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Potential Abuses of Group Visits

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Introduction

To fully capture the increased efficiency, multiple patient care benefits, and economic advantages which group visit programs can provide, it is important that these programs be set up in a group practice or managed care organization so as to be well designed, adequately supported, and properly run. A carefully thought-out group visit program can maximize benefits to patients, physicians, purchasers, insurers, and health care organizations alike; however, it is very important that any potentials for abuse also be thoroughly examined and scrupulously prevented if the benefits of the program are to be fully realized.

In another article,¹ we described three different models of group medical visits: the Cooperative Health Clinic of Colorado (CHCC),^{2,3} Specialty CHCC,^{2,3} and Drop-In Group Medical Appointment (DIGMA)⁴⁻¹⁸ models. These models are designed to serve different patient groups, and the effectiveness of these models depends upon meeting the needs of these patients at any given time as they try to live well despite one or more medical problems. These models are not mutually exclusive and work best if combined as patients' needs change over time. For example, geriatric patients with multiple medical problems including diabetes and hypertension would do well in a CHCC setting, might benefit from a specialty diabetic or hypertension group, and could use their own physician's DIGMA for continuity of care and for convenient routine blood glucose and blood pressure monitoring.

By definition, group visits (ie, group medical visits or group appointments) include delivery of medical care in a group setting with other patients—in fact, it is the delivery of medical care in a group setting that is the core characteristic of a group visit. However, because DIGMAs, CHCCs, and Specialty CHCCs differ in structure and function, each model suggests the need for different precautions to be taken during planning and implementation. This article outlines potential pitfalls inherent in implementing each model. These pitfalls can involve administrators, physicians, or patients.

Emergence of Group Visits in Mainstream Medical Care

Group visit programs are rapidly proliferating in group practice and managed care organizations throughout the United States in an effort to leverage existing resources and to provide high-value, high-quality health care in this era of increasing purchaser and patient demands for enhanced services at reduced cost. Substantial economic pressures are at work in today's rapidly changing, highly competitive health care environment. Despite working long hours and as hard and efficiently as possible, many physicians are nonetheless finding that their patient panels are becoming larger, that access problems are emerging, and that the increasing size of their practices is making them difficult to manage. Others are striving to move to same-day access but are finding that they need a tool such as group visits to help them achieve and then maintain this level of accessibility.

Health care organizations must address the fact that insufficient financial resources exist in the system to solve problems of workload, access, utilization, service, and quality of care solely through traditional means (ie, simply by hiring more physicians to give individual patient care). Despite organizational inertia and physician resistance to change, innovative group visit programs are gradually but steadily emerging in an effort to increase efficiency, leverage physician time, improve service and quality of care, and better manage high-risk patient populations. Various types of proven group visit programs will be used increasingly in the delivery of health care because of their ability to provide better, more efficient care at reduced cost and to create high levels of both patient and provider professional satisfaction. Therefore, it is important to safeguard against any potential for abuse and to begin planning for this possibility now.

Major Group Visit Models

Most group visits and programs for managing high-risk patient populations use one of two major group visit models which have emerged in recent years.¹ The Kaiser Permanente Cooperative Health Care Clinic in Colorado focuses on patient populations either by utilization behavior (eg, the CHCC model for high-utilizing geriatric patients) or by disease

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state (eg, the Specialty CHCC model), which is the foundation for programs which manage high-risk patient populations such as those with diabetes, asthma, hypertension, hyperlipidemia, congestive heart failure, depression, and irritable bowel syndrome.^{2,3}

The other 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. The DIGMA model focuses not on patient populations by either disease state or utilization behavior, but instead on

the entire patient panel of each individual physician.⁴⁻¹⁹ The DIGMA is an extended medical appointment with the patient's own physician, held in a supportive group setting. Open only to the physician's own patients, each DIGMA is custom-designed around the specific needs, goals, practice style, and patient panel constituency of the individual physician. Specifically focused on improving accessibility and enabling physicians to both leverage their time and better manage their entire patient panel, DIGMAs have been shown to dramatically increase physician productivity in a way which enhances patient and physician professional satisfaction while improving service, access, and quality of care.^{9,10}

As is true of traditional office visits, DIGMAs address whatever medical needs patients bring to the medical visit as well as routine health maintenance issues. However, due to the greater amount of time available and the presence of both the behavioral health professional and the group itself, the needs of both mind and body can be comprehensively attended to. DIGMAs give patients what they most want: prompt access, high-quality health care, and more time with their own doctor.

In addition to other successful models that might be developed in the future, the CHCC, Specialty CHCC, and DIGMA group visit models can be expected to play an increasingly important role in tomorrow's health care environment. These models work well not only as stand-alone programs but also when combined; indeed, combining these models can provide even greater efficiency than either model alone.

The Need for Safeguards Against Abuse

Not only must the group practice or managed care organization implementing a group visit program ensure that the program is properly designed, adequately supported, and well run; potential abuses must also be considered, and proper safeguards put in place. These new and innovative group visit models carry a real potential for being abused, and such abuse could both undermine the credibility of the entire program and severely reduce the economic, patient care, and productivity advantages that they offer.

Simply stated, health care organizations can "shoot themselves in the foot" if they fail to minimize the risk for abuse while maximizing the benefits of well-run group visit programs. Minimizing this risk will ensure continued support from patients, physicians, purchasers, and insurers.

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In today's challenging, competitive health care environment, group visits can be abused in two basic ways: 1) by putting fewer resources into group visits than adequately supported, properly run programs require, or 2) by attempting to extract more from group visits than is commensurate with good care.

If we wait until some abuse of group visits actually occurs and receives negative publicity, we could incur a public relations "black eye," which could seriously undermine the credibility of all such programs in the future—a predictable, preventable, and completely unnecessary injury to the image of group visit programs.

Should third-party insurers, upon recognizing the multiple economic and patient care benefits which group visits can offer, overincentivize them relative to individual visits, abuse could result which would reduce the voluntary nature of group visits for physicians and patients alike.

An interesting observation is that group and individual visits work well together and complement each other: the strengths of one model are often the weaknesses of the other, and vice versa.

Despite all of these concerns surrounding potential abuses, group visits will undoubtedly continue to grow in importance and be ever more frequently used during the coming years. Without question, group visits have an important role to play in the future of health care.

Well-designed, adequately supported, and properly-run group visit programs (such as DIGMAs, CHCCs, and high-risk patient population management programs—Specialty CHCCs) not only offer the benefits of greater efficiency and reduced costs through economies of scale but also offer the additional benefits of improved access, comprehensive mind-body care, better follow-up monitoring, and increased patient and physician professional satisfaction.



The group visit experience must be professional and of high quality. This is achieved through the specific advantages which group visits offer: additional time available, a more relaxed pace of care, increased efficiency and productivity, closer follow-up care, a focus on the needs of mind as well as body, and the information and support provided by others. Group visits integrate all these advantages into each patient's health care experience.

In today's challenging, competitive health care environment, group visits can be abused in two basic ways: 1) by putting fewer resources into group visits than adequately supported, properly run programs require, or 2) by attempting to extract more from group visits than is commensurate with good care. Problems in both of these areas can be reasonably anticipated as group visit programs continue to proliferate. Abuse must therefore be vigilantly and continuously guarded against if group medical visits are to retain credibility in the eyes of patients, purchasers, physicians, insurers, and health care organizations. From the outset, professional and ethical constraints, as well as "checks and balances," will be required as group visit programs continue to emerge.

The Importance of Addressing Potential Abuses Now

As the originators of the CHCC and DIGMA models, the authors are staunch advocates of well-designed, properly run group visit programs because they offer increased efficiency and multiple economic and patient care benefits—a "win-win-win" situation for consumers, providers, and insurers. Even at this early stage in the development of group visit programs, one is able to glimpse into the future, where full-scale implementation of group visits is likely to play a substantial role in health care delivery. Group visits represent an important tool for achieving improved access and optimal value, both in the medical services currently being delivered and in the cost-effective delivery of high-quality health care in the increasingly integrated systems of the 21st century.

However, the authors already have concerns regarding the potential for abuse of group visits. Safeguards against this abuse must be built in from the outset. Organizational self-interest demands that these concerns be addressed—even at this early stage in the development of various group visit programs—before fee-for-service billing codes are developed for group visits and before these programs become widespread and begin to play a major role in the delivery

of health care. If group visit programs are to achieve their full potential (which would include buy-in by corporate purchasers, patients, physicians, health care organizations, and insurers), abuse must be avoided at all cost.

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Because group visit programs such as DIGMAs, CHCCs, and high-risk patient population management programs (ie, Specialty CHCCs) offer a "win-win-win" situation for patients, physicians, health care organizations, and insurers, everyone has much to gain from well-run group visit programs. Therefore, we must be careful to avoid jeopardizing these benefits by succumbing to any temptation for abuse, the ultimate consequence of which could be rejection of all group visit models.

This paper examines potential abuses of group visits from the perspectives of patients, physicians, health care organizations, and insurers.

Preventing Patient Abuses of Group Visits

Abuses can be either intentional or unintentional. Along with the physician who is providing medical care, patients are in fact primary caregivers in chronic disease management because they have the most firsthand experience in coping with illness and in developing the requisite coping skills. Patients are also the key ingredient in the interactive educational process which occurs in the group medical visit milieu; and patients must be reminded of this as well as valued for it.

Although no one is required to comment at any specific time during the group visit, relationships between patients as well as healthy group dynamics are key to building self-efficacy skills and enabling patients to help one another. Conversely, nonparticipation adversely affects both the group dynamic and the benefit to each patient. Therefore, patients need to be encouraged to speak up openly and candidly.

The entire group visit environment must be designed to foster feelings of safety, trust, and comfort so that patients will be willing to speak up. When one person has a question, it is a virtual certainty that three or four other people have either the same

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question or another facet of that question which needs to be addressed. However, for this participation to occur, patients must trust the group visit experience—and this trust cannot grow unless patient abuses are scrupulously guarded against.

Do Not Restrict Access to Individual Visits

Restricting access to traditional individual office visits could precipitate unintended consequences and be perceived by patients as an abuse of group visits. All patients attending group visit programs such as DIGMAs, CHCCs, or Specialty CHCCs must be fully informed both that participation in these programs is completely voluntary and that patients who attend them are always entitled to still have individual appointments as needed. Using group visits to largely or completely replace individual office visits would violate this important condition and would restrict patient access to the appropriate use of individual office visits. Everyone should remember that group visits are tools for providing better care, for helping physicians to more efficiently manage their large patient panels, and for improving access to medical care; group visits are not meant to completely replace individual appointments or to give health care organizations an excuse to drastically reduce specialty and primary care staffing.

Group visit programs are designed to offer the advantages of increased efficiency, cost reduction, improved service, and more comprehensive attention to the needs of mind and body. Nonetheless, judicious use of individual appointments will always play an important role in health care delivery: Through proper use of group visits, patients best treated by group visits will be appropriately seen in group appointments, whereas patients who require individual appointments can still be seen individually.

Group visits excel in treating the relatively stable chronically ill, the “worried well,” patients who are lonely or who have extensive emotional and psychosocial needs, patients who need more physician contact and professional “hand holding,” and patients who require closer follow-up monitoring, surveillance, and care. Individual visits are usually superior for initial evaluations, one-time consultations, lengthy individual examinations, care of rapidly evolving medical conditions, acute infectious illnesses, most medical procedures, and for patients who refuse group visits.

Despite the almost certain rapid future growth of efficient and cost-effective group visit programs, pa-

tients will always have a need for individual care in the fully integrated health care delivery systems of tomorrow. Using group visits to largely or completely replace individual visits would cause purchasers, patients, and physicians to lose confidence in group visit programs.

Make Group Visits Voluntary, Not Mandatory

The authors’ group visit models were designed to be completely voluntary for patients as well as for staff and to give patients both freedom of choice and improved care. To insist that patients attend a group visit program despite their reluctance to do so would not only probably prove unsuccessful but would also be an abuse of the group visit concept. Patients who refuse group visits should never be forced to attend, and traditional office visits should always be made available to such patients.

However, when an individual appointment is required, two points are worth noting: 1) because group visit programs are designed to convert numerous individual visits into group visits, individual visits are eventually made more accessible to patients who want or need them; and 2) as patients become more familiar with the group visit program and hear positive comments about it from other patients (for example, in the physician’s lobby by hearing favorable remarks from other patients discussing their recent group visit experience while waiting for an individual office visit), the number of patients who refuse group visits has been observed to decline over time. An important component to winning patients over to group visits is to have physicians use 15 to 30 seconds during every routine office visit to personally invite suitable patients to have their next visit be a group visit.

Always Address Confidentiality and Privacy Concerns

Group visit programs must address any concerns that patients might have regarding privacy and confidentiality. Time must be allocated during each group visit session for patients to be able to have a brief private discussion or a brief individual examination with their physician as needed.

Confidentiality issues have seldom, if ever, been brought up by patients in DIGMA and CHCC visits. The rarity of these concerns is due in part to these group visit models being designed and conducted with sensitivity to patients’ confidentiality and privacy needs. For example, in the DIGMA model, patients are told at the beginning of each group session



(as well as in fliers describing the group visit program and by the physician and staff when inviting patients to join the program) that any patient who wants to speak to the doctor in private or who wants or needs a brief private examination will be given that opportunity toward the end of the group session. In the CHCC model, one-to-one time with the health care team is available both during the break and at the end of the group session.

In addition, physicians who have concerns about confidentiality in their group visit program can give all attendees a brief informed consent/full disclosure document describing the limits of confidentiality which requires the patient's signature. This document can be distributed at the beginning of each group session and can fully explain the limits of confidentiality in the group visit format, the availability of some one-to-one time with their physician during the group session, and that all patients attending a group visit program are still welcome to schedule individual appointments as needed.

Provide Adequate Facilities

Adequate facilities must be provided for all group visit programs. These facilities include conveniently located group rooms which are sufficiently large, adequately ventilated, and wheelchair-accessible with bathrooms nearby. The group room should be comfortable, well-lighted, clean, and equipped with enough chairs to accommodate all participating patients, support persons, and staff. A well-stocked examination room should be located nearby and contain all appropriate equipment and referral forms.

If no appropriate group room is available, creativity is required: Consider using conference rooms, unused space which could be converted to group rooms, or even the lobby during off-hours. If no such space is available for use as a group room, then consider taking the group visit program off campus to a nearby building or even into the community. Although health care organizations may need to make do with whatever facilities are available during the pilot phase of evaluating group visit programs, the obvious long-term solution (as they move toward full-scale, organizationwide implementation to fully capture the increased economic and patient care benefits that group visits can provide), is to reinvest a portion of the savings which group visits provide into retooling the physical plant in order to provide enough appropriate group and examination room space.

If no examination room is located in the vicinity of the group room, consider converting nearby space (such as a staff break room) to an examination room for the group. If all else fails, consider improvising an examination room by curtaining off one corner of the group room. In any case, always be careful to ensure that patients' privacy needs are attended to and that they are kept comfortable throughout the group visit session by use of adequate group and examination room facilities.

Provide Marketing Materials Which Have a Professional Appearance

Some group practices, HMOs, and managed care organizations might be tempted to consider saving money by not using professional-appearing marketing materials to make patients aware of the program. Instead of using carefully designed text and coordinated graphics for both the framed wall posters (ie, mounted in the physician's lobby and examination rooms) and program description fliers (ie, contained in a clear plastic dispenser mounted next to the poster), the organization might be tempted to tape to the wall a cheap announcement hurriedly produced on somebody's copier or personal computer. Worse yet, the organization might be tempted to omit these materials entirely.

Because patients have come to expect individual office visits with their physician, posters and fliers describing new group visit programs must be displayed prominently in appropriate places throughout the medical center if we want to adequately inform patients about new group visit programs and expect them to attend. In addition, informational materials must have a professional appearance to accurately represent the high quality of medical care which properly run group visit programs provide. The graphic design of the wall posters can be used as a template to establish a particular look for all marketing materials for all such group visit programs developed at that facility.

Excessive attempts to save money in this area will cause patients to be inadequately informed about new group visit programs and the many patient care benefits they provide. This result would not only undermine the success of the entire program but would also be unfair to patients who would want to attend if they knew about the new program and understood its benefits.

The appropriate way to save money in the area of marketing materials is to use the same high-quality

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graphics on all wall posters and fliers so that the materials look expensive even though they are not. By developing a graphic design template for all group visit programs, DIGMA organizers can generate any future posters and fliers from the template at minimal cost while preserving the professional appearance of the original; only the names of both the group and the physician will need to be changed. Additional savings can be realized by using inexpensive, premanufactured frames to complement the graphic design of the poster at minimal expense.

Use of inappropriate, cheap-appearing, or sloppy marketing materials is likely to result in poor attendance, lack of patient buy-in, reduced efficiency and productivity, and lack of success for the group visit program. Omission of all marketing materials—wall posters, program description fliers, announcements, and follow-up letters—could even more seriously undermine the success of the program.

Schedule Adequate Time for the Number of Patients Attending

To fully realize the benefits which well-run DIGMAs, CHCCs, and Specialty CHCCs can offer to patients, group visit sessions must be long enough for all attendees to receive a high level of care. Therefore, 90-minute DIGMAs should include not more than 15 to 20 patients (not counting caregivers or family members), even though larger groups have on several occasions been successful. One-hour DIGMAs should not include more than 13 patients, and two-hour DIGMAs should not include more than 25 patients. Similarly, 2.5-hour CHCC visits should not include more than 25 patients. We have observed that, when group visit census exceeds these numbers, patients begin to feel rushed, personalized care is diminished, and patients bond less with one another. In addition, if insufficient time is available to adequately attend to each patient's mind-body medical needs, then patients might begin to view the group visit program as a class or a support group instead of a medical appointment in a group setting.

Sessions which include too many patients and too little time constitute an abuse of group visits because such sessions sacrifice the high levels of quality of care, service, patient satisfaction, and physician professional satisfaction which group visits are intended to deliver. Carefully designed and properly run group visit programs offer substantial cost savings by increasing physician productivity and effi-

ciency while providing a myriad of patient and physician benefits. Group visit organizers should not become greedy by driving the time available per patient below acceptable limits in a misguided effort to achieve even more productivity and even lower costs; this effort is likely to result only in reduced quality of care and decreased patient and physician professional satisfaction.

Avoid Holding Group Visits Too Infrequently

If group visits are to be successful, they must be held with adequate frequency. DIGMAs are typically held weekly and occasionally held biweekly, although they could be held daily if the demand is high enough. CHCCs designed to accommodate high-utilizing geriatric patients are typically held monthly. Specialty CHCCs are held at more variable time intervals, depending on the particular needs of each patient population (ie, populations selected by diagnosis).

Consider, for example, the CHCC model—where adequate frequency of visits appears to be critical to success. In this model, increased contact with patients in the group format is not only clinically beneficial but also facilitates identification of problems before they become crises. A recent two-year study of a quarterly group intervention held every three months in a frail elderly population failed to show any effect on utilization, falls, incontinence, etc.²⁰

Experience at the Cooperative Health Care Clinic in Colorado has shown that if a monthly CHCC session is canceled for any reason, a large percentage of its patients will make an individual appointment during the weeks after the scheduled meeting. Whether this occurrence is psychologically motivated (eg, by a need to “touch base” with the physician) or medically necessary has not yet been studied. In either case, infrequent meetings seem to result in increased utilization of individual visits. Therefore, although other explanations might also account for these data, one possible interpretation is that monthly CHCC meetings are sufficient to meet high-utilizing geriatric patients' needs whereas quarterly CHCC meetings are not.

Preventing Physician Abuses

Avoid issuing “top-down” demands for all physicians to provide group visits

From their inception, DIGMAs, CHCCs, and Specialty CHCCs were intended for use by interested physicians on a voluntary basis to provide better and more cost-effective care, to increase productivity and



efficiency, and to enable physicians to better manage their large medical practices. The authors always envisioned that physician participation would be entirely voluntary and achieved out of self-interest at the grassroots level—ie, achieved “from the bottom up” instead of being imposed upon physicians “from the top down” by administration. “Top-down” imposition of group visits is likely to engender resentment, distrust, and passive-aggressive resistance among physicians.

Group visits must not be mandated for patients, physicians, nurses, medical assistants, schedulers, or nurses. All staff, including any guest speakers, must share in the positive perspective and enthusiasm which are required if the group visit program is to succeed. Reluctant participants communicate their resistance—if only through their body language—and inhibit the beneficial effect of the group process.

We strongly encourage that group medical practices, managed care organizations, and HMOs interested in establishing group visit programs implement them initially at a pilot site and then, if successful, eventually disseminate them throughout the organization. This gradual approach allows physician buy-in to develop on a voluntary basis at the grassroots level. To insist that physicians participate in group visit programs, regardless of whether they want to or not, would not only be self-defeating but would also constitute physician abuse of group visits as they were originally conceived (ie, as a way to help physicians instead of burdening them).

Do Not Create Large Increases in Patient Panel Size

In an earlier article, Dr Noffsinger cautioned against stripping away most or all of the benefits which group visits provide for physicians (eg, increased productivity and efficiency) through a corresponding large increase in the physician’s patient panel size.⁵ Physicians express this concern by asking, “Why should I start a group visit program when the net long-term effect will be 1000 more patients added to my panel?” Physicians in capitated systems are concerned that participation in a group visit program (which they otherwise might consider implementing to increase productivity and better manage a large practice) would only result in a corresponding large, long-term net increase in patient panel size. From the physician’s perspective, this result would completely nullify any net gain in efficiency that the group visit program might provide.

To create a “win-win-win” situation for patients, physicians, and health care organizations, physicians too must derive a substantial long-term net benefit from the increased productivity and efficiency provided by their DIGMAs or CHCCs. Physicians view this matter as one of fairness and trust.

A health care organization seeking to realize the many patient, physician, and organizational benefits offered by group visits must adopt long-term business policies which build physicians’ trust and which provide benefits to physicians as well as to patients and to the organization. Physicians in capitated and fee-for-service practices need reassurance from administrators that implementation of a DIGMA, CHCC, or Specialty CHCC for their practices will produce some meaningful long-term net benefit to themselves. Physicians in capitated systems must be assured that any future increase in panel size resulting from the increased efficiency that the group visit program provides will be reasonable, so that they will nonetheless be left with a substantial net gain for their efforts.

Avoid Excessively Large Group Sizes

Because increased physician professional satisfaction is a primary objective of the DIGMA and CHCC models and because physician buy-in is critical to success of these models, insistence on overly large group census (ie, imposed to extract even greater physician productivity) would be self-defeating and would constitute an abuse of these group visit models. It is important that all aspects of the group visit program stay within the physician’s zone of comfort—professionally, ethically, and in terms of productivity.

The limiting factor for maximum group census appears to be physician professional satisfaction. For 90-minute DIGMAs, physicians seldom like group census to exceed 22 members, even though patients have been satisfied with considerably larger group sizes. For example, after the conclusion of one particularly large DIGMA session of 28 attendees, the group gave the physician a standing ovation; nonetheless, the physician felt that the large size of the group created excessive workload demands. Therefore, because physician professional satisfaction remains a priority, the group census for 90-minute DIGMAs should not generally exceed 22 members. Of course, the DIGMA model cannot completely prevent occasions when this number is exceeded; no organizer can com-

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pletely control for the number of patients who will drop into any given session.

An interesting observation is that, in actual practice, the greatest census-related problem is not frequent excesses in group census; this problem happens occasionally, but not often. Instead, the greatest problem appears to be establishing (on the basis of medical economics) and then consistently maintaining a minimum group census for each group visit program.

An exception to this recommended maximum group census can be made for DIGMAs conducted by subspecialists whose patient panels have substantial emotional and psychosocial needs. This exception would thus apply to nephrology, oncology, and rheumatology DIGMAs; for these DIGMAs, experience has shown that the group census can occasionally be set slightly higher.

Reward Physicians by Giving Them Time

In the effort to increase access to care, administrators might be tempted to allow physicians just enough time to conduct the group visit for 15 to 25 patients, often high-intensity patients, and then expect the physicians to rush back to the clinic to see a large number of “routine” patients (ie, those who have acute minor illnesses or who come to the clinic on a walk-in basis) immediately after the group is over. In a fee-for-service practice, physicians may choose to do this to maximize productivity and revenue; however, in a capitated health care environment, this practice provides little incentive for physicians to be more efficient and is even a disincentive.

To ask physicians to be doubly efficient by seeing substantially more patients but reward them with nothing but more work will not help in the effort to recruit physicians to care for the burgeoning chronically ill population. Instead, consider providing physicians participating in group visit programs a meaningful reward such as additional time for “desktop medicine”—ie, phone calls and paperwork.

Provide Adequate Preparation and Training

If a group visit program is to be successful, sufficient staff preparation time and training must be provided. For example, the DIGMA model not only requires that the physician be prepared for his or her role in the DIGMA and know how to refer patients into it but also requires that training be provided for the other members of the DIGMA team (ie, the champion, behavioral health professional, nurse or medical assistant, scheduler, and reception staff).

When starting out with the CHCC model, the traditional, minimal-preparation method (ie, “see one, do one, teach one”) works reasonably well; however, if more than five or six groups are implemented, and especially if they are in different facilities, formal orientation and coaching of providers and patients becomes more important, as does subsequent monitoring of both quality and effectiveness of the groups. Our experience has shown that, ideally, these training and monitoring functions are done by a nurse-administrator, who can maintain as many as 40 or 50 CHCC groups with the help of a monitoring checklist.

Evaluate the Effectiveness of the Group Visit Program

Physicians’ professional satisfaction can be enhanced by showing the physicians that the group visit program is achieving its intended objectives in terms of cost savings, improved access, reduced utilization, leveraging of physician time, and increased levels of patient satisfaction, service, and quality of care.

This assurance is reasonable because group visits require physicians to deliver medical care in a way dramatically different from the individual office visit model, in which physicians have traditionally been trained and have become comfortable. If physicians are to be satisfied with the expenditure of time and effort necessary to adapt to the DIGMA or CHCC models, then they must receive a demonstrable benefit for this time and effort. The same is true for administrators in the health care organization.

The importance of the evaluation process needs to be emphasized. If use of group visits is to continue to grow and if they are to eventually be assigned a CPT code, ongoing documentation must show the effectiveness, efficiency, and consistency of these models in achieving their desired objectives.

Do Not Require Physicians to Conduct Group Visits Alone

Demanding that physicians run group visit programs alone (ie, without the assistance of important support personnel such as behavioral health professionals, nurses, medical assistants, schedulers, and reception staff) to further reduce costs would constitute an abuse of group visits. Physicians would dislike this demand, and professional satisfaction would decrease. In addition, such an arrangement would be unlikely to succeed because those support personnel play critical roles in the CHCC and DIGMA models. Further, it is the use of the less costly support personnel associated with the DIGMA, CHCC,

and Specialty CHCC group visit models that enables expansive physician time to be so highly leveraged.

For example, consider the DIGMA group medical visit model, which was designed to be led jointly by a physician and a behavioral health professional (eg, health psychologist, social worker, marriage and family therapist, nurse, or health educator) who possesses special, complementary skills for addressing group dynamic, emotional, and psychosocial issues. The behavioral health professional starts the group on time—even if the physician is late; handles group dynamic and psychosocial issues; keeps the group running smoothly and on time; takes primary responsibility for maintaining group census; conducts the group alone when the physician is called out on an emergency or leaves the group to conduct brief private examinations; and does everything possible to enable the physician to focus on delivering high-quality medical care.

Presence of a carefully selected behavioral health professional who is experienced in running groups, handling group dynamics, and in addressing psychosocial needs (and who is trained to assist the physician in running the DIGMA and is well matched to both the physician and the patients) is critical to success of the DIGMA. Enjoyable camaraderie and occasional bantering also occur between the physician and the behavioral health professional—which has been found to enhance physician professional satisfaction. Some physicians might be able to run the DIGMA alone, but not even one physician has indicated any interest in doing so—even though more than 9000 DIGMA patient visits have been logged in 22 different DIGMAs to date.

Prevent Physician Abuse of Group Visits

In addition to being misused by the organization, group visits can also be misused by physicians. For example, consistent lateness of physicians in arriving at their group sessions is likely to leave insufficient time to adequately attend to all patient needs. Similarly, although support personnel are trained to address most of the details in designing, implementing, conducting, and evaluating the group visit program, some physician involvement is nonetheless required during each phase.

Physicians cannot realistically expect a group visit program to be designed for them solely through the efforts of others without investing any personal time and effort. In addition, physicians must play an active role in achieving and maintaining the desired level of group census. This participation can

be achieved if physicians take 15 to 30 seconds during every routine office visit to personally invite suitable patients to have their next visit be a DIGMA visit. Similarly, physicians must continually advise all personnel associated with the program regarding which activities are being done satisfactorily or unsatisfactorily, what improvements still need to be made, and what suggestions the physician would make as to how to achieve the desired results.

Avoiding Organizational and Insurance Abuses

Do Not “Overincentivize” Group Visits

Clearly if insurers and health care organizations underincentivize group visits through inadequate reimbursement and support, there would be no reason or incentive for physicians to substantially alter their style of practice from traditional one-on-one care to include the offering of group visits. Clearly, underincentivizing group visits would undermine the entire program and preclude its widespread use.

However, there is another concern as well, and one that is less obvious: Once insurers and health care organizations become aware of the substantial economic and patient care advantages that group visits offer, they could overincentivize them relative to individual office visits.

The authors have concerns regarding the long-term potential for abuse of group visits by overincentivizing them at the expense of individual visits. These excessive incentives would reduce freedom of choice for patients as well as for physicians. In addition, an effective, fair billing system must be developed with appropriate billing codes for the different types of group visits; however, after such a billing system has been developed, it must be followed honestly and scrupulously by physicians and health care organizations alike.

At present, the authors are aware of no fee-for-service or Medicare billing codes specifically designed for group medical visits. Should third-party insurers, upon recognizing the multiple economic and patient care benefits that group visits can offer, overincentivize them relative to individual visits, abuse could result that would reduce the voluntary nature of group visits for physicians and patients alike.

Similarly, if health care administrators overincentivize group visits in terms of physicians' future salaries within the organization, physicians who would otherwise be reluctant or not be ready to start a group visit program might feel compelled to do so. The authors strongly

The authors have concerns regarding the long-term potential for abuse of group visits by overincentivizing them at the expense of individual visits.



Group visits are intended to work in conjunction with the judicious use of individual visits and not to completely replace them.

recommend against this practice because we have always intended that physicians participate in group visit programs strictly on a voluntary basis. To do otherwise would create physician resistance to the entire program.

Both Group and Individual Visits Are Important

Group visits are intended to work in conjunction with the judicious use of individual visits and not to completely replace them. In this way, patients who can appropriately be efficiently and cost-effectively seen in group medical visits will be seen in that venue whenever possible. By off-loading numerous individual visits appropriately onto group visits, individual appointments will be made more accessible for patients who need or want them. Both group and individual visits will be important for the future delivery of high-quality, cost-effective care. Nowhere will this importance be more evident than in the high-value care provided by the progressive, fully integrated health care delivery systems of the future.

As group visits begin to play an increasingly important role in the delivery of quality medical care, individual visits will nonetheless be expected to continue to play a key role in the delivery of health care. Therefore, it is important that the incentives for both group and individual visits be carefully thought out, appropriate, and fair.

An interesting observation is that group and individual visits work well together and complement each other: the strengths of one model are often the weaknesses of the other, and vice versa. For example, individual appointments are most appropriate for acute infectious illnesses, lengthy individual examinations, initial evaluations, one-time consultations, most medical procedures, and care of patients who refuse group visits. In contrast, group visits are most appropriate for relatively stable chronically ill patients, patients who are anxious or depressed, the “worried well,” patients who are difficult or demanding, patients who have excessive psychosocial and emotional needs, and patients who require more time with their doctor or who require more professional “hand holding.”

Miscellaneous Tips for Group Visits

Facilitate, Do Not Dominate!

In group visits, physicians should be interactive instead of giving lectures. The primary benefits of group visits, other than the excellent access and comprehensive medical care provided, include a combination of shared information, mutual support,

and an enhanced sense of self-efficacy for each member of the group. A world of difference exists between delivering a lecture on angina and asking the group: “Has anyone here ever had heart pain?”; “What was it like?” and “What did you do?” In an interactive group process, several people will respond to these questions and relate their own special stories. The physician acts as a facilitator, adds information, emphasizes key points, and elaborates as necessary.

This interactive model validates participants in the eyes of the other group members. The interaction shows that patients are legitimate sources of information for coping with particular health problems. Patients’ skills are reinforced by the physician as well as by the behaviorist or nurse, and everyone benefits from the therapeutic process of the group. Like physicians, patients enjoy being of value to others. In fact, patients often have more “hands-on” experience in coping with illness and aging than do the providers of care. It is important to validate the patients’ role in being their own caregivers.

In addition, physicians providing group visits should feel free to be themselves. Patients choose their physicians on the basis of the way the physicians normally interact with their patients. Physicians need not try to be either professorial or entertaining in the group visit. Patients simply want quality medical care and more time with their physician.

The “bottom line” is that the most important thing is what patients take home with them from the group visit session: What they have learned about better managing and coping with their illness. Patients will have learned much from the physician, from the support personnel (behaviorist, nurse, medical assistant), and in large part from interacting with other patients. Physicians should think of patients as “primary caregivers” who are learning to help themselves and each other to better manage their health problems. A critical aspect of achieving this is to foster interaction among patients and between patients and staff.

To undermine this sharing of information, mutual support, and dynamic interaction would be a mistake which could easily happen. Group visits can provoke anxiety in physicians because they have not been trained in conducting group visits during medical school and often have had little or no experience in running groups. Group visits can also be intimidating to physicians, as shown by statements such as: “What if I lose control of the group?,” “What if



negative emotions spiral out of control;” and “What if I say something stupid and embarrass myself in front of 15 or 20 of my patients at once?”

Physicians may try to cope with this anxiety by becoming professorial and turning the group into a class instead of conducting it as an interactive group. This approach is ultimately self-defeating, however, because it disrupts the normal social interaction and emotional support which group visits can provide. If the professorial approach is adopted—thereby reducing the healthy interaction both among patients and between patients and staff—the group visit cannot be nearly as helpful to patients, which can consequently reduce physician professional satisfaction.

Instead, physicians should remain aware of this tendency to adopt a professorial role and should guard against it so that the group maintains a healthy, lively, interactive nature whereby much information and support is exchanged and medical care is delivered. This type of group will not only prove to be maximally beneficial to patients but will also be much more professionally satisfying for the physician conducting the group visit program.

Focus on Patients Who Want to Attend Group Visits

Since CHCC groups began in 1991, experience has consistently shown that roughly 40% of older patients respond enthusiastically to the invitation to join a CHCC group. Twenty percent say they might be interested, and 40% decline to participate. The greatest economic benefit to the organization is clearly to be found in patients who respond with unqualified willingness to participate. These patients are the most likely to participate and thus to benefit; therefore, the focus should be placed on this patient population.

A related finding is that experience with DIGMAs has shown that with the passage of time, patients gradually become more familiar with, and accepting of, the group visit program. Eventually, the population of patients refusing to attend a DIGMA program grows smaller and smaller.

Remember: Support Is Required for Success

In another article published in this journal, we stated a point which cannot be overemphasized:

“A major hurdle for the CHCC model is the fact that the 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 CHCC, staff is frequently diverted to more visible demands. High-level administrative support for CHCC, even when present, is not enough. Dedicated nurse support is a necessity.”^{1:50}

This issue of invisibility is not a concern for the DIGMA model because it focuses on the entire patient panel of the individual physician and its benefits are highly visible to the physician conducting a DIGMA. Therefore, the physician then becomes a strong advocate for maintaining the DIGMA. However, the issue of necessary staff being diverted to more pressing demands of the moment is as real for DIGMAs as for CHCCs, where important scheduling or medical assistant support can be pulled from the group on any given week—the result of which is often a substantial reduction in that week’s census from what it otherwise could have been (in the case of the scheduler) or not having patients’ vital signs taken and other important duties performed (in the case of the medical assistant).

Speak Frankly about the Program

Physicians should not be afraid to state the goals of the group visit program. In focus group interviews, patients tell us that they are well aware of the overburdened state of most providers and actually sympathize with their physicians. For their part, patients often cut their question list short or decide that a particular symptom need not be mentioned during a “routine” visit for a different problem. They often make another appointment not only to deal with their issues but also to reduce the stress on their physician. All too often, the pejorative label of “high utilizer” is then applied to these patients.

When implementing a group visit program, physicians may find it helpful to openly acknowledge these facts and then explain that plenty of time is available to address everyone’s issues today; to respond fully to all questions; and then to follow-up on all issues, either individually or in the next group session. Physicians should explain that if the group visit program succeeds, it will result not only in multiple benefits to the patients attending, but also in cost savings for the organization, which will allow continuation of the program. Follow-up visits for routine care are always allowed but are encouraged, whenever possible, to occur within the group visit setting. Physicians can also increase patients’ awareness of critical symptoms (short-

Although aware of the long-term favorable results of CHCC, staff is frequently diverted to more visible demands.



ness of breath, chest pressure, etc.) during group visit sessions and can educate patients as to the appropriate use of same-day appointments and emergency care.

In the CHCC model, regular attendance is encouraged, both because of its economic impact and because of the effective group dynamic which it creates. Nonattendees should be replaced by patients who are more committed to the program. In the DIGMA model, patients attend only on an as-needed basis so that different patients are typically present during each week's session.

Conclusion

Despite all of these concerns surrounding potential abuses, group visits will undoubtedly continue to grow in importance and be ever more frequently used during the coming years. Although physicians are already working as hard and as efficiently as possible using traditional office visits, they are finding that this is often still not enough. What is needed now is an additional tool which will leverage physician time and increase productivity, improve access and quality of care, enhance patient and physician professional satisfaction, and do all this without requiring physicians to put more hours in at the office or to increase their fatigue due to workload demands. Group visits provide such a tool.

Without question, group visits have an important role to play in the future of health care. Well-designed, adequately supported, and properly run group visit programs (such as DIGMAs, CHCCs, and high-risk patient population management programs—Specialty CHCCs) not only offer the benefits of greater efficiency and reduced costs through economies of scale but also offer the additional benefits of improved access, comprehensive mind-body care, better follow-up monitoring, and increased patient and physician professional satisfaction.

Nonetheless, the potential for abuse of group visits is real and must therefore be carefully thought out in advance and scrupulously safeguarded against. This will preserve the credibility of group visit programs and protect the multiple economic and patient care benefits which they can provide. ♦

The views expressed in this article are those of the authors and do not necessarily represent those of The Permanente Medical Group.

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