive while both patients and physicians are highly satisfied. Although it is still too early in the implementation process to expect that the increased physician productivity delivered by these pilot DIGMAs would have significantly reduced the access backlog of pilot physicians after only two months, improved access is expected to occur

over time—other things being equal.

Results of this pilot project make it clear that part-time physicians, who consequently have correspondingly smaller patient panels from which to draw their DIGMA patients from, will be more likely to succeed with achieving targeted census levels if they utilize the all-inclusive heterogeneous DIGMA model rather than the more restrictive mixed or homogeneous DIGMA models. It is also clear that DIGMAs are potentially best able to dramatically increase the productivity of physicians whose pre-DIGMA productivity during individual office visits is relatively low. By contrast, physicians who are extraordinarily productive during traditional individual office visits present the greatest challenge to any model striving to increase physician productivity. Nonetheless, DIGMAs can be of great benefit even under this circumstance, although realistically census targets might then need to be reduced somewhat (i.e., from the typical goals of increasing primary care physicians' productivity by 300 percent and specialty care physicians by 400 percent to perhaps 200 percent and 300 percent, respectively).

As discussed in the previous article, health care organizations looking at DIGMAs as a means of helping them to solve their efficiency, access, service, and quality of care issues will find that group visits tend to magnify any pre-existing inefficiencies and problems that might already exist in the system. Unless addressed, all such systems problems tend to have the common effect of reducing group census and therefore the degree to which physician productivity is increased through the DIGMA program. The frustrations of such difficulties also tend to decrease both patient and physician satisfaction with the DIGMA program. However, once addressed, both DIGMA and individual office visits can experience substantial benefits.

Next Month: A Business Plan for Starting a DIGMA Program

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Physicals Shared Medical Appointments: A Revolutionary Access Solution

BY EDWARD B. NOFFSINGER, PH.D.


R. L. Burgard

The Physicals Shared Medical Appointment (Physicals SMA) model was originated by the author in 1999 specifically to improve access to physical examinations in primary and specialty care through the use of existing resources. It was designed to capture the multiple benefits and efficiencies that shared medical appointments can offer,[1] and to enable internists, family practitioners, and medical specialists to provide two to three times as many complete physical examinations as could be provided through traditional individual physicals in the same amount of time. This 200-300 percent increase in productivity for physicals, which can positively impact the bottom line, is achieved while simultaneously offering privacy to patients, quality care, and high levels of patient and physician professional satisfaction. The Physicals SMA model can be viewed as a series of one doctor-one patient physical examinations with observers, but with the added benefits of a behaviorist and the group itself.

Although this model was originally designed for internal medicine and family practice, it is now being expanded into other areas of medicine such as prenatal exams in obstetrics, digital rectal exams in urology, foot exams in podiatry, and well baby exams, school physicals, and sports physicals in pediatrics. In addition, extensions of this model have found application in other medical subspecialties, such as providing vaccinations for long- and short-term travelers in travel medicine, and cosmetic examinations and consultations in dermatology in order to free up more of the dermatologist's schedule for surgical procedures. However, for reasons that are discussed herein, the productivity gains in many of these areas are often closer to 200 percent, rather than the 300 percent efficiency gains frequently achieved in family practice and internal medicine.

THE PHYSICALS SMA MODEL ADDRESSES AN IMPORTANT CONTEMPORARY HEALTH CARE CHALLENGE THAT FACES MEDICAL GROUPS THROUGHOUT THE COUNTRY: PROVIDING PROMPT ACCESS TO PHYSICAL EXAMINATIONS, ESPECIALLY IN PRIMARY CARE.

Prompt Access to Physicals

The Physicals SMA model addresses an important contemporary health care challenge that faces medical groups throughout the country: providing prompt access to physical examinations, especially in primary care. Simultaneously maintaining desired levels of access to both physical examinations and follow-up appointments through use of existing resources presents a significant and ongoing challenge to many group practices in today's rapidly changing and highly competitive health care environment.

According to Al Fisk, M.D., medical director of The Everett Clinic, "One of our biggest problems is access. We have a huge demand for primary care appointments—for physical exams, new appointments, same-day visits, and re-checks. We also have a huge demand for specialty appointments. We are unable to grow fast enough to meet these needs."

Some might question the medical necessity of providing physical examinations at all; however, this issue is complicated by the fact that patients request physicals for a number of different reasons. While some requests for physicals are demands of questionable medical necessity, other requests involve necessary prevention, vague or specific symptoms, or chronic illnesses involving multiple organ systems that need to be closely monitored. The appropriateness of, the medical need for, and the ultimate benefit of physical examinations will undoubtedly differ considerably for different types of patient demands.

Providing good access to physical exams represents a significant and pressing health care delivery problem for many medical groups around the country. Many health care delivery systems simply lack the necessary resources to hire enough physicians and associated support staff to achieve and maintain good access to both physical exams and return appointments in primary and specialty care. Furthermore, when

emphasis is placed upon improving access (or achieving same-day access) for return visits, it sometimes results in deteriorating access for physical examinations. What is needed is a tool for "working smarter, not harder"—a tool that will leverage physician time, increase efficiencies, improve access, and positively affect the bottom line while simultaneously maintaining appropriate privacy and providing both quality care and satisfied patients and physicians.

Points of Clarification

Four important points of clarification about the Physicals SMA need to be made at the outset:

First, the difference between Physicals SMAs and traditional physical exams lies in the fact that all of the time-consuming verbal dialogue (i.e., the "social interaction" component of the exam) is conducted not with each patient individually, where the same information often needs to be repeated to one patient after another, but rather in the highly efficient group setting where the physician can have the added benefits of a behaviorist plus group interaction and support, and physician productivity can be increased as the physician only has to say things once—often in greater detail—and all present can listen and learn.

Second, all private components of the physical examination are conducted with each patient individually in the privacy of the exam room. Patients are not nude together, nor are they herded en masse from one station to another. Physicals SMAs provide a highly personalized approach to the delivery of physical examinations, with all boundaries for privacy that patients have grown to expect appropriately maintained. The issue of confidentiality in the Physicals SMA setting is handled by having all patients in attendance sign a separate confidentiality waiver drafted in patient-friendly terms by medical risk-management, and by also having the behaviorist address confidentiality in the introduction given during each session. To date, no difficulties have arisen in the area of confidentiality either in Physicals SMA sessions or in the more than 10,000 DIGMA[2] patient visits conducted by the author.

Third, Physicals SMAs deliver quality medical care with high levels of patient satisfaction. Patients who attend Physicals SMAs often report that they received more information and personal attention than they historically have through traditional physicals, and that they feel they have received quality care. Patients have uniformly appreciated the improved access and, to date, none have found the experience to be either an impersonal one or a "herd of cattle" approach to medical care. To the contrary, patients typically report that their Physicals SMA experience was highly personalized, informative, and very helpful to them.

Fourth, Physicals SMAs represent a series of one doctor-one patient encounters with observers. This is the case in the exam room—where the physician is providing physical examinations to patients individually and in private—and in the group room—where the interactive segment represents a series of customized individual risk reduction interventions. The physician is also addressing the unique medical needs of one patient at a time in the group room—but with the added benefits of more time plus help from the behaviorist and other patients.

First Clinical Applications

The Physicals SMA model, which was originated by the author in 1999 for application in primary care, continues to be refined and expanded into new areas of application in various medical specialties. While still in its early stages, the Physicals SMA model is already showing exceptional promise. The original goals of the Physicals SMA model were to deliver two to three times as many complete physical examinations as could be provided through traditional individual physicals in the same amount of time, thereby improving access to physicals—and to accomplish this while maintaining appropriate privacy and simultaneously providing quality care and satisfied patients and physicians.

The first clinical applications of this model in actual practice occurred in 2000 at the Palo Alto Medical Clinic (PAMC). PAMC is a large multispecialty medical group of approximately 225 primary and specialty care physicians in Northern California. Its payer mix is approximately 60 percent fee-for-service and 40 percent capitated. It conducts 700,000 outpatient visits per year with $200 million annual revenues (overall, about 10 percent of patients are Medicare). PAMC is a part of the larger Palo Alto Medical Foundation, where the author is Director of Clinical Access Improvement and heads the Shared Medical Appointment Department—which is responsible for launching 18 DIGMAs and Physicals SMAs per year in primary and specialty care.

The Physicals SMA model was originally implemented in primary care at PAMC to address significant access problems for physical examinations. Some physicians in family practice and internal medicine had backlogs as large as 200+ physicals (i.e., after all physical examination appointments for the next 3 months were already filled). Along with gains in efficiency, the model has been demonstrated to provide both quality care and high levels of patient and physician satisfaction, and it is now beginning to be implemented throughout the PAMC system.

The importance of group visits for

addressing access problems are pointed up by David Druker, M.D., president and CEO of the Palo Alto Medical Foundation, "Patient access is far and away our biggest concern—particularly in the area of primary care. Our access problems are based on a number of different factors, including difficulty recruiting physicians and staff, the demise of other medical groups in the area, tremendous patient demand, etc. In many ways this is a happy situation—to have this level of patient demand. On the other hand, it does produce these access problems and service issues. So, we are looking at ways to improve our access while maintaining our quality and we think that Shared Medical Appointments—particularly in the area of physical examinations—are a way to address this. Access is a problem, and the Physicals Shared Medical Appointment is a way to address this problem—both solving the access issue and achieving the highest level of quality and patient satisfaction."

PRIMARY CARE PHYSICIANS HAVE COMMENTED THAT THE TOTAL AMOUNT OF TIME THAT JUST THE PHYSICAL PART OF THE EXAMINATION TAKES REPRESENTS ONLY A SMALL PART OF THE TOTAL VISIT.

The Component Parts of Traditional Physical Examinations

Physicals SMAs deliver physical examinations to multiple patients at the same time—largely in a group visit setting—with dramatically increased efficiency. Yet this is accomplished while maintaining the appropriate degree of privacy, because the private parts of the physical are delivered to patients individually in the privacy of the exam room.

In its broadest sense, the traditional physical examination can be viewed as consisting of three major parts: (1) the actual **physical examination segment**; (2) the **interactive segment**, i.e., the dialogue, verbal components, and social interaction between the patient and physician, including review of symptoms, personal and family health histories, social history, risk assessment and reduction, patient education, etc.; and (3) the **documentation segment** of the visit, i.e., the extensive charting requirements. In turn, the "physical examination segment" can itself be divided into two parts: (1) **the private part** of the physical examination, i.e., those components of the physical which require privacy (prostate, rectal, and testicle exams for men; pelvic and breast exams for women; and any other components of the exam that either the physician or patient prefers to have conducted in private); and (2) the **non-private part** of the physical, i.e., the remaining components of the physical examination, which do not need to be conducted in private.

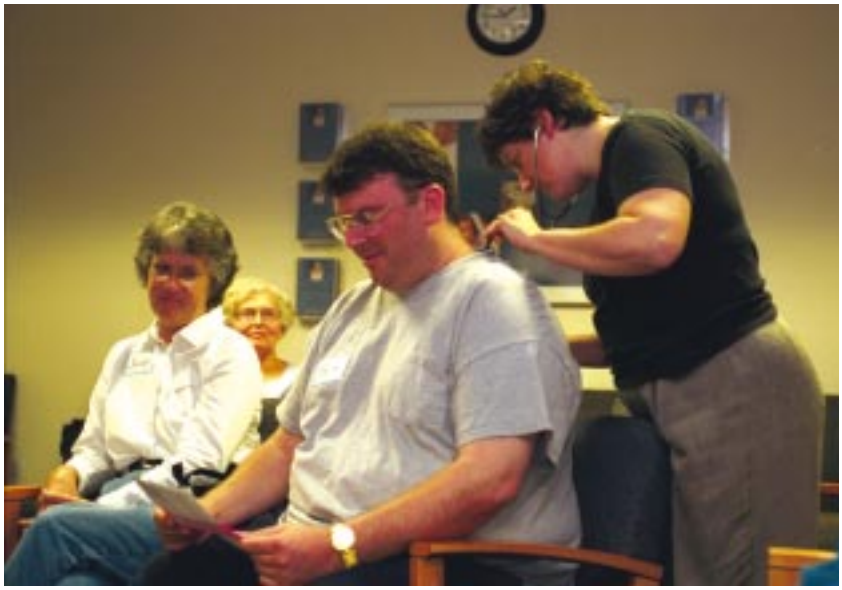
Interestingly, the "physical examination segment" actually takes only a small fraction of the total appointment time allotted for a traditional individual physical examination—typically just a few minutes for men and a minute or two longer for women. Many primary care physicians have commented that the total amount of time that just the physical part of the examination takes represents only a small part of the total visit.

Far more time is spent on the "interactive segment"—i.e., the combination of all the talking, social interaction, history taking, risk assessment, patient education, and psychosocial aspects of the physical examination visit. Because the "physical examination segment" represents a very small part of the total time required for a physical examination, by definition the subset referred to above as the "private part" takes even less time. Yet the "private part" is the only part of the physical examination that needs to be provided individually and in private. This means that the time-consuming "interactive segment" of the physical examination, and to a lesser extent the "non-private part" of the physical examination, could be performed in the interactive group setting—where they could be conducted with corresponding gains in efficiency.

Almost all "interactive segment" issues can be more efficiently handled during the interactive group

Warren Hukill

Cardiologist Aria DiBiase, M.D., conducts a group visit.



Warren Hukill

Dr. DiBiase with her cardiology patients.

segment of the Physicals SMA, and without the need of repeating the same information over and over to different patients individually in the privacy of the exam room. Such common topics as cholesterol, hypertension, diabetes, osteoporosis, HRT, breast self-exams, prostate, asthma, GERD, irritable bowel, fungus toenails, incontinence, sleep problems, stress management, depression, alternative medicines, direct pharmaceutical ads, information patients glean from the Internet, internal and community resources, etc.—issues that internists and family practitioners finds themselves repeating over and over during the day—only need to be addressed once in the group setting, where all patients present can listen and learn. In addition, because of the multiple benefits that a well-run Physicals SMA provides, such issues can be discussed not only once but also more comprehensively and in greater detail as the physician individually addresses the needs of one patient after another in the group setting.

Physicals SMAs in Practice

The central feature of the Physicals SMA model is the efficient delivery of complete physical examinations—largely in a supportive and informative group setting, but with privacy appropriately maintained. This focus also differentiates the Physicals SMA model from other group visit models such as the DIGMA and CHCC,[3] which are primarily directed at return visits and follow-up care—not physical examinations. High level administrative support and the best possible champion are critical to success—and are necessary to achieve the full benefit of the Physicals SMA model.

Typical Structure of a Physicals SMA

There are three subtypes of the Physicals SMA model: homogeneous, heterogeneous, and mixed—options that enable Physicals SMAs to be customized to the specific preferences, needs, goals, practice styles, and patient panel constituencies of individual physicians.

Physicals SMAs are generally held weekly for 90 minutes, although they could be of either shorter or longer duration, and could be held either less or more frequently. Primary care Physicals SMAs most frequently contain between 6 to 9 patients (typically of the same sex), and the physician typically provides the private physical examinations at the beginning of the session (followed immediately thereafter by the interactive group segment of the visit). The census in medical subspecialties is often somewhat larger, typically between 9 and 13 patients. Patients can be either new or existing patients for the physician.

In general, these patients are due (or past due) for a physical examination—and often meet certain selection criteria (such as position on the wait list, age, sex, diagnoses, etc.). In family practice and internal medicine, the most common goal is to complete between 6 and 9 physical examinations during the 90-minute Physicals SMA. Because these exams would normally require 30 to 45 minutes each when provided individually, the result is typically a 200-300 percent increase in the primary care physician's productivity for providing physicals (with 300 percent being the most common goal in primary care).

The "Patient Packet"

A "patient packet" is sent to patients when they schedule a Physicals SMA appointment. It can contain any of a number of items, and is customized to the requirements of the individual physician. For example, the patient packet can contain any of the following items: (1) a personalized cover letter (addressing all important details about the program) signed by the physician; (2) a program description flier (or another enclosure specifically designed to describe the program); (3) important informational handouts and educational materials selected for inclusion by the physician (e.g., recommended health maintenance screening schedule by age group); (4) personal and family health history forms, as well as health questionnaires; (5) forms for obtaining routine health maintenance that is due for the patient; and (6) forms for screening tests (to be completed prior to the session,

whenever possible).

The goal is to schedule patients into the Physicals SMA two to four weeks in advance of the session. The patient packet is then promptly sent to patients by mail, fax, or electronically (e-mail; Web site; etc.). The patient is instructed (both when scheduling the appointment and in the cover letter of the patient packet) to complete the enclosed forms as soon as possible, and then to promptly return them once completed by mail, fax, or electronically.

This amount of advanced scheduling provides enough time for patients to complete the medical questionnaires, health history forms, and at least some of the screening tests enclosed in the patient packet—and then to return the completed forms at least a week prior to the Physicals SMA session which they are to attend. In this way, the information contained therein can be abstracted into patients' medical charts prior to the scheduled session. Also, this amount of advanced scheduling can enable patients to complete some of the recommended routine health maintenance and screening tests in advance of the scheduled Physicals SMA session (the forms for which were enclosed in the patient packet). Thus, by the time the patient attends the Physicals SMA session, not only has the returned information been abstracted into the patient's medical record, but the physician might also be in receipt of some of the results of screening tests that were ordered. This updated information about the patient enables the physician to treat the patient based upon the most recent information and test results that are available, which can enhance quality of care in Physicals SMAs—as this most recent information from screening tests is typically not available for traditional physical examinations.

Efficient Delivery of Complete Physical Examinations

In the Physicals SMA model, the physician always provides the private part of the examination individually and privately in a nearby exam room—i.e., those parts of the exam that require patients to disrobe, plus any parts of the exam that either the patient or physician prefers to have in private. It is important to note that not every patient will require that all components of the private physical examination be provided to them, although most typically will.

BY STARTING A PHYSICALS SMA FOR HIS/HER PRACTICE, A PHYSICIAN CAN IMMEDIATELY BENEFIT FROM THE INCREASED PRODUCTIVITY AND EFFICIENCY WHICH THE PROGRAM OFFERS WHILE SIMULTANEOUSLY HELPING THE FACILITY TO IMPROVE ACCESS TO PHYSICALS.

Some physicians prefer to deliver as much medical care during the interactive group segment of the Physicals SMA as is possible and appropriate—including many non-private parts of the physical exam that do not require patients to undress (e.g., examination of gait disturbances, tremors, swollen ankles, varicose veins, thyroid, tennis elbow, wrist pain, skin lesions on the face and extremities, arthritis in the extremities, neck and leg pain, etc.). In this case, the primary care physician might divide the Physicals SMA into a 30-minute segment for private exams in nearby exam rooms, and a 60-minute interactive group segment.

However, most primary care Physicals SMA physicians seem to find it easier and more efficient to simultaneously provide both the private and non-private components of the physical examination in the privacy of the exam room (i.e., while examining the patient alone, without any distractions). In this case, the physician might choose to split the 90-minute Physicals SMA into 2 equal 45-minute parts for the private exams and the interactive group segment.

In every case, the intent is for the physician to be able to rapidly conduct the private components of the physical exam so that the total amount of time spent by the physician in the exam room does not exceed 30-45 minutes. In this manner, the physician can devote as much time as possible to the highly efficient interactive group segment of the Physicals SMA.

Hidden Benefits

In addition to the multiple benefits for which Physicals SMAs were designed, there are many potential benefits that are less obvious.

Consider, for example, the new physician whose schedule is not yet full and who works at a facility with access problems—i.e., having some very busy physicians with established practices and wait-lists for physical exams. By starting a Physicals SMA for his/her practice, this physician can immediately benefit from the increased productivity and efficiency which the program offers while simultaneously helping the facility to improve access to physicals. For this to be accomplished, the physician only needs to ask backlogged colleagues at the facility for permission to have patients who are wait-listed on their schedules attend the physician's Physicals SMA. While some colleagues might not agree to this arrangement, experience demonstrates that others will—plus be appreciative for the improved access to physicals in their practice and the increased service to their patients.

There are many other potential benefits of a carefully designed, adequately supported, and properly run Physicals SMA program. Take


R. L. Burgard

Richard Greene, M.D., conducts the private part of the physical.

for example, the patient who denies or fails to volunteer important health-related information to the physician. Another patient might bring up risk factors or discuss a health problem during the interactive group setting that in fact also applies to this patient, but which was not previously disclosed to the physician. When this occurs, experience demonstrates that the patient will often let the doctor know that this discussion also applies to him/her—which permits this medical issue to then be properly addressed.

With traditional individual physical exams, late cancellations or no-shows can result in inefficiency and underutilized physician time; however, this problem can easily be avoided with Physicals SMAs by simply overbooking sessions sufficiently to compensate for the expected number of late cancels and no-shows.

Another hidden benefit of the Physicals SMA program is improving compliance with recommended treatment regimens. Other patients in the group will often support the physician in getting the non-compliant patients to rethink their position and follow the doctor's treatment recommendations—and do so in a kind and gentle manner. Patients refusing a treatment or lifestyle change that is being recommended by the physician can often be persuaded to comply by other group members—for example, by those who have already taken insulin, started dialysis, or quit smoking. Similarly, patients who are reluctant to take a medication—or to undergo a recommended diagnostic procedure such as a sigmoidoscopy—can often be persuaded to do so by other patients who have already taken the medication or undergone the procedure and encourage the patient to do likewise (often pointing out that it is not as difficult as it sounds).

MANY OF THE ISSUES DISCUSSED IN THE INTERACTIVE GROUP SETTING ARE OF COMMON INTEREST TO SEVERAL PATIENTS AT ONCE—WHICH AVOIDS THE NEED TO REPEAT THE SAME INFORMATION.

The Physicals SMA Team

In the Physicals SMA, the **physician** is assisted by a **behavioral health professional** (i.e., a behaviorist, such as a psychologist, social worker, etc.) and a **nurse** or **medical assistant** (M.A.)—typically the physician's own nurse or M.A. The behaviorist's duties include handling group dynamics and behavioral health issues, keeping the group running smoothly and on time, and taking over the group temporarily while the physician is documenting the chart note after working with each patient. A nurse or M.A. has duties that include rooming patients, taking vital signs, performing other special duties (such as injections, feet examinations, and routine health maintenance), and making entries into patients' charts.

Other personnel perform vital support functions for each Physicals SMA. These additional members of the Physicals SMA team include:

- The Physicals SMA **champion**, the pivotal person who has overall responsibility for developing the Physicals SMA program in the system, and then moving it forward throughout the entire health care organization
- The **scheduler**, a trained clerical person who telephones patients from the physician's wait list for physicals (or from other lists of patients whom the physician wants invited to the Physicals SMA), invites them to attend, and sends follow-up "patient packets" to patients who agree to attend
- A **program coordinator** (in larger systems) whose responsibilities include conducting the operational and administrative details for the Physicals SMA program and assisting the champion
- **Documentation support personnel** charged with the responsibility of assisting the physician by handling—to the maximum degree possible—the extensive charting responsibilities that physical examinations entail: before (e.g., abstracting), during (e.g., scribing, making the EMR as "user friendly" as possible,

Warren Hukill

Dr. DiBiase can give information to the whole group.

etc.), and after (e.g., entering changes, corrections, and additional details) each session

Component Parts of the Physicals SMA

Like traditional individual physical exams, Physicals SMAs can be divided into two parts: (1) the actual **physical examination segment**, which is largely provided individually in the privacy of an exam room; and (2) the **interactive group segment**, which occurs in the supportive group setting—with the physician and behaviorist present throughout—where all present can listen, learn, and encourage one another as the physician addresses the questions and medical concerns of each patient in turn. As is the case for the traditional individual physical examination, the physical examination segment of Physicals SMAs can likewise be divided into the **private part** and the **non-private part**.

Physical Examination

In the Physicals SMA, only the private part of the physical examination—which requires comparatively little time—needs to be provided in the privacy of the exam room. Virtually all of the time-consuming interactive segment of the physical, as well as the non-private part of the exam, can be provided in the group setting—although most Physicals SMA physicians find it more efficient to provide much or all of the non-private part in the exam room. Whenever possible and appropriate, any discussions or questions brought up by patients in the exam room should be tactfully deferred by the physician to the interactive group setting.

The actual physical examination segment of the Physicals SMA—which always includes the private part, and may or may not include the non-private part—typically lasts 30 minutes, and should not last more than 45 minutes. It is typically during this segment of the Physicals SMA, when the physician provides physical exams individually and in private, that patients are roomed by the nurse or M.A. (typically 2 at a time in nearby exam rooms) and vital signs are taken. It is also during this time that the behaviorist takes over leading the group (i.e., for those patients in the group setting), and focuses upon asking what patients' pertinent medical concerns are, distributing informational handouts that the physician wants given to patients, and addressing behavioral health, stress management, and psychosocial issues.

Depending upon the physician's preference, vital signs could also be taken at other times during the session by the nurse or M.A. However, taking vitals in the privacy of the exam room does offer certain advantages: (1) patients can talk to the nurse or M.A. without disturbing the group; and (2) patients' weights can be taken in private, as this is one component of their care that many patients do not wish to share with others.

Interactive Group Segment

The interactive group segment of the Physicals SMA session (in which the physician, behaviorist, and patients are all present in the group room—and which often also includes the nurse or M.A.) typically lasts between 45 and 60 minutes. It is in this part of the Physicals SMA that the majority of discussion occurs between the patients, physician, and behaviorist. Discussions in the interactive group setting frequently cover such topics as diabetes, hypertension, cholesterol, arthritis, asthma, osteoporosis, HRT, breast self-exams, incontinence, exercise, nutrition, depression, treatment options, medications and side effects, community and internal resources, etc.

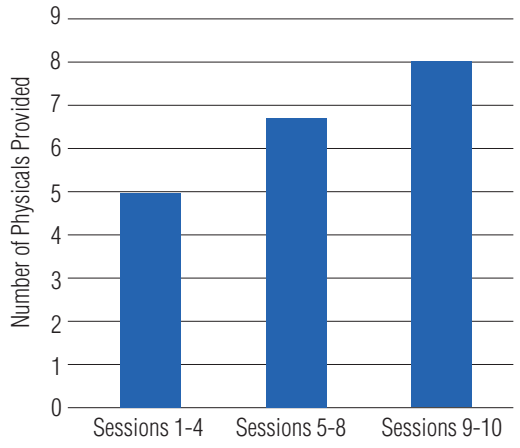
It is here that almost all verbal interchanges between patients and the physician occur. Questions are asked and answered; health concerns are addressed; important health care information is provided; healthy lifestyles are encouraged; disease self-management strategies are explained; treatment options and medication side-effects are discussed; non-compliance is addressed; prescriptions are changed or refilled; many tests and procedures are ordered; and internal as well as outside referrals are made.

The physician works individually with one patient after another in the

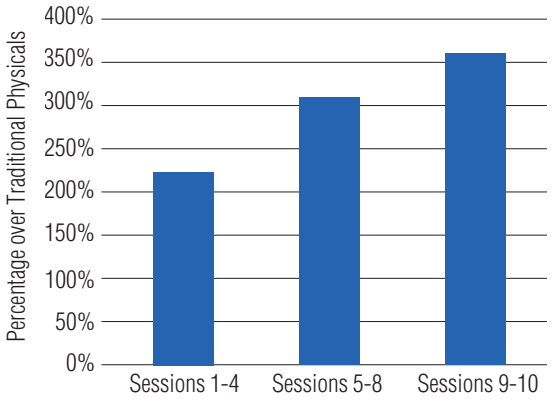
One Physician's Experience with the Physicals SMA Model

Dr. James Stringer, a senior family practitioner at the Palo Alto Medical Foundation, began a Physicals SMA for his practice on August 2, 2001. He is enjoying his Physicals SMA, and the efficiency and productivity gains that it is providing. He has recently made the decision to start a second weekly Physicals SMA in his practice. During clinic hours, Dr. Stringer schedules 30-minute appointments for uncomplicated individual physical exams on healthy patients under 50, and 45-minute individual physicals for complicated patients and those over 50. During the normal work week, he has approximately the same number of 30- and 45-minute appointments on his schedule. This scheduling mix, together with the occasional patient who no-shows or late cancels, results in his productivity for individual physical examinations being approximately 2.2 physicals per 1 hour of clinic time.

Increase in Physician's Productivity



Percentage Increase in Physician's Productivity



The charts depict (1) the productivity (in actual numbers of physicals provided) and (2) the percentage increase in productivity (over the 2.2 individual physicals that are typically provided in 1 hour of clinic time) that Dr. Stringer has experienced in providing physicals in his Family Practice Physicals SMA during the first 10 sessions of operation.

Clearly, census has rapidly increased from initial levels as the physician and entire Physicals SMA team have gained experience with the program, and with achieving targeted census levels. Another benefit of experience has been that more recent sessions are finishing approximately on time, whereas earlier sessions often ran late. The documentation support piece is still a work in progress. A major breakthrough in efficiency occurred after the fifth session, when the delivery of physical exams was moved from the last part of the session to the beginning. Minor tests and procedures are often provided individually for a couple of patients at the end of the session—e.g., liquid nitrogen treatments, removal of ear wax, or brief hearing tests. Interestingly, the combined number of no-shows and late cancels has been relatively small—approximately one patient per session. In part, this is due to patients receiving two phone calls just prior to the session: the standard appointment reminder call for the PAMF system 3 days before the session, and a second, personal phone call from the scheduler or program coordinator on the morning of the session. Dr. Stringer has increased his maximum census accordingly to compensate for the expected number of no-shows and late cancels. His maximum census has therefore risen to 9 as he finds that he now ideally likes to have 8 patients present.

Dr. Stringer comments on his experience:

These groups have improved both patient satisfaction and my own professional satisfaction. The initial appeal for the patients is just being able to get an appointment for a physical exam quickly. Then, once they get into the group, they enjoy the extra time with the doctor and the opportunity to discuss their questions and concerns. They like the focus on preventive care and the patient information sheets that we have prepared on common problems. They often learn as much from the questions raised by other patients as from the ones they brought themselves. The feedback from the patients who attend has been uniformly positive.

For me, the initial appeal of the groups was the opportunity to shorten the wait time for physicals, which had become a major source of patient dissatisfaction. Once the groups began, I found that they provided an opportunity for effective patient education, since we have more time to discuss common topics. Almost every patient has been interested in discussing preventive health care—they have heard a lot of ideas about how to stay well from various community sources, and they really want to know what their doctor thinks. Also, it feels more efficient to say something once to a group of eight men than to say it eight times during individual exams. The groups are a stimulating change in the daily routine. The discussions are often lively, and it can be a challenge to guide them so that everyone's concerns are addressed by the end of the session. Patients express their appreciation after each group and even at subsequent visits. The overall experience has been very satisfying.

Access to physicals has definitely improved as well. Now that my wait list has shortened, there are occasional sessions in which there are openings for wait-listed patients of my colleagues. These men appreciate being seen sooner, and their doctors benefit from having their wait list shortened.

group setting while fostering group interaction. Group discussions are often stimulated by various patients' questions and health concerns—and helpful suggestions are often made by other patients. Many of the issues discussed in the interactive group setting are of common interest to several patients at once—which avoids the need to repeat the same information over and over to different patients individually, and results in increased efficiency.

An Access Solution

Physicals SMAs are very similar to traditional individual physical examinations in that they both focus upon delivery of medical care from start to finish; are similarly structured into physical exam and interactive components; review symptoms and assess/reduce risk; address history and medical decision-making; provide similar health-related information; deliver the same procedures and medical care; and update routine health maintenance. Like the traditional individual physical examinations, Physicals SMAs also provide comprehensive physical examinations and maintain privacy. Addressing the unique medical needs of one patient at a time, the Physicals SMA model can be viewed as a series of one doctor-one patient physical examinations that occur one after the other (i.e., in both the exam room and the group room), with the added benefits of the behaviorist and the group itself. Complete physical examinations are provided during the two parts of the Physicals SMA, with all of the same components of care being provided to patients in the Physicals SMA setting as are traditionally delivered to patients during individual physical examinations.

According to David Hooper, M.D., senior administrator of clinical services at Palo Alto Medical Foundation, "The Physicals SMA and DIGMA programs are the only methods I have ever seen that simultaneously improve M.D. morale, improve patient satisfaction, improve access, improve the healing experience for patients with chronic symptoms, and make money. The Physical Exam SMA is even more important to this organization than DIGMAs are for return visits. This is because the single most expensive service we provide in the outpatient setting is the annual exam. We don't have enough M.D. capacity to do the preventive services that our patient population needs from us. We have to get creative about how to provide these services more efficiently. We will not be able to hire enough doctors to keep up with the growth of our practice."

References

1. In addition to the group visit model discussed in this article, the author also pioneered the Drop-In Group Medical Appointment (DIGMA), and has written extensively about the model in this publication, most recently in Edward P. Noffsinger, Ph.D. 2001. Solving Access Problems with DIGMAs. *Group Practice Journal*. 50(10): 26-36.
2. See previous reference.
3. CHCC refers to the Cooperative Health Care Clinic, pioneered by John C. Scott at Kaiser Permanente Medical Group in Colorado. CHCC was featured in a series of articles in *Group Practice Journal*. For the first in the series, see Edward B. Noffsinger, Ph.D., and John C. Scott, M.D. 2000. Understanding Today's Group Visit Models. *Group Practice Journal*. 49(2): 46-58.

Next Month: Operational Issues to Consider with Physicals SMAs

Acknowledgements

The author would like to thank the following: Dr. David Hooper for his consistent support, encouragement, thoughtful review of this article, and many helpful suggestions, the Administration at the Palo Alto Medical Foundation for their ongoing support of this work, and the primary and specialty care Physicals SMA physicians at PAMC who were willing to embrace innovation and to try something new and different in a difficult era involving busy practices and extensive change.

Edward B. Noffsinger, Ph.D., is a health psychologist and the director of clinical access improvement at the Palo Alto Medical Foundation. He is also an independent consultant and a pioneer in the area of group visits. He originated the Drop-In Group Medical Appointment (DIGMA) model at the Kaiser Permanente San Jose Medical Center in 1996 <TheDIGMAmodel@aol.com>.

Drs. Noffsinger and David Hooper will be speaking about the Physicals Shared Medical Appointment at AMGA's National Conference on Physician Directed Health Care, February 21-23, in San Diego, California. For details, see page 49.

Part II

Group Medical Appointments

The Behaviorist Role

The Behaviorist—A New Healthcare Role

Better to be a guide on the side,
than a sage on a stage.
The Behaviorist Role In A Nutshell—Origin Unknown

A New Healthcare Role

The behaviorist name and role are new to healthcare. **See *What's in a Name?* DVD #2**

Perhaps the closest analogy to this new team role is that it is like an orchestra conductor. The 'orchestra' is the patients and other providers. The 'soloist' is the physician. The role of the conductor is to collaborate closely with the soloist, and then match the orchestra with the soloist's timing. One indication of a good performance is when no one notices the conductor, only the music.

Thus, collaborative team building combined with active direction form the essence of the behaviorist role. A sign of a job well done is when providers and patients remember only the giving and receiving of quality medical care.

In general, the behaviorist manages—

- Group dynamics
- Group discussion
- Psychosocial issues
- The time

The professional background of behaviorists is not as important as the desire and characteristics to assume the role. Many different professions can function as behaviorists—MOAs, all nursing levels, social workers, mental health workers, medical students, nursing students, clinical educators, and, of course, psychologists.

Behaviorist Duties For DIGMAs & Physicals SMAs

- Arrives 15 to 20 minutes early and meets patients as they arrive
- Warms up the group by asking about each patient's 1 or 2 concerns and writing them on a flip chart
- Begins the group on time with an introduction speech **See *The Speech* DVD #2**
- Leads the Group Medical Appointment
- Ends the appointment on time
- Stays afterward for a brief time to look after miscellaneous patient concerns
- Participates in a short debriefing after the group

A New Healthcare Role (Continued)

Characteristics Of An 'Ideal' Behaviorist

The behaviorist role is more than just one of group facilitation. Due to the fundamental nature of GMAs, behaviorists tend to inject more of their personalities into the role, have a passion for healthcare innovation, and are actively involved in health behavior change in themselves and their patients/clients.

Following are some characteristics that describe an ideal behaviorist. Anyone who fulfills the essence of these characteristics should consider the behaviorist role.

Professional Background

- Previous experience speaking in front of others
- Previous experience working within teams
- Active in a healthcare role that interacts with patients/clients
- Some understanding on how to guide people in the change process (eg. Motivational Interviewing, Stages of Change, 5As **See Using 'NH 5As' in GMAs**)
- Some knowledge of Quality Improvement issues, process, and movement

Practice Style

- Affirms the patient's freedom of choice and self-direction (self management)
- Seeks to understand the patient's agenda, particularly via open-ended questions and reflective listening
- Vigorously supports even small changes of behavior
- Elicits and selectively reinforces the patient's own self motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change
- Monitors the patient's degree of readiness to change—ensuring that resistance is not generated by jumping ahead of the client

Using the 'NH 5As' in GMAs

The 'NH 5As' are a collection of words beginning with the letter 'A'. Each 'A' is meant to trigger a brief communication/counseling strategy that improves the likelihood of behavior change occurring. 'Northern Health's 5As' combine a selection of 'A's used in standard 5A templates with elements of Motivational Interviewing and Stages of Change. While this tool is useful for behavior change conversations, many use it as a basic template for respectful communication in general. Both uses will be of benefit for the behaviorist. (**See 'NH 5As' template pg 5-1**).

Following are some suggestions for adapting the 'A's to group medical appointments.

The 'NH 5As' & GMAs (Continued)

ASK

Refers to finding out the patients' individual health concerns.

- When patients are arriving—*"What are 1 or 2 of the top concerns you would like the doctor to deal with today?"*
- During the group visit—*"What concerns you about …?"*

AGREE

Refers to focusing on the patients' agendas—permission to talk about health concerns:

- During the introduction speech—*"Is this OK with all of you?"*
- Regarding a specific patient concern—"*Is it OK if we talk about this in the group?"*

—to exploring health concerns agendas:

- Group information needs—*"What have you heard about…?" "What is your understanding of…?"*
- Individual information needs—*"How satisfied are you with what you know about (this condition)?" "What do you want to know about…?" "Is this making sense?" "What would you like to do about this?"*

ASSESS*

Refers to confirming a possible change goal and determining stage of change (readiness). *ASSESS conversations are individual focused. However, one way this 'A' could be adapted to group medical visits is as follows:

- *"How many here are interested in (stopping smoking, etc.)?"*
- *"How many are ready to do something about it?"* Go to ASSIST.

ASSIST

Refers to suggestions that might help to reach a behavior change goal.

- Eliciting suggestions from other patients—*"What has worked for you?"*
- If you have a tip, **ALWAYS** start with—*"<u>Some people</u> have found that..."*
- Asking a patient about a self-management plan—*"How do you think you might do this (ie. specific plan for making this change)?"*
- Using the Confidence Scale—*"If 10 means being absolutely sure, what number out of 10 would you choose to indicate your confidence to reach your goal?"* (If less than 7 out of 10)—*"What would have to change in order for that '#' to become at least a seven?"*

ARRANGE

Refers to a plan for follow-up. Document any patient's change goal for follow-up at next visit.

- As much as possible, arrange any behavior change related follow-ups (eg. support group, specialists, 'how to access…') during the GMA.
- *"If you like this (group visit), you can come back anytime you want."*

Becoming a Behaviorist

In practice, DIGMAs are a bizarre and bizarrely appealing combination of Marcus Welby MD and Oprah.

US News and World Report April 2002

Nurture

Nurture your interest

- Watch all DVDs, particularly 'The Behaviorist Role'
- If possible, observe a Group Medical Appointment
- Compose your own Behaviorist Speech
- Practice behavior change 'communication' with your patients/clients

Discuss

Discuss your potential involvement in Group Medical Appointments with your manager. Northern Health is committed to the integration of our health care system.

These models are a practical and supported application of that commitment. Perhaps one could regard involvement as an redesigned way to fulfill a current role and not as an 'add-on'.

Contact

Contact the CDPM coordinators or your local Primary Health Coordinator with your expression of interest. If required, they will help bring together a team.

Attend

Attend a Group Medical Appointment Learning Session with the team and participate in the pre-launch 'Mock' appointment.

'Just Do It'

Just Do It!' It is usual to hold a GMA soon after the Learning Session with a mentor present.

Thereafter, ongoing support is individualized according to your need.

Behaviorist FAQs

See FAQs on DVD #2

- The discussion was really good, why not let it develop more?

  Unlike a support group, too much interaction will slow the DIGMA and patient medical care may become too hurried at the end. Limit the interaction to what is most important to the patient or the group.

- What can I do about the patient who wants to be the center of attention?

  Try these—

  Have the physician start with the patient one over and proceed in the opposite direction so the dominant patient is seen last.

  *Be **direct**. You might say, "It sounds like we've dealt with 2 or 3 of your issues but you still have more to deal with. Let's wait until the end of the group and if we have time we'll deal with it then." Should the patient feel that he/she needs more time, the behaviorist can suggest that he/she return to the next session to have more of their questions addressed.*

- What can I do for the shy, non-communicative patient?

  If you sense that some patients may be uncomfortable speaking in the group, you could ask if they would rather have you go to the next person and come back to them later. They may feel more comfortable if they hear others first.

- What can I do about the 'class clowns' syndrome?

  It is best to deal with this "head on" in a pleasant way, then get back to the group; or ask them to share with the group.

For more on group dynamics see—

Dealing With The Different Types of People/Situations in Group Settings

Pages 3-21 to 3-27

- What's the best way to establish group rules?

  Establishing group rules is not recommended for both of Dr. Noffsinger's models. In the first place it takes away valuable time from the visit. Secondly, it's not necessary for several reasons—the behaviorist's speech at the beginning sets the tone and the structured process of individual physician/patient interactions seems to produce a respectful environment. The only group norm established is confidentiality, which is covered by the introduction.

- What do you do about patients who are 'under the influence' of alcohol or drugs?

  *This is not a common problem. Decide ahead of time with the physician whether it would be acceptable for such a patient to stay or not. With underserved patient groups, if the level of intoxication is **minimal** (eg. violent or inappropriate behavior is not expected), there may be benefit from the group process to allow the patient to stay.*

FAQs (Continued)

- What do I do about a physician who spends too much time on a patient?

  Be proactive. Work out a signal to indicate that it is time to move on. Some point to the clock, others simply interrupt at a pause and say something like this, "Dr. Jones, I see we have a few more patients to see, is it OK with you if we move on?"

- What is the biggest mistake made by beginning behaviorists?

  Allowing too much time for the first 2 patients. Work out with the physician ahead of time to allow 6 to 8 minutes of interaction for each of the first 2 patients, not including documentation time. This will avoid rushing at the end and also establishes reasonable expectations in the minds of the patients.

- What do you do about patients who come to group with colds, or flu symptoms?

  There is no more exposure to bacteria and viruses in a group visit than in a typical waiting room. However, decide ahead of time with the physician—whether to direct these patients elsewhere or to deal with these patients first and have them leave.

- What is a 'Mock' DIGMA?

  A 'Mock DIGMA is a 'dress rehearsal' before launching a group visit. Usually it is directed by the behaviorist with the assistance of a mentor or trainer. During this time, all details regarding holding the group appointment are discussed, such as room layout, snacks, computer troubleshooting, etc. Some teams decide to hear the behaviorist's speech and have the physician role play a medical appointment.

- What is reviewed in a debriefing session and how often are they held?

  With the launch of Group Medical Appointments, short (15 minutes) and informal debriefing sessions should be planned. From those conversations, ideas are generated that can make the next session even better. It is advisable to implement and test one or two small changes at a time.

  If group visits are offered regularly, it usually takes 1 to 2 months to become a 'well-oiled machine', after which the need and purpose for debriefing diminishes. Thereafter, periodic meetings usually focus on evaluation—'Are we accomplishing what we set out to do?' **See Part 4 *Evaluating…***

Dr. Noffsinger's Introduction Speech

Welcome here today. For how many of you is this your first time? You're probably wondering what this is all about?

W.I.I.F.M. (What's In It For Me)

You may notice that sometimes it's hard to get in to see Dr. Jones, or things may seem rushed in your appointment. You may find yourself waiting more than you would like, either in the waiting room or in the examination room. Well that's not going to happen here! We're going to start on time and end on time, you're going to have one and half hours with your doctor and with others who have similar health issues. You're going to get answers to questions you may have never thought to ask. If you like this, you can come back any time you want. We ask that, you always call first, just in case the group is not meeting at the regular time—sometimes even doctors take vacations, or can become ill.

What to Expect

I also want to mention what to expect. Some of you have already met the nurse who besides taking your vital signs, will be trying to get all your medical care up-to-date, just like one stop shopping. After the group starts, the nurse will be calling the rest of you out to finish all that. When Dr. Jones comes in, she will be dealing with you just like in a one-to-one visit, but it will be done in front of everybody so that we all have the privilege of listening and learning. And, if you have something helpful to share that might be helpful to others, by all means, share it, because that's one of the benefits of this…we can help each other and it makes it fun, too!

When it's your turn, be sure to bring up the 1 or 2 most important issues you want to deal with today. If we can't address all your issues today, you're most welcome to come back to the next group.

About Confidentiality

Let's talk about confidentiality. Is there anybody here that hasn't signed the confidentiality release?

In the confidentiality release, it says that your medical issues will be discussed in front of other people and that's OK with you. And more importantly, you will not talk about other people's health problems when the group is over. Is that OK with everyone? On the other hand, you are free to take home things you have learned and talk about them with your loved ones.

About Personal Comfort

In terms of personal comfort, the bathrooms are _____, snacks are over there…please help yourself at anytime, get up and stretch if you need to, that's OK! A group like this is like organized chaos…one person is going to the bathroom, another is seeing the nurse, but always, the focus is on your doctor giving each and every one of you medical care.

In your patient packet is a feedback form for you to fill out at the end. Your comments will help to make these sessions better.

(Optional) Do any of you need to leave early?

Another Behaviorist's Speech

My name is _____ and I'm here to help _____ with his/her first ever DIGMA. We are all here to learn together and we'll make some mistakes but we'll also have fun.

W.I.I.F.M. and What are DIGMAs

They stand for Drop-In Group Medical Appointments. The purpose is to provide medical care in a comfortable group setting. You'll see Dr. _____ for a medical visit just like you would in your office visit, but it will be in a group setting. If some private time is needed, we'll have time at the end of the group time to do that. Also, I want to assure you that this does not take away from making a private office visit with your doctor if you need it.

But for now, you'll have 90 minutes of the doctor's time; you'll get answers to questions you may never have thought to ask; and there'll be opportunities to learn from each other.

What to Expect

Some of you have already seen the nurse. For those who haven't, _____ (the nurse) will see you one at a time to take your BP and up-date your immunizations.

The doctor will be here shortly and will talk to you one at a time. As I mentioned earlier, if you need to see the doctor privately, there will be time left at the end of the session for this. Be sure to address the 1 or 2 concerns that you have today.

One of my jobs is to keep us on time. We'll end today's group at _____.

About Confidentiality

You have all received a patient information package. In it is—a flier, some reading material, a patient satisfaction form, and confidentiality agreement.

Have people signed the agreement? (If no, have them sign).

I would like to go over a couple of things around confidentiality. People will be sharing information in the group. You can take home any of the information you find useful but it is very important that you don't share anyone's name or personal information outside of this room. It's important that this is a safe place for people.

Is everyone OK with this?

About Personal Comfort

It's important that you are comfortable.
The bathrooms are _____.
There's coffee/tea/water and some snacks. Feel free to get up and help yourself.

Your feedback of this experience is very important to us, so before you leave today we will ask you to fill out a patient satisfaction form.

(Optional) Before we start, does anyone have to leave early?

Your Behaviorist Introduction Speech

Writing out and rehearsing your own Behaviorist Introduction Speech is a good way to become comfortable with the role.

WIFFM

What to Expect

Your Speech (Continued)

About Confidentiality

About Personal Comfort

Part III

Group Medical Appointments

Cooperative Health Care Clinic

Cooperative Health Care Clinic Model

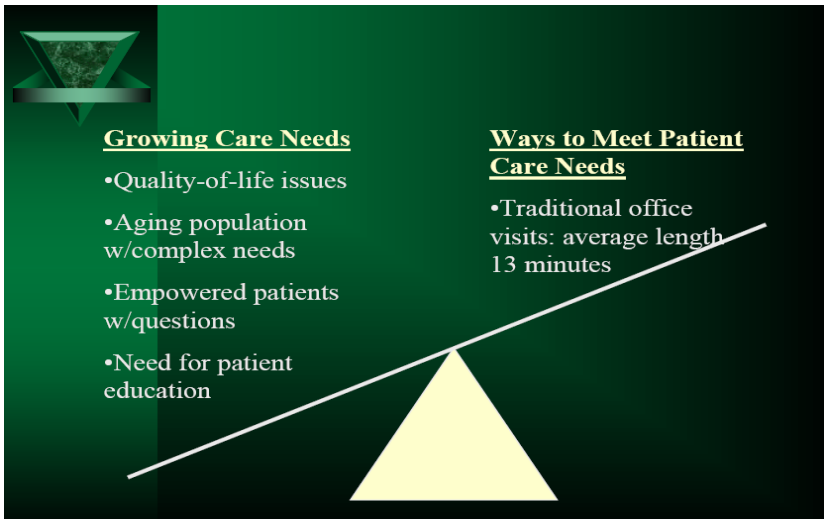
One day in 1991, Dr. John Scott closed the door on 8 patients in a row that he knew had more medical and psychosocial issues to address, but he didn't have time, other people were waiting…"That didn't feel very good."

From DVD#3 *Instillation of Hope*

"I had heard that people cannot heal in isolation, because isolation and alienation is a disease. I had heard that in the circle, it is the hope that people will come to understand that they are not alone—in their joys, neither in their fears, their guilts, nor their sorrows. Their time together in the circle presents them with the opportunity to take their first frightened step towards creating healthy connections."

Andy Yellowback, Elder

With the support of Kaiser Colorado, Dr. John Scott went on to develop a new medical care delivery model. At first, Dr. Scott used the model with his elderly patients. Since then, CHCCs have been applied, and the original format adapted, to other patient groups.



What CHCCs, along with DIGMAs, and Physicals Shared Medical Appointments offer patients, is a **choice**—one that may be better suited for the kind of health care some people need to self manage well. These models are complementary to traditional care and traditional groups, not exclusive.

Characteristics of all Group Medical Appointments

- Voluntary
- Interactive
- Medical Care Delivered
- 1:1 Time Available
- Efficient
- Effective
- Fun

Question—Answer

What are CHCCs?

The CHCC model, developed by Dr. John Scott in 1991, is short for Cooperative Health Care Clinic. It is a program in which a multidisciplinary team provides interactive care to the same group of patients for a set frequency of visits, usually monthly.

See *Instillation of Hope* DVD #3

What are the purposes of CHCCs?

The purposes of CHCCs are to—

- Provide a more effective way to deliver care
- Address physical as well as psychosocial needs
- Educate patients about their health
- Conduct health maintenance more effectively
- Increase patients' participation in their health care
- Increase provider satisfaction in providing care

Who attends CHCC visits?

CHCCs are most effective with patients who—

- Are high utilizers of the health care system
- Are over 65
- Are interested in a group
- Have multiple chronic conditions
- Have been invited by their physician to attend

Is the CHCC model adaptable to other groups?

The CHCC model is adaptable to a large number of diseases and population groups (eg. hypertension groups, diabetes groups, well baby groups).

Who should not attend?

CHCCs are not designed for—

- Patients not interested in groups
- Patients with severe hearing loss or dementia

How do patients benefit from CHCC visits?

Patients benefit by—

- Increased satisfaction with their medical care
- Better health outcomes and quality of life
- Higher feelings of self-efficacy to manage chronic diseases

QA (Continued)

How does the organization benefit from CHCCs?

CHCCs provide—

- More efficient management of patients with complex health problems
- Fewer urgent appointments
- Increased patient satisfaction
- Increased provider satisfaction

How large are the groups?

Group size is 15-20 patients.

How often do groups meet?

Typically, the frail elderly groups for whom CHCCs were originally designed for, meet monthly at the same time and place, indefinitely. Some specialist groups are self limiting, meeting only several times. A diabetes group may meet for several months, and then semi-annually.

Do the same patients meet each time?

The same group of patients attend each time, although new patients are added when group size decreases due to relocation or death.

How long is a CHCC visit?

CHCC visits last 1.5 hours with an additional hour for private office visits.

Who comprises the core CHCC provider team?

The physician, the nurse and the MOA comprise the core CHCC team.

What does a typical CHCC look like?

A typical CHCC consists of—

- Socialization for 10 minutes
- Interactive education for 30 minutes
- One to one care in the group for 25 minutes
- Questions and answers for 20 minutes
- Planning for the next visit for 5 minutes
- Individual office visits, as needed, for 60 minutes

QA (Continued)

Are CHCCs effective?

CHCCs have been shown to reduce hospitalizations, and emergency room visits. They increase patient satisfaction and self-efficacy.

Why are CHCCs effective?

CHCCs are effective for a variety of reasons—

- Patients feel they have 90 minutes with their physician
- The physician/patient relationship is strengthened
- Interpersonal learning occurs
- Patients receive support from others facing the same challenges
- The group members instill hope
- There is ample opportunity to ask questions
- The CHCCs address the physical and psychosocial needs of the patient

See '*Why does this stuff work*' DVD #3

When invited, how many patients accept?

In the words of Dr. John Scott, "50% readily accept and attend. The other 50% think you're crazy!"

"I think if our health care system had evolved differently, had it evolved dealing with chronic diseases – which is the issue today – rather than acute diseases, we probably would have started with group visits. And now, someone would probably be preaching about the benefits of an individual office visit as a better model for acute disease management."

Dr. Ed Noffsinger

CHCC Group Visit Starter Kit

Information to prepare this Starter Kit was received from Colleen Hawes of Group Health Cooperative, Kate Lorig of the Stanford Patient Education Research Center and John Scott of Kaiser-Colorado. Thanks to all the clinics and individuals who have shared materials and tools they have used.

Group Visits: Introduction

This Group Visit Starter Kit is designed for health care teams who want to begin offering group visits for their patients. It contains information on:

- What are group visits
- Why they are useful
- How to plan and implement the visits
  - Who does what
  - References
  - Agenda for 1st & regular CHCC sessions
- Materials and Resources
  - Sample letter to patients
  - Material/resource suggestions
  - Group visit norms poster
  - Vitals & medication record for patients
- Dealing with people and situations
- Task list and timeline

What is a "Group Visit"?

The term is applied to a wide variety of visits designed for groups of patients, rather than individual patient-provider appointments. This Starter Kit describes the Cooperative Health Care Clinic (CHCC) model developed by the Kaiser Colorado staff. We will refer to it simply as a "group visit." Group visits were pioneered with frail elderly patients who were high utilizers of primary care.

In this model, the health care team facilitates an interactive process of care delivery in a periodic group visit program. The team empowers the patient, who is supported by information and encouraged to make informed health care decisions. The group visit can be conceptualized as an extended doctor's office visit where not only physical and medical needs are met, but educational, social and psychological concerns can be dealt with effectively.

Invitations are extended by the health care team to specific patients on the basis of chronic disease history and utilization patterns. The patients typically remain in the same group together. Members may be added to groups if the group size decreases.

Variations of this group visit format have been used for disease or condition specific populations, such as:

- Diabetes
- Hypertension
- Orthopedic procedures
- Heart failure
- Cancer
- Asthma
- Depression
- Fibromyalgia
- Hormone replacement therapy
- Chronic pain
- Hearing impaired population

Some groups begin with monthly meetings and later adjust the interval to quarterly. Additional information on diabetes specific group programs was published in Diabetes Care. *[Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, Watson R, Swain BE, Selby JV, Javorski WC Diabetes Care. 1999 Dec; 22(12):2011-7.]*

Additionally, some clinics find it is helpful to provide periodically a group meeting for new patients as an orientation to the clinic, or to initiate a new clinical guideline.

Why Have Group Visits?

Evidence from a randomized trial of group outpatient visits for chronically ill elderly members of Colorado Kaiser HMO indicates that group visits had the following impacts:

- 30-percent decrease in emergency department use
- 20-percent decrease in hospital use/re-admissions
- Delayed entry into nursing facilities
- Decreased visits to sub-specialists
- Increased total visits to primary care
- Decreased same day visits to primary care
- Increased calls to nurses
- Fewer calls to physicians
- Increased patient overall satisfaction with care
- Increased physician satisfaction with care
- Decreased cost (to the system) per patient per visit by $14.79

In focus groups, patients tell providers that they value:

- Trusting relationships with their provider:
- Hands-on care.
- Time with the provider.

Group visits are a way to address those needs.

Summary

Group visits offer staff a new and more satisfying way to interact with patients that makes efficient use of resources, improves access and uses group process to help motivate behavior change and improve outcomes.

Planning and Implementing Group Visits

Two Months Before the First Group Visit

Initiating a group visit requires some planning and coordination.

It is important to begin planning at least two months before the first visit is scheduled to occur. Make sure that you have support from the leadership at your site. With the leadership, discuss what outcomes you want from your group visits. Some suggestions include patient/provider satisfaction, achievement on clinical standards of care and utilization. The next step is to determine a measurement plan.

At a team meeting, determine the population you would like to invite for group visits. Recall that between 30 and 50% of patients are amenable to participation in group appointments. Therefore, the population you wish to include should be at least 50 patients or the group that results from your invitation may be too small to make the visit efficient for your team. Chronic illness registries and reports of patients with frequent visits can be used for this purpose. At this first team meeting, review the letters of invitation, the agenda for the first meeting, and the roles of the team members. A task list and timeline is provided in the following section. Give top priority to scheduling the primary care provider, the nurse and/or MOA to assist with vitals during the "break" in the group visit. Don't forget to schedule the room.

One Month Before the First Group Visit

When a list of potential patients is obtained, the team should quickly review the list for patients who are not appropriate in a group. The typical exclusions are patients who are terminally ill, have memory problems, severe hearing problems, need a translator (unless you are offering a second language session) or are out of the area for significant portions of the year.

Create your mailing list and letters now. Plan to have letters reach patients about one month before the first session. The letter is viewed as more important if it is personally signed by the primary care provider, and followed up one or two weeks after the mailing with a personal phone call from the office staff, preferably one who will assisting with the group visits.

It is a good idea to have a second team meeting during this time. Each patient will be provided with a folder or three ring binder to bring with them to each visit. Use this meeting to review the binders' contents.

Review any assessments or documentation tools you wish to use. Discuss how the calling is going (or went) and who is expected to attend.

Review the agenda and roles of the team. Some clinics like to provide coffee or a snack for the break in the visit. Arrange this as needed, as well as the materials for the folders, binders, a flip chart, BP cuffs and stethoscopes. It's a good idea to use nametags, especially for the first few visits.

One Week Before the First Group Visit

About one week before the first session, enlist someone to call the attendees. Remind them of their appointment, describe the purpose of the visit, what is likely to occur at the visit, and encourage the patient to attend. The caller should reinforce that **this is a** medical appointment, not a class or workshop, and people are expected to call and cancel if they cannot attend. Many teams request the charts of those who will be attending and review them for preventive care needs or other concerns.

Day of the First Group Visit

The day of the first session, prepare the room well in advance, as some patients will arrive early. Tables or chairs should be set up in the shape of a horseshoe with the open end pointing toward the speaker.

Start on time to create the expectation that the visit has a beginning and an ending. At least one team member should be in the room to greet patients. Help patients to write the name they wish to be called in very large letters on their name tag.

Don't hog the airtime!

If the facilitator has been talking about him/herself for more than one minute, it's time to stop!

The primary care provider should open the meeting with a sincere welcome. All staff and team members are introduced. The patients are then given a format to follow for introductions.

It is very important to include sharing in the introduction, as this will help to form the supportive relationships between group members. For the older patients, reminiscence can be very helpful. The primary care provider should **model** the introduction. The provider should introduce himself or herself again using the exact format they want the participants to use. For example, "My name is (use the name you wish to be addressed by). When I was young, my favorite childhood toy was my bicycle. We used to ride all around our neighborhood in Fraser Lake on our bikes." This modeling will help participants to be brief. If participants begin to tell extended stories, one might need to interrupt gently by saying something like "Thank you, Mr. Jones. We need to make sure we have time to hear from everyone."

The introductions should take about 15 minutes.

After the introductions, the provider gives an overview of the group visit (30 minutes). Allow lots of time for interaction and questions. Review the group norms, which cover the expectation of confidentiality for the group.

Before the break, the provider and nurse should explain what will happen. The nurse will start at one end of the horseshoe and take vitals while and the physician will start on the other end and cover any individual issues. Some groups have found it helpful to have an MOA take vitals in addition to the nurse. Vitals are recorded for the patients in their notebooks, and for the medical record. All team members should be assessing patients for those who may need an individual visit at the end of the group session.

We all like food

Consider offering simple refreshments.

In some groups, the members will take on the responsibility and offer to bring items to share.

After the break (15 minutes), reconvene the group for an open question/answer period. If the CHCC group is new, prompting might be necessary to encourage participation. Asking what people have heard or seen on the news or in the newspaper will often get the questions rolling. The provider should involve the team as much as possible and refer questions to the nurse to demonstrate that this team works together.

After the question and answer period, the group discusses what topic they would like to discuss in the next group visit (typically one month in the future.) Writing down a list of all the ideas on a flip chart can be a very helpful technique.

Patients typically bring up topics that the provider team also feels are important and rarely suggest frivolous topics. If they do, reaction from other group members is usually enough to end the idea.

Some provider teams may want to get a quick reaction from participants regarding what they liked or how the meeting could be improved. Thank the participants for coming.

Tips for Using Flipcharts

- Write in clear large letters
- Use bullets for lists
- Use alternating colors to clearly separate items

Group Interaction is Powerful

Health care professionals are often tempted to use group visits as an opportunity to lecture patients—to tell patients everything they think patients should know about the disease process, treatment, etc. This can seriously undermine the success of the group visit. Resist the temptation to take over and lecture!

Trust the group to lead the way. The role of the health care team is to facilitate the group interaction.

Patients who require an individual appointment remain and are seen at 10 minute (or typical 1:1 length) intervals. The nurse and provider may both have individual appointments. This part of the visit lasts 30 to 60 minutes.

Happy Endings

It's important to end each session with a strong, clear closing statement. Think about the difference between the following closures:

Example #1: "This was a great session. You all did a wonderful job discussing issues of medication management and thinking of creative solutions to the problems that some of you have experienced. I really appreciate your openness and your willingness to share. At the next meeting, we will be discussing ways to increase activity levels. Thanks for coming and we'll see you all on March 12th."

Example #2: "Well, I guess that's it. I can't think of anything else. OK, then. Bye."

After the first group visit, the team may want to have a short debriefing meeting. Discuss what went well and what didn't go so well. As you discuss things you might want to do differently, remember that the basic format of the group has been tested in clinical trials, and deviations from the outline may not have the same positive results.

Providers have found that few materials should be prepared in advance of the group visit. A quick review of the patient binder contents is usually all that is required.

What the patients want to hear about is the basic information they need to know and how others have dealt with the situation. Group leaders should strive for each session to be interactive.

Supplies for a Group Visit

- Charts
- BP cuffs & stethoscopes
- Specialty Tools (ex: monofilaments for diabetes foot exam)
- Forms (sign-in sheets, order forms, etc.)
- Pens
- Nametags
- Flip charts and markers

Let the Group Answer Questions

When questions arise, health care professionals tend to want to give the answers. Instead, learn to leverage the power of the group.

"Has anyone else experienced this problem? What worked for you?"

This increases the participants' confidence in their own problem solving ability.

See Page 3-21 *Dealing with the Different Types of People/Situations in Group Settings*

Monthly Follow-Up

The team should hold a brief meeting each month to review the participants' topic suggestions and plan how to address them.

Review the roles of the team members and any changes that the team would like to test for the upcoming session.

Who Does What

Each team should review the tasks and roles and determine how best to use their team. The result might look something like this:

Office 'Champion' / MOA

- Pulls charts 3-5 days before the group visit.
- Reminds primary care provider about the upcoming group visit.
- As agreed upon by team, reviews charts.
- Gives results of chart review to provider.

Day of Group visit

- Checks room set-up.
- Takes charts and supplies to room.
- Takes vitals as needed.
- Enters data into registry if appropriate.

Appointment Personnel

- Makes reminder phone calls to patients.
- Checks on room reservation.
- Ensures name tags are ready.

Day of Group Visit

- Prepares charts and labels.
- Prints out registries for patients if appropriate.
- Completes billing information as needed.

MD

- Participates in planning of the visit with the team, following suggestions of participants.
- Reviews charts, identify problems for review with individual patients.

Day of Group Visit

- Conducts discussion and group visit.
- During break, reviews individual needs and makes 1:1 individual appointments for after the visit.
- Documents all visits.

'Nurse'

- Coordinates the planning of the visit with the team.
- Coordinates materials and information for the visit.

Day of Group Visit

- Circulates in room during break, takes vital signs, performs immunizations, etc., and identifies patients who need individual attention.
- After visit, follows up with patients via telephone as needed.

Others: Pharmacist, Behavioral Health, Nutrition, Physical Therapy

It is sometimes helpful to provide access to other specialists during the group visits. It is important that the team adequately brief anyone brought into the group visit so they adhere to the high degree of interactivity encouraged in the group. Discourage these guest presenters from lecturing to the patients or providing them with excessive prepared materials.

A good model for these presentations is for the physician, nurse, or presenter to have the group list all the questions they have right before the presenter speaks. If these are listed on a flip chart, they can be checked off as they are discussed. The presenter can suggest topics that the patients may not be aware of if they are not included on the list.

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Group Visit
Agenda for First Session

15 minutes **Introductions/Welcome**

- Physician opens the session.
- All team members present are introduced.
- Introductions follow around the room, with sharing included. Example for older patients: Give your name as you would like to be called, and share your favorite childhood game (or where you were in 1972 when Paul Henderson scored, or favorite childhood holiday memory, etc.).

30 minutes **Group Visits**

- What are they?
- Why are we doing it?
- What should you expect?
- Questions from the group.
- Group visit norms.
- Review folder/notebook.

15 minutes **Break**

- Physician starts on one side, nurse on other.
- Take blood pressures, ask about specific concerns for the day (look for patients who need 1:1 visits).
- Refill meds.

15 minutes **Questions and Answers**

- Ask for any questions the group has about their health, the visit, etc.

15 minutes **Planning**

- Topic for next month.
- Announce time and date.

60 minutes **1:1 visits with provider and nurse as needed**
Provider discretionary time

Group Visit
Regular Agenda Template

15 minutes **Introductions/Welcome**

- Physician opens the session.
- All team members present are introduced.
- Introductions follow around the room, with sharing included.

30 minutes **Topic of the Day**

- Physician and nurse provide information, interacting with the participants whenever possible.
- Some suggestions to make the session interactive include asking:
  - "Has anyone here ever had this problem?"
  - "How has anyone dealt with this situation before?"
  - "What have you heard about _____ ?"
- Always intersperse the presentation with questions from the group

15 minutes **Break**

- Physician starts on one side, nurse on other.
- Take blood pressures, ask about specific concerns for the day (look for patients who need 1:1 visits).
- Refill meds.

15 minutes **Questions and Answers**

- Ask for any questions the group has about their health, the visit, recent topics in the news, etc.

15 minutes **Planning and Closing**

- Determine topic for next month
- Thank everyone for coming, providers proceed to 1:1 visits

60 minutes **1:1 visits with provider and nurse**
Provider discretionary time

Medical Office Letterhead

Date

Dear ,

I want to invite you to participate in a new way of delivering medical care. This program is designed specifically for (describe group: patients with _____, patients over 65). By choosing to participate you will be asked to:

- Become a member of a small group of patients with ___. This group will meet every month with me to address medical and other issues of concern to you.
- Help us develop the program for your particular group.
- Help evaluate the success of the program in meeting your needs.

Most of the time when you come in to the clinic, you are ill or have a specific problem that we need to talk about. Discussions about managing or improving your health are often hard to fit into these short visits. The purpose of this group is improved health. In the group we will discuss ways you can maintain or improve your health and make sure you are up-to-date with care recommended for you.

The first group visit will be held _____ (day and date) from _____ (am or pm). These group visits will be held at _____. We encourage you to bring a family member with you. Since this visit is a medical appointment, please cancel if you cannot attend.

If you are interested, please RSVP by _____ (date) to _____ (name) at _____ (phone number). If you are not interested, you will continue to receive usual health care.

Your Physician

Assessment Questionnaire

For some types of group visits, the clinic may want to have the participants complete a questionnaire or health assessment before the group visit. It is highly recommended that when teams consider using assessments that they utilize instruments that are brief and have been tested before. One resource is *Lorig et.al. Outcome Measures for Health Education and other Health Care Interventions, SAGE Publications, 1996.*

Curricula

It is very tempting for the team to develop detailed lesson plans and curricula, but this is not recommended. Researchers have found that groups of patients will choose the topics that health professionals want to discuss. By leaving the choice of discussion topic up to the participants, the group forms closer bonds and develops a sense of self-confidence. A great deal of the information that patients find helpful is hearing how other people have handled similar situations. The information that patients want from professionals tends to be basic information and it is rarely necessary to research a topic or refer to books to work with patients. If this is necessary, it can be accomplished in the period between meetings, since the participants should be setting the topic for the upcoming meeting in the preceding one. Some groups have found it helpful to keep a checklist of topics they would like to cover and periodically review the checklist.

Patient Education Materials

If you wish to choose and order patient education materials for your group visits, carefully review them to make sure they are consistent with your approach to patient care. Remember to use materials accepted for use in your setting so you will avoid the need to explain discrepancies in standards for care.

Clinic Brochures

You may wish to include brochures giving patients information about your clinic and phone numbers to call for appointments and other needs. Check to see if someone has already compiled this information.

Group Visit Norms

We will…

- Encourage everyone to participate
- State our opinions openly and honestly
- Ask questions if we don't understand
- Treat one another with respect and kindness
- Listen carefully to others
- Respect information shared in confidence
- Try to attend every meeting
- Be prompt, so meetings can start and end on time

Group Visit
Vitals Record

Date	Blood Pressure	Pulse	Questions

Group Visit
Medication Record

Date	Medication	Dose	Reason

DEALING WITH THE DIFFERENT TYPES OF PEOPLE/SITUATIONS IN GROUP SETTINGS

The following descriptions of different types of people and potentially difficult situations are presented here to stimulate your thinking about how **you** might handle these effectively during a group session that you are leading. Preparing ahead of time may even help you prevent such problems. Each situation is different, therefore use your best judgment to determine what suggestions might be effective in real situations.

If a difficult situation persists, discuss it with your co-workers. Together, you will get the support you need and can decide how best to handle the problem.

The Too-Talkative Person

This is a person who talks all the time and tends to monopolize the discussion.

The following suggestions may help:

- Remind the person that we want to provide an opportunity for everyone to participate equally.
- Refocus the discussion by summarizing the relevant point, then move on.
- Spend time listening to the person outside the group.
- Assign a buddy. Give the person someone else to talk to.
- Use body language. Don't look toward the person when you ask a question. You may even consider having your back toward the person.
- Talk with the person privately and praise him/her for contributions, and ask for help in getting others more involved.
- Thank the person for the good comment, and tell him/her that you want everyone to have a turn at answering the question.
- Say that you won't call on someone twice until everyone has had a chance to speak once first.

The Silent Person

This is a person who does not speak in discussions or does not become involved in activities.

The following suggestions may help:

- Watch carefully for any signs (e.g., body language) that the person wants to participate, especially during group activities like brainstorming and problem solving. Call on this person first, but only if he/she volunteers by raising a hand, nodding, etc.
- Talk to them at the break and find out how they feel about the group session.
- Respect the wishes of the person who really doesn't want to talk; this doesn't mean that they are not getting something from the group.

The "Yes, but . . . " Person

This is the person who agrees with ideas in principle but goes on to point out, repeatedly, how it will not work for him/her

The following suggestions may help:

- Acknowledge participants' concerns or situation.
- Open up to the group.
- After three "Yes, but's" from the person, state the need to move on and offer to talk to the person later.
- It may be that the person's problem is too complicated to deal with in the group, or the real problem has not been identified. Therefore, offer to talk to the person after the session and move on with the activity.
- If the person is interrupting the discussion or problem-solving with "Yes, but's," remind the person that right now we are only trying to generate ideas, not critique them. Ask him/her to please listen and later we can discuss the ideas if there is time. If there is no time, again offer to talk to the person during the break or after the session.

The Non-Participant

This is the person who does not participate in any way.

The following suggestions may help:

- Recognize that the people in the group are variable. Some may not be ready to do more than just listen. Others may already be doing a lot, or are overwhelmed. Some may be frightened to get "too involved." Still others may be learning from the sessions, but do not want to talk about it in the group. Whatever the reason, do not assume the person is not benefiting from the group in some way, especially if he/she is attending each session.
- Do not spend extra time trying to get this person to participate.
- Congratulate those participants who do participate.
- Realize that not everything will appeal to everyone in the same way or at the same time.
- Do not evaluate yourself as a leader based on one person who chooses not to participate in activities.

The Argumentative Person

This is the person who disagrees, is constantly negative and undermines the group. He/she may be normally good natured but upset about something.

The following suggestions may help:

- Keep your own temper firmly in check. Do not let the group get excited.
- If in doubt, clarify your intent.
- Call on someone else to contribute.
- Have a private conversation with the person; ask his/her opinion about how the group is going and whether or not he/she has any suggestions or comments.
- Ask for the source of information, or for the person to share a reference with the group.
- Tell the person that you'll discuss it further after the session if he/she is interested.

The Angry or Hostile Person

You will know one when you see one. The anger most likely has nothing to do with the leader, group or anyone in the group. However, the leader and groups members are usually adversely affected by this person and can become the target for hostility.

The following suggestions may help:

- Do not get angry yourself. Fighting fire with fire will only escalate the situation.
- Get on the same physical level as the person, preferably sitting down.
- Use a low, quiet voice.
- Validate the participant's perceptions, interpretations and/or emotions where you can.
- Encourage some ventilation to make sure you understand the person's position. Try to listen attentively and paraphrase the person's comments in these instances.
- If the angry person attacks another participant, stop the behavior immediately by saying something like: "There is no place for that kind of behavior in this group. We want to respect each other and provide mutual support in this group."
- When no solution seems acceptable ask, "At this time, what would you like us to do?" or "What would make you happy?" If this does not disarm the person, suggest that this group may not be appropriate for him/her.

The Questioner

This is the person who asks a lot of questions, some of which may be irrelevant and designed to stump the leader.

The following suggestions may help:

- Don't bluff if you don't know the answer. Respond, "I don't know, but I'll find out."
- Redirect to the group: "That's an interesting question. Who in the group would like to respond?"
- Touch/move physically close and offer to discuss further later.
- When you have repeated questions, say, "You have lots of good questions that we don't have time to address during this session. Why don't you look up the answer and report back to us next week."
- Deflect back to topic.

The Know-It-All Person

This is the person who constantly interrupts to add an answer, comment, or opinion. Sometimes this person actually knows a lot about the topic and has useful things to contribute. Others, however, like to share their pet theories, irrelevant personal experiences and alternative treatments, eating up group time.

The following suggestions may help:

- Restate the problem.
- Limit contributions by not calling on the person.
- Establish the guidelines at the start of the session and remind participants of the guidelines.
- Thank the person for positive comments.
- If the problem persists, invoke the rule of debate: Each member has a right to speak twice on an issue but cannot make the second comment as long as any other member of the group has not spoken and desires to speak.

The Chatterbox

This is a person who carries on side conversations, argues points with the person next to him/her or just talks all the time about personal topics. This type of person can be annoying and distracting.

The following suggestions may help:

- Stop all proceedings silently waiting for the group to come to order.
- Stand beside the person while you go on with workshop activities.
- Arrange the seating so a leader is sitting on either side of the person.
- Restate the activity to bring the person back to the task at hand or say, "Let me repeat the question."
- Ask the person to please be quiet.

The Suicidal Person

Rarely, you may encounter someone who is very depressed and is threatening to take his/her own life or expresses severe hopelessness or despair.

- Talk to the person privately. One professional can accompany the person out of the room, and perform a further assessment of suicide risk.
- Engage mental health services

The Crying Person

Occasionally, a group discussion may stimulate someone in the group to express their feelings of depression, loss, sorrow or frustration by crying. People cry for many reasons. They may feel that someone finally understands what it has been like, which makes them feel safe to express emotions they have been suppressing for a while. Crying is usually a release that promotes emotional healing. To allow a person to cry is helpful; it may also help to bring the group closer together, providing mutual support to one another. Your role is to convey that is okay to cry so the person does not feel embarrassed in front of the group.

The following suggestions may help:

- Always have a box of tissues handy and pass it to the person.
- Acknowledge that it is all right to cry — having a health problem is difficult, then continue on with the class.
- If the person is crying a lot, one leader may want to accompany the person out of the class to see if anything needs to be done. The other leader should continue on with the rest of the group.
- Generally, if no one tries to stop the crying, within a short period of time, it will play itself out. Tension will be released and the person will feel better and the participants will feel closer to the person.
- At the break or after the session, ask if the person is okay now and if he/she needs help with anything. Reinforce to the person that crying is a perfectly normal, healthy behavior and that he/she is not the first to cry in this class. In fact, it has happened quite often and probably will in the future.

The Person in Crisis

The person in "crisis" is the one with the problems who wants help and/or just needs to talk about these problems.

The following suggestions may help:

- Listen attentively, be empathetic, use open-ended questions and use reflective listening.
- If after five minutes it is obvious that the person will need more time to "unload," talk to person during the break or afterwards, as you will have to go on with the group activities.
- Don't take up session time and energy with the very "needy" person because it takes time away from the other participants who can be helped. Refer them to appropriate services, such as social work or behavioral health.

The Abusive Person

This is someone who verbally attacks or judges another group member.

The following suggestions may help:

- Remind the group that all are here to support one another.
- Establish a group rule and remind everyone that each person is entitled to an opinion. One may disagree with an idea someone has but under no circumstances will personal attacks be appropriate. If the abuse continues, ask the person to leave.

The Superior Observer

This is a person with a superior attitude who says he/she is present out of curiosity, and that he/she already knows everything about their health and is coping well.

The following suggestions may help:

- If the person knows a lot and is doing well, you may want to have them provide examples of what they do at selected times for the group.
- A person may also act superior if he/she feels uncomfortable and not a part of the group. If so, include him/her in some way.
- If the person wants to be ignored, then ignore them. They will get bored and leave or start to participate.

Task List and Timeline

Date	Action	Responsibility	Done	Comments
Two months before first session				
	Meet with leadership Determine goals and measurement			
	Team meeting (1 hour or less) Determine type of group visit (ex: frail elderly) Discuss plans and team member roles Review agenda and letters			
	Schedule room (2-hour block)			
	Schedule provider (2-hour block)			
	Schedule RN (2-hour block)			
	Schedule MOA for vitals during “break”			
	Obtain list of potential participants			
	Review list for inappropriate invitees			
One month before first session				
	Send out invitation letters to 40-50 people			
	Call all patients who received letter (2 weeks after mailing)			
	Team meeting (45 minutes or less) Review agenda and roles, attendees, patient notebooks			
	Arrange refreshments, if desired			
	Create records for patients (folder/notebook for 25 per group)			
One week before				
	Create roster of attendees and sign-in sheet			
	Review charts for potential immediate needs			
	Call attendees to remind them of their appointment			
Day of Visit				
	Set up room (horseshoe)			
	Materials to room (patient folders, coffee, BP cuffs, stethoscopes, flip chart, nametags, tissues)			
	Be in room early to greet patients			
	Hold visit			
	Debrief after visit: What went well? What didn’t go as well?			
Monthly	Plan next group visit			

Part IV

Group Medical Appointments

Resources & Support

DVDs

Watch all these DVDs on your TV. For computer viewing, right click on the DVD drive, then click PLAY.*

A Model For Our Time

summarizes 2 days of talks regarding DIGMAs and Physicals SMAs presented by their developer, Dr. Ed Noffsinger.

In the first chapter, Dr. Noffsinger acknowledges that, though these models are barely a decade old, the idea of healing in groups is an ancient one. Chapters 2 and 3 describe in more detail the concept and structure of GMAs. Finally, outcome studies that demonstrate group visits are effective, particularly in solving access issues and improving patient/provider satisfaction scores are discussed in Chapter 4.

A bonus FAQ section is included with this disk.

Running time: 129 minutes

Sound design:
Forrest Gump Suite

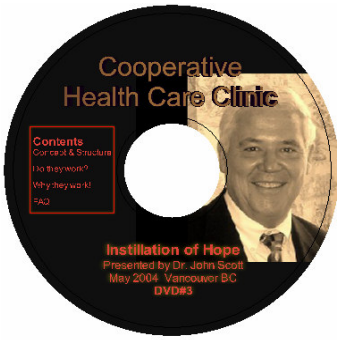
The Behaviorist Role

Several months after his initial presentations, Dr. Noffsinger returned to Northern Health to train behaviorists. The first half of the DVD describes what it takes to become a behaviorist and how the role is new—more than just group facilitation. Included is a clip from Cleveland Clinics promoting their use of DIGMAs and Shared Physicals. Not to be missed is Dr. Noffsinger's personal 3½ minute 'The Speech'.

The second half explores specific behaviorist challenges and a 'behind the scenes' look at GMAs that will be of interest to all team members. The format is Question—Answer. A pre-launch 'Mock' DIGMA completes this disk.

Running Time: 107 minutes

Sound Design:
St Elmo's Fire



Instillation of Hope

Dr. John Scott presented his CHCC model at the CHF Collaborative Closing Congress in 2004. Highlights from this DVD include a convincing section on CHCC outcome studies and thoughts on "Why Does This Stuff Work?"

Dr. Scott's commitment is to provide a quality healthcare experience for both patients and providers. His talk is delivered with passion and humor.

Running Time: 53 minutes

Sound Design:
The Man From Snowy River

***NOTE—Your DVD player must be able to read *DVD-R* or *DVD+R* disks.**

The End of the Beginning
Launching a Group Medical Appointment

Participation in Group Medical Appointments is voluntary for patients, NH staff, and physicians. Hence, thank you ALL for your interest!

Northern Health is supporting GMAs by offering training and coaching, promotional materials at no cost, and when possible, contributing NH staff to the team.

If, as a physician, you are wondering how to start your own Group Medical Appointment, then this section is particularly for you. Other potential team members may find this section useful to generate interest.

Please note, this is a suggested pathway. It can be customized for your situation.

What You Can Do	What NH Can Offer

To express interest in offering or participating in any of the Group Medical Appointment models, please connect with your local Primary Health Coordinator or call/email the coordinators at the end of this section.

✓ *Nurture*
The Interest

- Watch all DVDs
- Review this manual
- Enlist the support of your office staff
- Use local contacts to build a team
- Observe a group visit
- Ask: 'What do you want to accomplish by offering a GMA?' **See *Evaluating…*in Part 4**

- Answer your questions
- Arrange for NH team members
- Arrange a GMA observation
- Arrange a local meeting for further discussion
- Supply learning resources for the team

✓ *Promote*
The Option

At least one month prior to launch, work out with office staff how to make group visits an attractive appointment option. Begin inviting patients.

- **See *Promotional Materials* in Part 4**

- Supply—
  - ➲ Wall plaque
  - ➲ Posters
  - ➲ Brochures

Launching (Continued)

What You Can Do	What NH Can Offer

✓ *Rehearse*
The GMA

Shortly before launch, a half day Learning Session (LS) can serve as a rehearsal.

- Arrange for personal and key office staff attendance at the LS
- Review the purpose of your group appointment with the team
- Arrange for last minute GMA needs

- Training team
- Half day learning session stipend per physician
- Arrange attendance of NH team members
- Arrange meeting logistics
- Lead the 'Mock' DIGMA
  See *The 'Mock' DIGMA* DVD #2

✓ *Launch*

- **Just Do It!**

- Participate in first GMA as coach(es)
- Lead first debriefing session

Connecting With Us

Alice Domes	250.565.7448	alice.domes@northernhealth.ca
Marvin Barg	250.565.7432	marvin.barg@northernhealth.ca
Victoria Stewart	250.624.7503	victoria.stewart@northernhealth.ca

Promotional Materials

Promoting your Group Medical Appointments

Typically, 19 out of 20 patients who attend a Group Medical Appointment indicate they are satisfied with this appointment option and would return.

However, inviting a patient to attend a GMA in the first place takes more than just offering it as an appointment option. With no prior experience, the idea of appointments in groups conjures up 'army physicals', or AA meetings and the like.

If you believe in this appointment option, following is a promotion template for any type of Group Medical Appointment.

1 Personal Letter of Invitation

Send out a letter of invitation to your patients. Following is a sample.

From the office of Jill Jones MD

Dear Patient,

I'm starting a new program just for my patients. This program allows you to spend about 90 minutes with me in a Group Medical Appointment. You're going to get all the care you would normally receive in a one to one office visit, but we will have more time to deal with more of your concerns and go into greater detail about how to manage your health. There's no waiting, we begin and end on time. Best of all, you get to learn about health and well being from others in the room. Plus, we serve snacks and laugh a lot.

Next time you have a health need, please join me for a Group Medical Appointment. I know you won't be disappointed.

Sincerely
Jill Jones MD

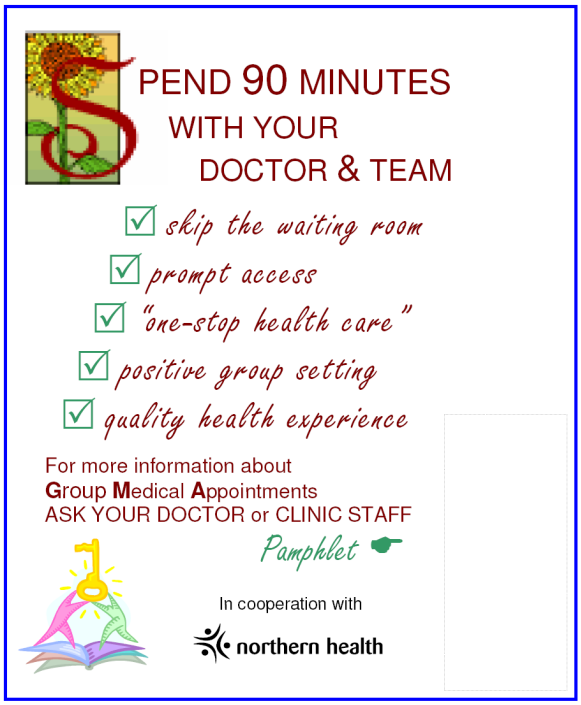
Promotion (Continued)

2 Plaques, Posters, Pamphlets

Hang a large plaque advertising group visits in the waiting area. Attached should be a holder for brochures. Further, place smaller posters in each exam room, along with a holder for brochures. (These items can be ordered at no cost from Northern Health. Please contact your Primary Health Coordinator.)

WALL PLAQUE

For waiting room walls, this plaque measures approximately 50 cm x 60 cm (20 x 24 inches). Comes with plastic holder for about 50 pamphlets.



EXAMINING ROOM POSTER

Poster measures approximately 30 cm x 45 cm (11 x17 inches). Comes with pamphlet holder.

Promotion (Continued)

PAMPHLET

This trifold brochure can be personalized for your office.

What is possible during a Group Medical Appointment—

- 90-minutes with your own doctor
- Private physical exams
- Prescription changes or renewals
- Arrangements for tests and procedures
- Discussion of test results
- Answers to your medical questions
- Discussion of medication side effects
- Discussion of treatment options in depth
- Receive preventative tests, exams, and vaccines
- Share helpful hints with others to live life more fully
- Learn more, enjoy some light refreshments, and have a fun, positive health care experience

You may find the following helpful for health information and care.

BC Nurse Line	1-800-215-4700
Dial-a-Dietician	1-800-667-3438
Adult Mental Health Concerns	1-866-565-2966
NICC Smoking Cessation Program	240-565-7344
Poison Centre	1-800-567-8911

Ask clinic staff or your doctor about attending the next—

- ☐ DIGMA
- ☐ Physicals Shared Medical Appt

Time: _____

Location: _____

Place
Clinic Name
Address &
Phone Number
Here

AN APPOINTMENT WITH YOUR DOCTOR IN A GROUP SETTING

Introducing the

Group Medical Appointment

In cooperation with

northern health

Group Medical Appointments

We live, work, and play in groups—families, associations, sports teams, camps, meetings of all kinds.

The purpose of Group Medical Appointments (GMA) is to provide health care in a comfortable and helpful group setting. After attending a Group Medical Appointment, more than 80% of people indicate they would return to receive medical care in this way.

In a Group Medical Appointment, **you will spend 90 minutes with your doctor and a team of health care providers.**

GMAs offer the possibility of all your health concerns and questions being addressed at once. Group visits aim to provide "one stop shopping".

Group visits designed to meet routine medical needs are called DIGMAs. For specialized appointments or examinations, Physicals Shared Medical Appointments are held.

About DIGMAs
Drop-In Group Medical Appointments

- **Ideal for routine medical care, follow-up appointments and health maintenance.**
- 10 to 15 patients participate, some with conditions similar to yours.
- A member of your immediate family or a support person is welcome to attend with you.
- If needed, a brief private medical examination or an individual private discussion can be held towards the end of the DIGMA.
- Sensitive personal information about others must remain confidential. Each person attending a Group Medical Appointment will be asked to sign a Confidentiality Commitment.

About PHYSICALS
Shared Medical Appointments

- **Ideal for specialized physical exams or consultations** (eg prenatal visits or specialist appointments).
- 6 to 12 patients participate with health concerns similar to yours.
- A member of your immediate family or a support person is welcome to attend with you.
- Examinations carried out promptly and efficiently at the beginning.
- After this, the doctor discusses your consultation in front of, and with the support of others in the group.
- Sensitive personal information about others must remain confidential. Each person attending a Group Medical Appointment will be asked to sign a Confidentiality Commitment.

Please call the doctor's office the day before your visit, so that—

- we can verify the group appointment will be meeting that week
- we know approximately how many are coming

Please arrive on time, and plan to stay for the hour and half.

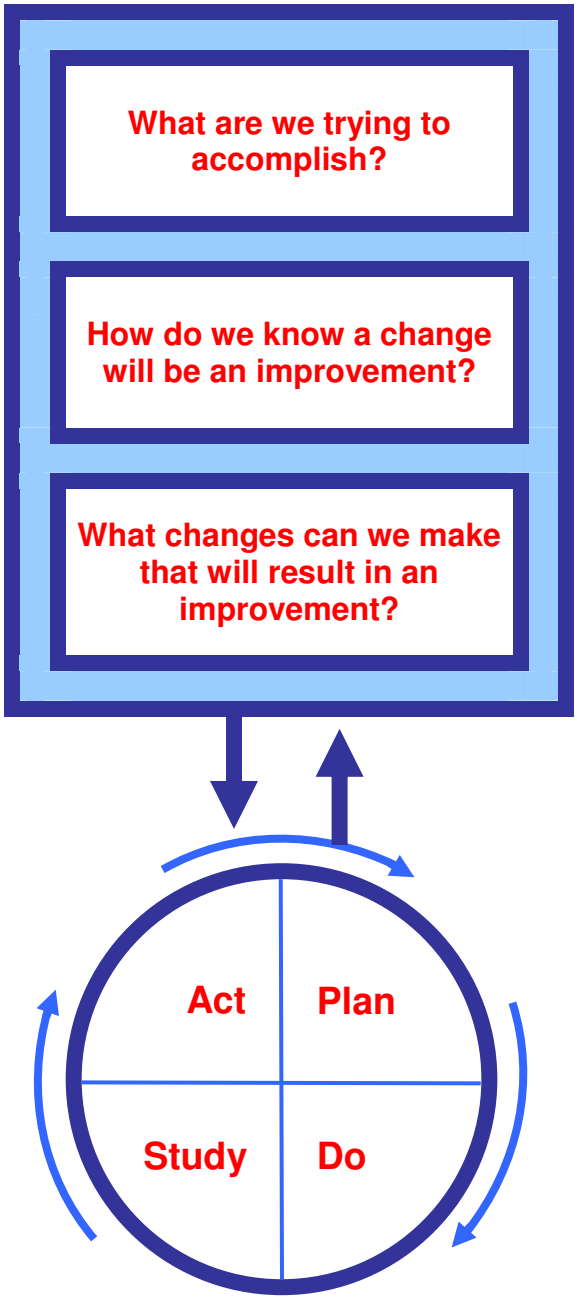
Promotion (Continued)

3	**The office staff are enthusiastic**	A personal invitation from the office receptionist. Following is a sample script. *I notice you're here to see Dr. Jones. She asked that I give you this invitation (hand brochure) to her new Group Medical Appointment. I'm hearing good things from other patients about it. If she asks you to come, why don't you consider it? Perhaps you can read this while you are waiting.*
4	**The invitation is repeated**	A personal invitation from the office MOA, nurse, etc upon rooming the patient. Following is a sample script. *Oh, by the way, Dr. Jones is offering a new option to her patients, it's called Group Medical Appointments, and I'm there myself. I'm not sure if you saw the poster in the waiting room, but here, let me give you a flyer. We have a lot of fun and even serve snacks. Please think about joining us for your next appointment.*
5	**The doctor is excited**	A personal invitation from the doctor. Following is a sample script. *I would like to see you again in 3 months. By the way, I've started something new for just the kind of health issues you are dealing with, it's only for my patients, you're going to meet others who have similar concerns, and I'm going to be able to go into more detail than I could in the rush of an individual appointment. We'll spend about 90 minutes together, we serve Tim Horton's coffee and we have fun, do you want to come?* If yes, book them. If no— *I'm so sure you'll like this, will you try it once for me?*

Evaluation/Feedback & Your GMAs

What would you like to accomplish with group visits? Are they meeting your expectations?

This section suggests some reasons regarding what you may be trying to accomplish with group appointments and evaluative questions to ask. After looking at data, many use the Institute for Healthcare Improvement's (IHI) Quality Improvement Model to make small beneficial changes.



Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

All improvement requires making changes, but not all changes result in improvement. Teams therefore must identify the changes that are most likely to result in improvement.

The Plan—Do—Study—Act (PDSA) cycle is shorthand for testing a change in the real work setting by—

- **Planning it**
- **Trying it**
- **Observing the results**
- **Acting on what is learned**

4 Questions Worth Asking—Evaluation (Continued)

Does your GMA improve access?

Things to measure—

- Waiting times for appointments
- Enabling of open access
- Reduction in urgent appointments
- Productivity gains/cost effectiveness

Does your GMA help you meet clinical guidelines?

Choose several clinical practice outcomes that you are currently tracking.

- Are you noticing a spike in completion rates? (eg. 90% of diabetes patients measuring A1c q3mon)
- Is the percentage of patients meeting target improving? (eg. 70% of diabetes patients have A1c below 7.0)

I developed these models based on what they can provide patients, for they truly give our patients more and not less…it's just a serendipitous side effect that one sees a 2, 3, or 4 fold increase in productivity for the same amount of time.

Dr. Ed Noffsinger

Is your GMA improving quality of care for your patients?

Things to measure—

See *Patient Evaluation Form*

- What percentage rate the GMA as excellent?
- What percentage would definitely return?
- What percentage feel their health questions and concerns were addressed?

Are you (team) satisfied with the GMA experience?

Things to measure—

- Has your professional satisfaction improved?
- Are you able to offer more comprehensive care?
- Are you satisfied with the level of support you are receiving to offer group appointments?
- Is your office redesigning so that the group visit option is routinely offered?
- Are other GMA providers satisfied with their participation?
- Have the other providers involved expanded their scope of practice?

Group Visit Communication Form

*Group Medical Appointment Communication Form

- Please use this form to share how Group Medical Appointments are working for you.
- Click on the **Grey** areas to complete. Press **F1** for **Help** on some items.
- This form can be attached to email or faxed—see end of form.

Part I: GMA Summary			
Physician/Provider Name:		Date:	
GMA Type (inc group focus	☐ Heterogeneous DIGMA ☐ Homogeneous DIGMA ☐ DIGMA Other ☐ Physicals SMA ☐ CHCC		
Census	Booked Attendance		
Team Provider			
Role	Name (inc credentials eg. PhD, MOA)	Role	Name
Behaviorist		Documenter	
'Nurse' 1		Guest 1	
'Nurse' 2		Guest 2	

Part II: General Impressions & Stories

Part III: What are you trying to accomplish? (pls comment on any or all of the following areas)	
Improve Access:	
Comprehensive care:	
Patient satisfaction:	
Provider satisfaction:	

Part IV: PDSAs tried this visit

Part V: PDSAs for next time

Attach Form to Email **or Fax 250.983.6822**

***This form is available on the CD of resources for electronic completion and sending.**

Invitation Letter

From the desk of Jill Jones MD

Dear Patient,

I'm starting a new program just for my patients. This program allows you to spend about 90 minutes with me in a Group Medical Appointment. You're going to get all the care you would normally receive in a one to one office visit, but we will have more time to deal with more of your concerns and go into greater detail about how to manage your health. There's no waiting, we begin and end on time. Best of all, you get to learn about health and well being from others in the room. Plus, we serve snacks and laugh a lot.

Next time you have a health need, please join me for a Group Medical Appointment. I know you won't be disappointed.

Sincerely,

Jill Jones MD

Welcome Letter

From the desk of Jill Jones MD

Dear Patient,

As your doctor, I wish to personally welcome you to today's appointment. This type of visit is called a Group Medical Appointment. It allows you to spend about 90 minutes with me and others in a group appointment setting. Today, we wish to provide all the care you would normally get in an individual office appointment plus there is no wait and we end on time. Speaking of time, there is usually enough to have most, if not all, your concerns answered. Best of all, you get to learn about health and well being from others in the room.

At the end of the group appointment session, please fill out an evaluation of this type of appointment with myself and others who helped me provide care today. I wish to assure you, that even if you are participating in this appointment, you are most welcome to make typical office appointments with me should the need arise.

Sincerely,

Jill Jones MD

Confidentiality Commitment

Confidentiality Agreement—Group Medical Appointments

with Dr _____

During group medical appointments, your medical issues will be discussed in front of others. And, you will hear about other participants' health issues and personal information. As a matter of trust, it is your duty to keep everything you hear confidential. Nothing that identifies a participant in any way (including job, ethnicity, religion, etc.) can be shared outside of this group setting. Of course, you are welcome to discuss things you have found helpful with friends and family, providing nothing that you say identifies others.

Like any health appointment, appropriate information about *you* becomes part of your clinic medical chart. Group data may be used for the purposes of research and/or medical publication, but no individual or identifying information will be disclosed for any reason.

Confidentiality Commitment

- I accept that the health care team will discuss my medical issues in front of others.
- I will keep the confidentiality of group members' personal or health information heard during a group medical appointment.
- I am committed to maintaining this confidentiality even if I am no longer participating in group medical appointments.

NAME: | | | | | | | | | | | | | | | | | | | |

SIGNATURE: _____

SUPPORT PERSON SIGNATURE: _____

DATE: _____

Each person will be asked to sign this commitment before each Group Medical Appointment Thank You!

Patient Evaluation Survey

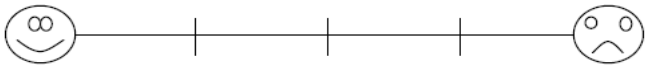
I have this to say about…
Group Medical Appointments

Place: _____ **Date:** _____

1. It was helpful to be in a group appointment like this.
   (Please put an X on the face or line.)

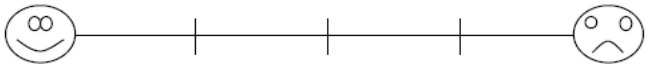
YES NOT SURE NO

2. I was able to ask my questions.



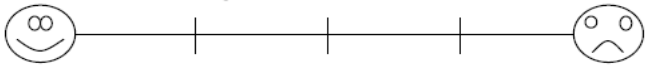
YES NOT SURE NO

3. I would recommend this to others.



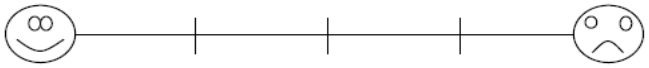
YES NOT SURE NO

4. I would come to another group appointment like this.



YES NOT SURE NO

5. Overall I was satisfied with today's appointment.



YES NOT SURE NO

What did you like about today?

Is there any thing you would like to change about today?

Anything else you would like to say?

Thank you for showing us how to make this health experience better.

Part V

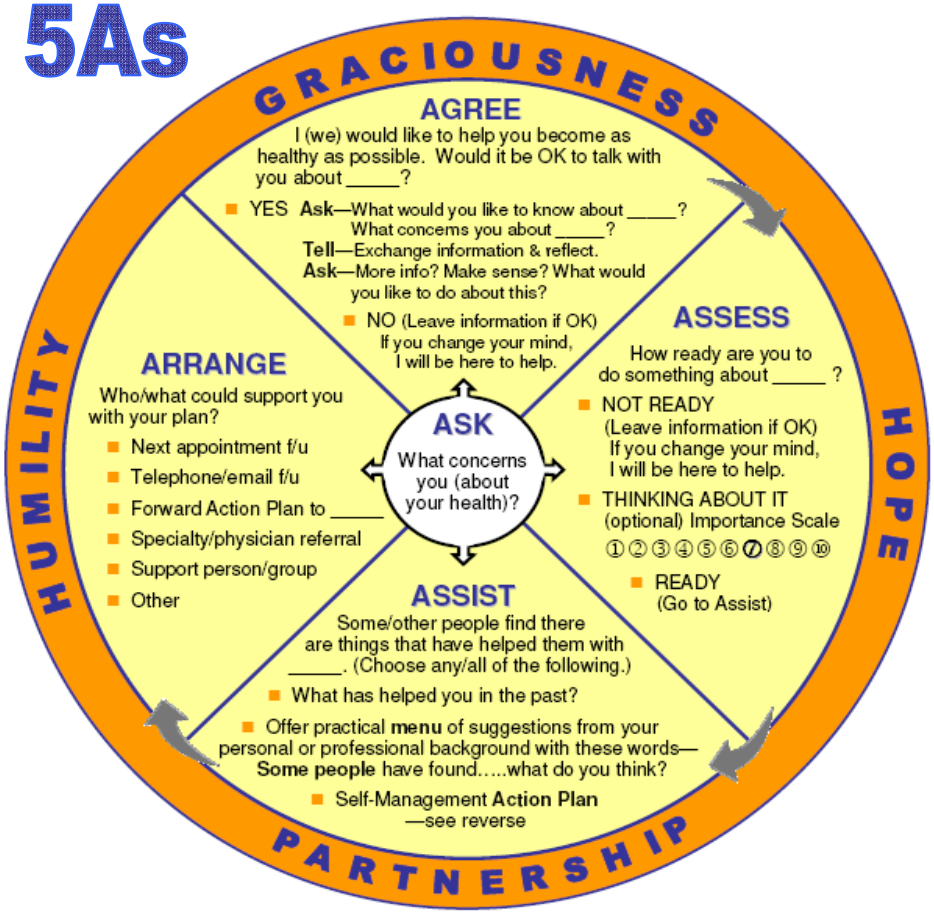
Group Medical Appointments

Miscellaneous

'NH 5As'

Northern Health's 5As is intended as a respectful behavior change conversation tool with patients…and one another. 'NH 5As' can be used in very short 'sound-bite' conversations or as an outline for a longer session. It is a fusion of several 5A templates, harmonized with components of Motivational Interviewing and Stages of Change theory. All aspects have been scripted and formatted so that the 'NH 5As' can be printed on a reference card (laminated reference card available). However, more than simply remembered acronyms or set of techniques, it recognizes that the philosophy (or some refer to 'spirit') of the provider is paramount. The 'A's themselves are merely an expression of that attitude.

NH 5As



- **For conversations about initiating & guiding (health) behavior changes**
- **Brief Intervention tool—utilize any part according to conversation flow & time available**

northern health

Self-Management Is Being Able To Make Small Healthy Changes in Behavior

Most people are interested in managing their health better, but are stuck between desire and action (ambivalence). Below is a Self Management Action Plan template (administer orally or written) based on the following assumptions about human change behavior. (The Action Plan is also found on the reverse of the 'NH 5As' reference card.)

- Most people already know what they want to change
- Most change involves making and reaching small plans of action
- Most people will change if they are confident they can change
- Most change occurs in the context of support (follow-up)

To Become More Healthy

IS THERE SOME THING you have been thinking about to become more healthy?
Many people have used the following steps to change thought into action.

Step One Please write down some thing you would like to try in the next week.

How many times ☐ ? and/or How? When? Where?

Examples Only: *I'd like to walk 5000 steps 4 times next week.*
I'd like to eat oatmeal porridge 2 times next week.

Step Two How confident are you that you can/will do it? Please circle a number.

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
not confident at all very confident

IF YOU CHOOSE 7 or above, you are likely to do it. **Go for it!**

IF YOU CHOOSE 6 or lower, how might you change this plan so that your confidence is higher. Please go to Step Three.

Step Three Change your plan so that your confidence reaches 7 or above.

Example: Truthfully, I don't think I can walk 5000 steps 4 days next week, but I'm really confident I can do it 2 times next week.

Your turn…in the next week, I can—

My confidence to do this is now ⑦ ⑧ ⑨ ⑩ (please circle one).

CUT OR TEAR HERE AND LEAVE WITH STAFF

Step Four We would like to support you in your action plan by giving this portion to your doctor .

Is this OK with you? ☐ Yes ☐ No

Name _____

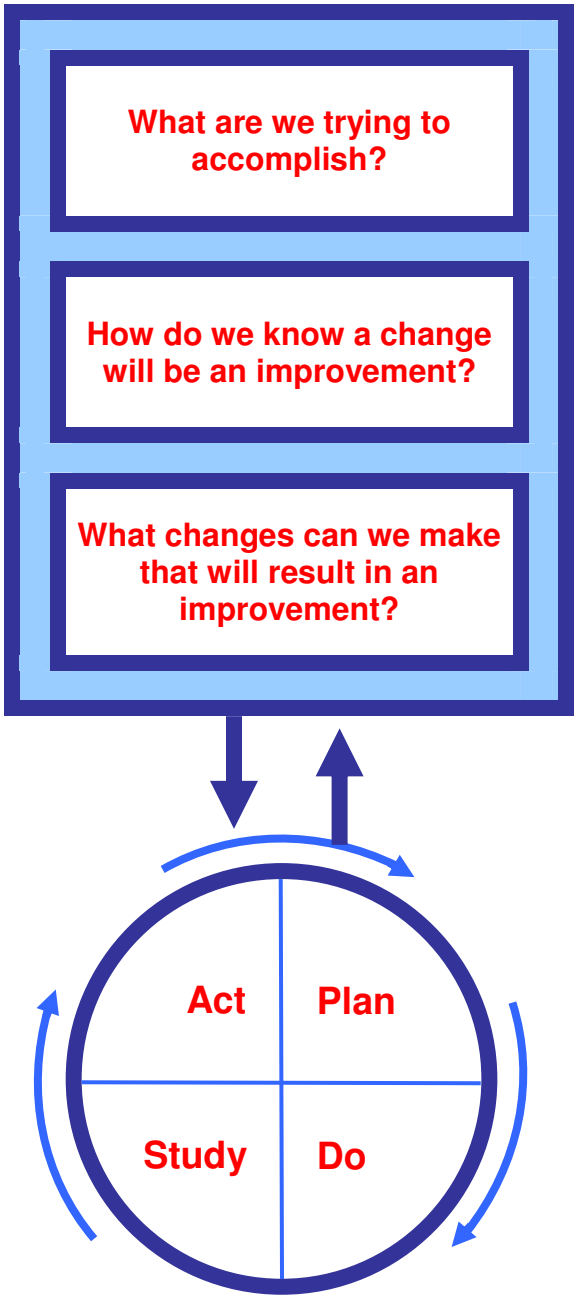
Doctor_____

Please write down your action plan (include confidence level) below:

_____

_____

IHI—The Model for Improvement



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- Planning it
- Trying it
- Observing the results
- Acting on what is learned

Group Visit—Services Needed Form*

GROUP VISIT—Dr. _____

Date: _____

Name	Lab	Foot Exam	Influe Inj	Pneu-movax	Book Eye Exam	Other
Joe Blow		X			X	
Tammy No	A1c, ACR		X	X		
Jim Who	A1c	X				
Suzie Q			X			
Linda						Questions for dietician

*Submitted by Tuula, Quesnel

Notes

Notes