

CHAPTER 8

Group medical visits and other non-traditional encounters

One morning in 1991, Dr. John Scott was running from room to room, seeing one patient after another, frustrated by the rushed atmosphere of each visit. The faces of John Scott's patients mirrored the reality of hamster health care (see Chapter 1).

"There has to be a better way," fumed John Scott. He realized that each patient sits isolated in a room behind closed doors waiting for the doctor's late entry and hurried exit. Moreover, most of the patients experienced similar medical problems. A mental light bulb switched on: "Why don't I see them all together?" That day, in the Kaiser Permanente facility at Wheat Ridge, Colorado, the group medical visit was born.

Dr. Scott did not rush to implement his idea. Together with Colorado Kaiser's research office, he designed a study comparing group medical visits with usual care for elderly people with chronic health problems. The results were encouraging: the group visit patients had fewer emergency room and specialist visits, stayed healthier, and had higher patient satisfaction. Total costs per patient per month dropped by \$14.70.¹

Since John Scott's innovation at Kaiser Permanente in Colorado, the group visit concept has branched out into three distinct varieties: the Cooperative Health Care Clinic (Dr. Scott's model), the specialty group visit, and the Drop-In Group Medical Appointment (DIGMA).²

Group visits are not the only alternative to the traditional patient visit. Telephone care, remote telemedicine, e-mail, fax, and web-based encounters are growing in importance. This chapter examines the three varieties of group visits and briefly discusses other innovations in clinician-patient interaction.

The Cooperative Health Care Clinic

John Scott's Cooperative Health Care Clinic model is an alternative, not an add-on, to individual physician visits. Patients choosing the group model see their physician during a once-a-month group session. If they need more physician time they can also make an individual physician appointment, but generally the group visit is the way in which they receive their primary care. This model emphasizes continuity of care; the same patients attend their physician's group. Dr. Scott has some patients who have been seeing him in group visits for ten years.

The Cooperative Health Care Clinic model targets elderly people who are chronically ill but not frail. Those who are hearing-impaired or demented cannot participate in groups. Otherwise, virtually all diagnoses are accepted. The group of 15-20 patients, sitting around a large table, first receives a brief educational talk about a health problem. While the nurse performs blood pressures, blood sugars, diabetic foot exams and other functions, the physician goes around the room taking focused histories and whatever portions of physical exams are needed and appropriate in a group setting. Patients are referred to physical therapy, specialty care or dietary counseling as needed, prescriptions are written, plans are made for the management of each problem, and the physician charts the visit into the Kaiser-Permanente/Colorado electronic medical record. Some patients call others during the month to see how they are getting along.

For those few patients who need privacy for a sensitive discussion or physical exam, the physician schedules some time following the group.

As the physician is directing attention to one patient, the others may listen, talk quietly with one another, or chime in with their suggestions and experiences. Dr. Scott recounts: "I was talking about arthritis one time, and a little voice in the back of the room said: `You mean I'm going to have to live with this? How am I going to live with this?' Another woman held up a disfigured rheumatoid hand and said, 'Honey, at the break I'll tell you how.'"³

At a Kaiser Permanente/Colorado group visit in December, 2000, Dr. James Hardee asked the group "Do you know what 'high risk' means?" One man piped up: "If you are about to lay down and die you are high risk." During that group session, one person had a blood pressure of 150/112, and Dr. Hardee adjusted his medications. One patient wanted to know the pros and cons of back surgery for a herniated lumbar disc; two other patients -- one treated with surgery and one without -- gave their experiences. A patient wanted results of a recent shoulder x-ray; Dr. Hardee accessed the information on the computer, showed it to the group, and discussed the patient's treatment options. Another patient wanted her lipid results, resulting in a discussion that interested the entire group. The group ended with a 20 minute discussion between Dr. Hardee, a patient with amyotrophic lateral sclerosis (ALS) and the patient's family. After the discussion, one other patient who had stayed to listen remarked: "I thought I had a problem, but after hearing this, I have nothing to complain about."

Not only do group visits allow patients to help each other, they also give patients the feeling that they are spending adequate time with their physician. Even though each patient may receive only 5 or 10 minutes of the physician's attention, they experience being in the room with the physician for 90 minutes.

Kaiser Permanente/Colorado has a group visit coordinator who has initiated and mentored 40 groups in the Denver area. KP's investment in group visits is justified by the latest results of its controlled trials. After 2 years, comparing groups with usual care, those who actually attend the groups have fewer emergency room visits and hospital days, generating savings of \$48.17 per member per month. Group members showed slower decline in activities of daily living than controls and rated their quality of life higher than controls.⁴ For both physicians and patients, groups are entirely voluntary. Physicians are trained in conducting groups and are mentored until they feel comfortable.

Specialty group visits

Group visits on the Cooperative Health Care Clinic model can be arranged for a group whose members have the same diagnosis: diabetes, hypertension, arthritis, fibromyalgia, congestive heart failure, and other chronic conditions. Kaiser Permanente Northern California's Pleasanton facility has pioneered group visits for diabetics. The visits combine patient education with clinical management of individual patients in the group setting. In a randomized controlled trial, members of these groups lowered hemoglobin a1c levels by 1.3% compared with 0.2% for control subjects. Group members had reduced outpatient and hospital utilization and improved satisfaction with their care.⁵

Drop-In Group Medical Appointments (DIGMAs)

In 1996, Edward Noffsinger, clinical psychologist, developed the concept of drop-in group visits at Kaiser Permanente's Santa Teresa facility in San Jose, California. In contrast to John Scott's continuity model -- in which the same patients attend their physician's group for years -- DIGMAs have different patients each time. Patients may call in advance or simply drop in.

DIGMA's generally run 60-90 minutes with a census of 12 to 20 patients.⁶ DIGMAs may be conducted by primary care physicians, mixing patients with a variety of diagnoses, or by specialists concentrating on one diagnosis. The initial DIGMAs piloted at Kaiser Permanente were led by physicians in primary care, oncology, neurology, and rheumatology.^{7,8} In Dr. Noffsinger's model, groups are led by a physician, behavioral health specialist, and nursing staff.

Whereas the Cooperative Health Care Clinic model emphasizes improved quality and financial savings, the DIGMA's main benefit is improved access. Rather than having receptionists squeeze -- into a physician's filled schedule -- patients requesting visits on a semi-urgent basis, they can add these patients into a weekly DIGMA. DIGMAs work well with same-day access scheduling (see Chapter 7), enabling physicians to see two or three times more patients than individual appointments would allow. As with John Scott's groups, physician leaders have time following the DIGMA to see patients who need privacy. Patients must always be given the choice of an individual physician visit and physicians volunteer -- are not assigned -- to lead DIGMAs.

Randomized controlled trials of DIGMAs have not been done. Physicians have testified that the number of phone calls and double-booked appointment slots drop when they offer DIGMAs. If a physician sees 6 individual patients in 90 minutes but 12 patients in a 90-minute DIGMA, costs might go down in capitated systems and reimbursements might increase under fee-for-service.⁹

As in John Scott's groups, patients in DIGMAs help one another. One poorly-controlled diabetic patient refused to take insulin in spite of numerous entreaties by his physician; at a DIGMA another diabetic remarked, "you remind me of myself before I had my first amputation." The patient started insulin.

Edward Noffsinger has launched a number of primary care and specialty DIGMAs at the Palo Alto Medical Foundation in California. Two patients with fibromyalgia had suggestions for one another. One patient had acute back pain, and after the physician did a history and brief physical exam in front of the group, others gave advice regarding spine classes, home exercises and other treatment modalities. Medications prescribed at the DIGMA were electronically faxed to the patient's pharmacy. Two patients needed blood pressure medications changed and two diabetics were properly managed. One patient wanted a drug for weight reduction and instead received a 5-minute educational discussion from the physician with other patients adding their experiences.

Obstacles to the spread of group visits

Group visit models have begun to spread across the United States, albeit slowly. The Institute for Healthcare Improvement (IHI) views both the Scott and Noffsinger models as part of its Idealized Design of the Clinical Office Practice collaborative. Several academic medical centers have experimented with groups, as have Kaiser

Permanente regions. John Wasson at Dartmouth has organized group visits for local physicians and the Mayo Health System has piloted groups.⁹

In a series of practical articles, Edward Noffsinger and John Scott discuss obstacles to the success of group medical visits.^{2,6,7,8} In the case of both Cooperative Health Care Clinic and DIGMA models, an efficient administrative and scheduling infrastructure must be in place to manage the groups. In order to fulfill the business case for group visits, physicians should be able to see more people in the group setting than they would have seen as individual visits in the same time period. If the group census is not adequate, group visits are not cost-saving in the capitated environment and are not productive in the fee-for-service world. Kaiser Permanente in Northern California has backed off from group visits due to difficulty maintaining an adequate census.

Physicians leading group visits must be trained and their first groups should be attended by an experienced mentor. A tendency exists to turn group visits into patient education classes, which is not their primary purpose. Thus far, experienced mentors are few and far between; a cadre of such mentors needs to be developed similar to the master trainers for patient self-efficacy groups trained by Kate Lorig. Kaiser Permanente in Colorado appears to be overcoming these obstacles by having an experienced and energetic group visit coordinator to work on census building and physician mentoring.

Other non-traditional encounters

An estimated 15% to 20% of all ambulatory care contacts in the United States are telephone contacts.¹⁰ In 1992, John Wasson and colleagues compared two groups: less frequent clinic visits plus scheduled phone calls vs. more frequent clinic visits. The telephone-care patients had less medication use, fewer hospital days, and 28% lower expenditures compared with controls.¹¹ However, Wasson's study was repeated by one of his co-authors, and no benefit was found when substituting scheduled phone calls for some clinic visits.¹⁰

The telephone can be utilized by nursing personnel or office staff to treat patients with simple problems such as upper respiratory infections or urinary tract infections. The use of protocols, as performed in Charles Burger's office (Chapter 10) allows such encounters to offload physicians and improve access.

Telemedicine involves a two-way computer hook-up with patients in their homes, allowing caregivers to "visit" the patient electronically. The patient and caregiver can see each other, the patient can place a home stethoscope on the heart so that the caregiver can listen, blood pressures can be electronically sent to the caregiver's computer, wounds can be examined, and patient use of insulin or inhalers can be observed.

E-mail is utilized by a small number of physicians to communicate with their patients, and is likely to explode into a common feature of medical practice. E-mail may take physicians less time than phone calls and bypasses the problem of phone access faced by many primary care practices. E-mail exchanges can be filed in patient charts. Requests for lab results, prescription refills, monitoring of blood sugars, and non-urgent advice are ideal topics for e-mail encounters. E-mail can reduce patients' needs for one-on-one visits. Certain rules must be made clear to patients about how e-mail is to be used; most importantly, for nothing urgent. If a patient thinks he or she needs to be seen in person, the traditional visit must take place.^{13,14} E-mail overload can be managed by

routing e-mail messages first to office staff. Privacy is not protected in e-mail messages unless the messages are encrypted.¹⁵

Joseph Scherger writes: "a physician caring for about 2000 patients has about 40 patient interactions on any given day. Currently, 20 to 25 patients are seen each day in the office and the rest are handled by telephone. Many of these interactions could be handled by e-mail. The physician and other office staff would spend one to two hours a day on the computer, interacting with 20 to 30 patients. Our offices could be much quieter, with 30- to 60-minute appointments given to the six to eight patients who really need to be seen."¹⁶ Not all physicians agree with Dr. Scherger. Some find that e-mail does not save time, but increases workloads, adding to visits, phone calls and paperwork.¹⁷

Web-based interaction between patients and caregivers is beginning. Congestive heart failure patients can answer questions about their symptoms and weight on an internet site; the data goes back to care managers who can intervene if necessary. Patients can receive diabetes education through the internet and can input their blood sugar levels. Patients can be sent charts showing trends in hemoglobin a1c, lipids and other measures.¹⁸ Drug prescribing on the web is controversial, but legitimate prescribing is possible and likely.¹⁹

The computer has the potential to improve quality of care. Computerized order entry systems for drug prescribing is one electronic health innovation that has been shown to improve quality by reducing medication errors.²⁰ In addition to meeting the promise to improve quality, the challenge to electronic health pioneers is to develop systems that both help patients and reduce workload for physicians. One computer-savvy but skeptical physician explained, "We've all heard from companies how their systems will make our lives easier and save us money, and it ends up costing us more and is more complex."²¹

Can the electronic revolution free primary care physicians from the hamster treadmill (see Chapter 1)? Thus far, the answer is No. Every interaction takes time, whether in person, on the telephone, or in cyberspace. While e-health shows promise, the simple innovation of the group visit -- allowing patients to interact in an unhurried way with their clinician and with each other -- may turn out to be a more powerful antidote to the hamster syndrome.

References

1. Beck A et al. A randomized trial of group outpatient visits for chronically ill older HMO members. *J Am Geriatr Soc* 1997;45:543-549.
2. Noffsinger EB, Scott JC. Understanding today's group visit models. *Group Practice J* 2000;49(2):48-58.
3. Kolata G. Harried doctors try to ease big delays and rushed visits. *New York Times*, January 4, 2001.
4. Information provided by Dr. John Scott
5. Sadur CN et al. Diabetes management in a health maintenance organization: *Diabetes Care* 1999;22:2011-2017.

6. Noffsinger EB, Scott JC. Preventing potential abuses of group visits. *Group Practice J*, 2000;49(5):37-48.
7. Noffsinger EB. Increasing quality of care and access while reducing costs through drop-in group medical appointments. *Group Practice J* 1999;48(1):12-18.
8. Noffsinger EB et al. Physicians evaluate the impact of DIGMAs on their practices. *Group Practice J* 1999;48(6):22-33.
9. Lippman H. Making group visits work. *Hippocrates*, July 2000, pp. 33-37.
10. Welch HG. Telephone care as an adjunct to routine medical follow-up. *Effective Clinical Practice* 2000;3:123-130.
11. Wasson J et al. Telephone care as a substitute for routine clinic follow-up. *JAMA* 1992;267:1788-1793.
12. *Health Care Strategic Management*, February 2000.
13. Finger AL. Do more for your patients by seeing some of them less. *Medical Economics*, October 23, 2000, pp. 65-75.
14. Morasch LJ. Making the most of physician-patient e-mail. *Hippocrates*, November 2000, pp. 33-39.
15. Abdulla A. E-mail security. *Physicians and Computers*, June 2000, pp. 8-11.
16. Scherger JE. A new way of practicing. *Hippocrates*, August 2000, p. 8.
17. Guariglia V. Physicians race to embrace internet tools. *Physicians Financial News*, September 30, 2000.
18. Cross M. Disease management on the web. *Internet Health Care Magazine*, November 2000, pp. 50-55.
19. Perlmutter C. Prescribing on the web. *Hippocrates*, September 2000, 39-45.
20. Teich JM et al. Effects of computerized physician order entry on prescribing practices. *Arch Intern Med* 2000;160:2741-2747.
21. Chin T. E-health fails to fulfill promise. *American Medical News*, August 21, 2000.