RPCC

Regional Primary Care Coalition

Group Medical Visits

A Literary Review and Discussion of Jeanie Schmidt Free Clinic's use of Group Medical Visits in Herndon, Virginia

Brittany Stanley

Princeton Project 55 Fellow

June 2010

I would like to acknowledge Kathy Dickman, DNP, FNP-BC, for providing a detailed description of the group medical visits taking place at the Jeanie Schmidt Free Clinic.

We know that there just aren't enough doctors in this county to provide the sort of care that's required…and the situation is only getting worse…--Dr. Zeev Neuwirth[i]

Growing physician pressure to increase productivity in the face of an influx of new patients has spurred innovative work around the country. Many healthcare professionals point to the group medical visit as the most promising work to help the shortage problem and need for quality care. In fact, Dr. Zeev Neuwirth of the Harvard Vanguard Medical Associates says "quite honestly, I don't know of any other innovation—there is no policy fix, there is no insurance fix—that is going to be able to fix this problem… the best I've seen is the shared medical appointment[ii]."

Picking up on the growing challenge to increase efficiency and quality of care, providers around the National Capital Region have begun offering group medical visits. At the Jeanie Schmidt Free Clinic in Herndon, Virginia, diabetic and hypertensive patients were recruited to participate in a group medical visit pilot, and health outcomes were closely monitored to assess the efficacy of this method. The pilot was an overwhelming success, with patients recording a statistically significant increase in physical activity and the accomplishment of one personal goal. A literary review of exemplary group visit pilots will precede a full discussion of the Jeanie Schmidt pilot.

Group Medical Visits: A Literary Review

The literature strongly supports the group medical visit as the practice innovation of the future. The Agency for Research and HealthCare Quality (ARHQ) is home to many of these innovations—many that take the form of pilot studies examining the effectiveness of group medical visits, especially for the management of chronic diseases. A 1999 ARQH Health Care Innovations Study stated that:

Timely access to office-based medical care is a persistent problem, causing long waits for appointments and excessive emergency department (ED) use. As a result, physicians face continued pressure to increase their productivity, especially as they are called on to provide care to growing numbers of patients with chronic illnesses. One innovative alternative to one-on-one office visits is a group visit, in which physicians simultaneously provide follow-up care and counseling to 10 to 15 patients with the same chronic illness.[iii]

The study examined an independent physicians' practice in Northern California, the Hill Physicians Medical Group, which began offering 60-90 minute group appointments for patients with chronic conditions like diabetes, hypertension, asthma and COPD. The ARHQ study found that diabetes patients receiving group care "had better outcomes than those receiving usual care, including being more likely to meet goals related to blood glucose, blood pressure, and low-density lipoprotein cholesterol levels".

The benefits of the group visits included longer physicians-patient interaction (an hour group appointment compared to a 15 minute one-on-one visit); access to the same level of clinical care including lab tests, prescriptions, and blood pressure readings; and the assurance of confidentiality for all participants. Participants developed an action plan to track their progress and set goal they could manage themselves. The Hill Physician Medical group was not only successful at capturing better health outcomes among patients in group visits, but they were also able to address the reimbursement problem by setting a group visit rate at the one-on-one visit rate. Patient copayments were also the same for group and one-on-one visits with a provider.

A much smaller study conducted at the Sastun Center of Integrative Health Care in Kansas found similar outcome results as the Hill Group. Overall, patients participating in group medical visits lost more weight and ended with lower cholesterol levels than those patients in the control group. The studied differed from the Hill

Physicians group in that the participants were not managing chronic illness, but were instead looking to make lifestyle adjustments to improve their overall health[iv].

A more recent ARHQ study, *Willingness to attend group visits for hypertension treatment* looked at medically disadvantaged patients to measure their propensity to participate in a group medical visit for management of their chronic illness. The researchers agreed that group visits improved health outcomes, stating that "group visits for management of chronic disease have improved patient satisfaction and clinical outcomes, while reducing use of care[v]"—however they wondered whether patients, particularly disadvantaged patients, would be willing to attend.

Over 250 patients with hypertension were involved in the study. They were predominantly Black and had low monthly incomes (<$1,000). Of the participants, 68% were willing to participate in a group visit after getting a brief description of the model. When participants were given three incentives—"reduced waiting time to see their physicians, having more time with their physicians and parking or transportation subsidies[vi]"—the willingness to participate increased to 80%. The study concluded that group medical visits may prove to be especially helpful for underserved communities because of the strong desire participants had to spend more time with their physicians (63% of all surveyed). The researchers also concluded that patients' desire for a stronger patient-physician relationship could indicate a desire for more social or emotional support, which may also be captured in a group visit setting.

While the aforementioned studies of group medical visits did result in better health outcomes for patients, it is important to note some potential pitfalls of the group medical visit. In 2000, the Permanente Journal reported potential abuses of group visits which included the reduction of access to one-on-one visits; making group visits mandatory instead of voluntary; not properly addressing the question of patient confidentiality; infrequent group visits scheduled; and excessively large group sizes for the visits[vii]. Without taking the proper steps to avoid any of these potential dangers, the

group visit risks being labeled negatively by the public and will likely lose its appeal among both providers and patients.

A 2009 ARHQ supported study conducted by the University of California San Francisco Center for Vulnerable Populations noted that there are superior methods to the group medical visit that include the automated telephone self-management support (ATSM). When tested against the Group Medical Visit, ATSM participants increased interpersonal skills, physical activity, goal setting, and self management behaviors. ATSM also worked better for vulnerable populations with initial barriers to communication[viii].

Group Visits being piloted in the National Capital Region: The Jeanie Schmidt Free Clinic of Herndon

The Jeanie Schmidt Free Clinic, serving patients in Northern Virginia with hypertension and/or diabetes, established three main goals for their group medical visit pilot:

1. To increase access to care by being able to serve a larger volume of people at a time.
2. To support patient's self management of their chronic illnesses by creating a support network around them of people with shared problems.
3. To make sure that the quality of care was not diminished in the group vs. one-on-one setting

In order to implement this project, the clinic recruited people to participate. Patients either had non-insulin type-2 diabetes (HbA1C less than 9), or hypertension (blood pressure less than 160/90). The pilot was open to English or Spanish speakers over the age of 18. JSFC created formal documents for this pilot in order to standardize the methodology and systematically track patient feedback/progress. These documents included a recruitment letter, information sheet, progress report form, and a goal setting form. As a part of the group visit, the clinician provider and the patient created an action plan using the goal setting form. The form, which was signed and dated by both the patient and the clinician, asks the patient to agree to improve his/her health by selecting

from a list of activities that include staying more physically active, taking medications, and improving food choices. After selecting an activity, the patient is asked to rate his/her confidence level, or "how sure I am that I will be able to do my action plan?" The patient then defines in detail how he/she will perform the selected activity and how much he/she would do and when.

The project was run with four different groups of patients: two groups were conducted in Spanish, one in English, and the other was bilingual. Each group had between 10 and 12 patients and by the end of the project, four monthly visits had been conducted. For the first 15 minutes of the visit, patients went around the room introducing themselves in order to foster an environment of optimum comfort. After the introductions, the facilitator led the session with education being a major focus and the provider began the actual evaluations. As the facilitator educated the group, the provider went around to each patient individually and checked blood pressure, lab work, wrote any necessary prescriptions, and made plans for follow up care. To close the group visit session, the group visit team helped patients set measurable goals and allowed them to ask questions about their health status and ways they could manage their diseases. Each session was approximately two hours long.

The group visit project was founded on the principles of a team approach. The team consisted of a medical assistant, a nurse practitioner, and a facilitator (diabetic nurse educator). Each member of the team performed a specific function, and each of the members was a trained member of the Jeanie Schmidt Free Clinic staff. The medical assistant sets up the rooms, sent reminder calls to participants, checked vital signs of the patients before the clinician performed his/her focused exam, and instructed the patients on check out procedures and documentation. The nurse practitioner reviews the charts prepared by the medical assistant, performs a focused exam on the patient, adjusts his/her medications if necessary, and orders any lab work needed and gives referrals for specialty treatment if applicable. In addition to these two team members, the facilitator plays an important role in the group visit as well. The facilitator

directs the portion of the visit that is more interactive and gives patients educational materials.

When asked, the overwhelming majority of patients participating in the JSFC group visit pilot felt they'd received excellent services (83%), with the remaining percentage reporting they'd received very good services. 100% of participants improved their health, accomplished at least one personal goal, and would recommend the group visit to someone else. Some specific successes among participants included smoking cessation, loss of weight, decreased blood pressure, and increased exercise coupled with improved diet. Patients participating in group visits reported a statistically significant increase in their physical activity. Most patients achieved a measurable goal and improved clinical outcomes, and all patients reported that they felt better in the group setting than in the one-on-one patient-provider setting. Jeanie Schmidt was able to see an average of 7 patients in a 3 hour time period which was far more efficient than a normal provider-patient visit in the clinic.

The implementation and evaluation of group visits at Jeanie Schmidt Free Clinic was Kathy Dickman's doctoral Capstone Project at George Washington University. Dipti Patil, Kathleen Gold (diabetic nurse educator), and Dr. Coleen Kivalahan were members of the group visit team. When asked, Kathy said that not only are group visits a way to increase access to care, but that they are an effective strategy for meeting the needs of the uninsured with chronic diseases. Kathy thinks that this model can have applications outside of the chronic diseases targeted in the Jeanie Schmidt pilot—including use in obese populations. A major challenge to group visits is reimbursement. Because you can't bill a group visit the same way you bill an individual visit, the payment strategy of the agency would need to be modified—which is often times not an easy change to make.

The Jeanie Schmidt pilot provides strong support in favor of group medical visits, and can serve as model for other agencies looking into the method. Additional resources are abundant on the web, including the American Academy of Family

Physicians' work on planning group visits and some work published by *Medscape* by WebMD[ix].

More information about the specific pilot at Jeanie Schmidt Free Clinic can be obtained by contacting Kathy Dickman:

Kathy Dickman, DNP, FNP-BC
Assistant Professor
Nurse Practitioner Program Coordinator
George Mason University
(703)-993-1941
kdickman@gmu.edu

[i] Dr. Zeev Neuwirth is an internist and the Vice President for Clinical Effectiveness and Innovation at the Harvard Vanguard Medical Associates.

[ii] "Group Medical Visits Seek to Relieve Physician Burden, Improve Care". Brande Victorian. Nephrology Times, January 2009. 2 (1)..

[iii] ARHQ Health Care Innovations Exchange, Group Primary Care Visits Improve Outcomes for Patients with Chronic Conditions. 1999. Page 2

[iv] "Group medical visits and lifestyle modification". Journal of Family Practice. January 2005. Jane L Murray, Kaia Everson.

[v] Kawasaki, L., Muntner, Hyre, and others. May 2007. "Willingness to attend group visits for hypertension treatment". The American Journal of Managed Care. 13 (5), pp 257-262

[vi] Kawasaki, L., Muntner, Hyre, and others. May 2007. "Willingness to attend group visits for hypertension treatment". The American Journal of Managed Care. 13 (5), pp 257-262

[vii] Potential Abuses of Group Visits. Edward Noffsinger and John Scott. The Permanente Journal Spring 2000. Vol 4(2)

[viii] AHRQ. Chronic Disease: Self management support results in better diabetes outcomes. October 2009.

[ix] *Planning Group Visit for High Risk Patients*. American Academy of Family Physicians. Steven Masley, Julie Sokoloff, Collene Hawes.

Group Medical Visits at a Family Medicine Center: Analysis and Resolutions. Medscape for WebMD