Group Visits: Our Experience With This Adjunctive Model To Chronic Care Management

R Jaber, A Braksmajer, J Trilling

Citation

R Jaber, A Braksmajer, J Trilling. *Group Visits: Our Experience With This Adjunctive Model To Chronic Care Management*. The Internet Journal of Family Practice. 2004 Volume 4 Number 1.

Abstract

Objective: This article presents our experience with group visits for asthma, lipid management and osteoporosis that have been offered to community patients as well as to our practice patients.

Methods: A series of three to four group sessions that include didactic and experiential education ranging from biomedicine to nutrition, exercise and mind body as well as interactive facilitation of self efficacy building, behavior change and self management. Individualized private medical appointments are held before or after with all patients in order to optimize management and personalize group instructions.

Results: From May 2001 to October 2004, 245 patients participated in group visits. Seventy-one percent were new to our practice. Patient satisfaction with the programs has been high.

Discussion: There is a need to refine processes of care before measuring impact of our
program on hard outcomes such a function, health outcomes, healthcare utilization and behavior change.

Conclusion: Our group visit program has succeeded in taking our integrative, patient-empowering philosophy of care into the community, while providing evidence of the feasibility of this practice model

Practice Implications: The administration of a group visit program is time-intensive and requires a specific point of contact. Patients are charged only for their individual assessments and are expected to pay their usual co-payment at the time of visit. We have maintained but not increased financial productivity.

INTRODUCTION

Chronic illness has become the most pressing public health issue of the 21st century. Stange et al. (1998) has reported that 24% of visits to family physicians in the United States are for chronic illness[1]. Furthermore, in an analysis of the effects of chronic illness on health-related quality of life across eight countries, Alonso et al. (2004) found that 24.9% of the 24,936 adults (mean age 44.4) surveyed had one chronic condition, 13.4% had two, and 16.8% had three or more[2]. Comorbidity is even more prevalent among the elderly. Primary care physicians bear the brunt of care for comorbid conditions[3].

Managing chronic illness may be especially difficult considering demands on physicians' time. Zyzanski et al. (1998) reported that physicians in high-volume practices provided visits that were 30% shorter and included significantly lower rates of up-to-date preventive services[4]. Furthermore, such physicians may sacrifice comprehensive knowledge of their patients and patient trust, two variables linked to patient satisfaction and adherence to treatment recommendations[5]. Risk behaviors may also be neglected[5].

The purpose of this article is to present our experiences with group visits for asthma, lipid management and osteoporosis at our Wellness and Chronic Illness Program.

Group visits represent an adjunctive approach to chronic care management that allows physicians to spend more time with patients and deliver extensive education and self-

management skills, while optimizing patient-centered care. In addition, group visits offer similarly ill patients opportunities to share knowledge and interact with each other

WHAT ARE GROUP VISITS?

Group visits, first publicized by Scott[6] and Noffsinger[7, 8], combines most elements of an individual medical visit with practitioner-led group educational sessions that address a variety of topics, including patient self-management. Individual medical visits may be conducted privately or within the group. Groups may focus on a specific diagnosis, or they may be targeted towards all chronically ill patients in a given practice[8]. A variety of practitioners (i.e., dietitians, behaviorists) may facilitate educational sessions and conduct individual appointments. The level of focus on group processes, building self-management skills, and patient self-efficacy varies by program.

Group visits differ from other forms of group interventions such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians.

METHODS (GROUP VISIT PROGRAM SERIES)

PROGRAM HISTORY

The Wellness and Chronic Illness Program is a division of the Department of Family Medicine at Stony Brook University Hospital. The program offers integrative, evidence-based primary care as well as chronic illness consultations that combine conventional therapies with mind/body and nutritional medicine. Our chronic illness load is high, accounting for approximately 80 – 90% of visits. We collaborate with a large network of non-physicians, mostly mind/body therapists (i.e., experiential psychotherapists, hypnotherapists) and manual practitioners (i.e., physical therapists, osteopaths, massage therapists).

Patient demand for our practice, which accepts most forms of insurance, has grown exponentially through the years, quickly exceeding our capacity. While other programs offer group visits to their existing patient panel, our program, which began in May 2001, was intended in part to serve our community and the patients that we could not accommodate in our one-on-one practice. Our group visits program is in accordance with the philosophy and principles of the Wellness and Chronic Illness Program, which emphasize sharing information and the development of patient awareness, self-efficacy and personal strengths.

RECRUITMENT

We recruit our community patients by disseminating flyers, press releases in local newspapers, campus-wide e-mails, and advertisements in our hospital's quarterly newsletter, as well as in the main campus monthly newsletter. The majority of our group visit patients (approximately 70%) are, therefore, new to our practice. We encourage these new group visit patients to stay with their primary care practitioners, and send medical summaries to their physicians upon request.

PROGRAM STRUCTURE

Our practice currently features group visits for asthma, lipid management, and osteoporosis. We also offer stress management and cold/flu workshops that do not include individualized medical sessions. Our group visit programs are delivered in the evenings over three or four consecutive weeks, as opposed to most programs described in the literature that run their groups monthly or quarterly over the course of a year or more[9,10,11]. In addition, we offer follow-up visits once or twice a year, which are illness-specific and are open to all of that particular group's previous participants. To our knowledge no one has evaluated session spacing and number in relation to learning and behavior change.

A family physician and a nurse practitioner, both trained in nutritional and mind-body medicine, jointly facilitate meetings. We usually have an average of 8-12 participants per session. Patients expressing a desire to bring loved ones to group sessions are encouraged to do so. The total time demand for the physician/nurse practitioner team is three and half hours; this includes individual medical visits, group activities, which take 90 minutes, and time to collect notes and complete charts.

INDIVIDUALIZED MEDICAL APPOINTMENTS

In order to facilitate individualized medical appointments, which take approximately ten minutes, participants are mailed a disease-specific health history questionnaire two weeks prior to the initial group. They are asked to bring all relevant labs, tests, medications, and nutritional supplements or herbs. Appointments are scheduled so that individual examinations are staggered; half precede and half follow group activities. Participants are evaluated in order to determine symptom/condition severity and the appropriateness of current treatment, taking into account patients' expectations and goals. Beginning with the second visit, practitioners ask questions regarding the extent to

which patients have applied knowledge learned in previous sessions. Practitioners then adjust recommendations in a patient-centered manner, making specific adjustments for both physical (i.e., pain) and psychosocial factors (i.e., depression, beliefs) that prove to be obstacles to behavior change.

We conduct individualized medical visits privately instead of within the group, because we value one-on-one, patient-centered interaction. Furthermore, private encounters allow the personalization of group instructions, which we believe is crucial to the understanding and application of knowledge.

GROUP EDUCATIONAL SESSIONS

Our approach to content is integrative and evidence-based. The first session usually focuses on biomedical assessment and pharmacologic management of the condition, while the rest are dedicated to discussing condition-specific lifestyle changes and self-management. One session is usually dedicated to discussing relevant nutritional changes, while one or more sessions are set aside for experiential instruction in exercise and/or mind-body interventions. We utilize a contiguous physical therapy space for exercise instruction. In all sessions, we emphasize comprehension of physiology and biochemical mechanisms of disease in order to create a sense of mastery, but simultaneously strive to simplify information delivery. For example, in our asthma group, we may discuss the role of leukotrienes in the pathophysiology of asthma, the mechanisms of action of leukotriene inhibitors, as well as dietary modifications, such as increasing omega-3 fatty acids and bioflavonoids, which also leads to a decrease in the levels of inflammatory leukotrienes.

Our process of education started by being didactic, yet personalized. It has, however, shifted to include more self-management and behavioral change discussions that in turn have yielded more active participation and livelier sessions. Our patients now outline specific behavioral objectives to accomplish between sessions. We will soon be increasing the length of our programs by one or two weeks in order to accommodate our increased emphasis on group process, self-management and the development of self-efficacy.

The group visit program occasionally leads to differences in opinion between patients and their primary care practitioners. In such situations, we encourage patients to become their own health advocates, negotiating with and educating physicians about the rationale behind their choices. Patients and physicians thus become equal partners in care, collaboratively deciding on appropriate treatments.

Community patients who elect to return for follow-up sessions are sent prescriptions for relevant labs/tests to be done prior to the visit, or are asked to bring their latest results. These sessions are organized around a potluck meal, which reflects pertinent nutritional suggestions made in prior group educational sessions. They assist patients in consolidating knowledge and maintaining or re-attempting behavioral changes, as well as allow us to share new knowledge, assess patients' progress, and collect updated information. These sessions are usually attended by an average of 6-12 patients.

RESULTS

ATTENDANCE AND PARTICIPATION

From May 2001 to the beginning of October 2004, 245 patients participated in group visits given by the Wellness and Chronic Illness Program (Table I). One hundred and seventy-four participants (71.4%) were new to our practice and therefore were community patients who benefited from our programs while continuing their primary care elsewhere. While several patients expressed an interest in joining our practice, we discouraged this from the outset, as our practice was full (we made accommodations, however, in extreme cases). For the most part, we did not send reports to these patients' primary care physicians, as most patients were self-referred.

Figure 1

Table 1: Participant Count by Program as of October 2004

Topic	Date Program Began	Aggregate Number of Attendees
Asthma	May 2001	33
Breast Cancer*	October 2001	14
Elevated Lipids and Cholesterol	February 2002	46
Osteoporosis	September 2001	87
Colds/Flu Workshop	December 2001	13
Stress Workshop	May 2002	52
TOTAL:		**245**

*Terminated due to poor attendance secondary to a preexisting support group in which we already participate.

The osteoporosis program is our most popular and has attracted a total of 87 patients. (Table I). Most of our participants are female, 50-70 years old, and have private managed care insurance. (16% Medicare and 0% Medicaid) (Table II).

Figure 2

Table 2: Patient Demographics: Age, Gender,& Insurance

Topic	Age			Gender		Medicare?**	
	Mean	Median	SD	M	F	Yes	No
Asthma	50.7	56.5	18.8	9 (27.3%)	24 (72.7%)	3 (9.1%)	30 (90.9%)
Breast Cancer	53.4	55.5	9.8	0	14 (100%)	2 (16.7%)	12 (83.3%)
Elevated Lipids and Cholesterol	56.8	57.0	11.3	15 (32.6%)	31 (67.4%)	8 (17.4%)	38 (82.6%)
Osteoporosis	59.4	58	8.0	0	87 (100%)	17 (19.5%)	70 (80.5%)
Stress Management	53.5	53.5	10.6	11 (21.2%)	41 (78.8%)	9 (17.3%)	43 (82.7%)
TOTAL:	55.6	57.0	11.4	35 (14.3%)	210 (85.7%)	39 (15.9%)	206 (84.1%)

**Note: No demographic data for Colds & Flu Workshop*
***No patients were on Medicaid.*

Program staff has estimated that 80% of registrants attend the programs. Generally, there are few patient drop-outs during the post-registration period.

PATIENTS' RESPONSE TO GROUP VISIT PROGRAM

Program evaluations are collected after each session; available patient satisfaction data has been summarized in Table III. Overall, patient satisfaction with the programs was high. A number of participants cited physical and stress management exercises as well as information on nutrition, as their favorite aspects of the program. Others cited greater understanding of their medical management, including care maps, laboratory tests, and drugs. Most negative feedback arose from instances where individual medical visits took more time than expected, causing the educational session to run late. Other negative comments were made about the "technical" terminology our facilitators used at times, as well as confusion regarding conflicting research data.

Figure 3

Table 3: Aggregate Patient Satisfaction Data* (Mean Scores)

Group**	N (total)	N (responded)	Did you learn any new information?	Did the session reinforce what you already knew?***	Was the information provided relevant?	Will you act upon the suggestions provided?	Will you change the way you manage your condition?	Total
Asthma	31	23	4.4	4.4 (n = 4)	4.4	4.1	4.1	4.3
Breast Cancer	14	12	4.1	5.0 (n = 2)	4.5	4.0	3.8	4.3
Lipids	43	25	4.0	4.5 (n = 7)	4.4	4.2	4.0	4.2
Cold & Flu	13	13	4.4	3.3 (n = 4)	4.4	4.1	4.6	4.2
Osteoporosis	72	54	4.2	4.2 (n = 21)	4.4	4.1	4.1	4.2

** Scores based on a scale of 0-5, with 0 representing the least favorable rating and 5 the most favorable rating.*
*** No satisfaction data for Stress Workshop*
****Not all participants responded to this question, since some assumed all information was new.*

DISCUSSION

Our summary data indicate high levels of patient satisfaction and the feasibility of offering group visits to community patients, either as a means of expanding one's own primary care practice or as an adjunctive service to patients who are cared for by other physicians. While there is research suggesting that group visits may also lead to improvement in health services utilization[9, 10, 12], healthy behaviors[11, 13, 14], physical function[15], quality of life[12, 13], and illness-specific health outcomes[11, 13, 14], there is great heterogeneity of the structure and processes of the reviewed programs and the results cannot be generalized. Our program format (3-4 weekly sessions followed by optional annual to biannual follow up sessions) is different from the more usual monthly or quarterly format[16,17,18,19]. We are planning on measuring the impact of our group visit model on above stated outcomes in addition to measuring health outcomes of other comorbid diseases not specifically targeted by the program. Since positive behavioral changes relating to nutrition, exercise, and stress reduction are useful for all chronic conditions; group visits may represent a potentially rewarding investment in a world with increasing chronic illness and co morbidity. We are currently scrutinizing and refining our processes of care, a necessary step before measuring above stated hard-core outcomes and hoping to have results reproducible in other settings. In addition, we have started a new group visit program for menopause, and plan to develop additional programs for hypertension and arthritis.

In addition, there is a need for new models of clinical education that emphasize chronic disease management[20]. Group visits may be part of an ambulatory care program in which medical students and residents are taught chronic

care.

CONCLUSION

Our group visit program has succeeded in taking our evidence-based, integrative, patient-empowering philosophy of care into the community, while providing evidence of the feasibility and high patient satisfaction of this relatively new practice model.

PRACTICE IMPLICATIONS

The administration of a group visit program is time-intensive and requires a point of contact in the office that will advertise the program, register patients, keep schedules, send reminder letters, and pull charts for review by medical staff before each yearly follow-up meeting in order to mail the appropriate requests for laboratory evaluations.

We believe that our low no-show rate during the post-registration period is due to the short duration of our programs, which in turn creates a stable patient cohort. We think our no-show rate will remain stable, despite the anticipated one or two weeks increase in programs length.

In the United States, there is still no optimal way to bill for group education. Patients are charged for the individual medical visit component of each group visit (not the educational session), and are expected to pay their usual co-payment at the time of each visit. These visits are usually coded as a Level III or IV visit, depending on complexity. Patients are billed a flat fee for the Colds and Flu and Stress Management Workshops; no insurance forms are submitted, and patients do not provide a co-payment for these two workshops.

Two medical assistants help obtain vital signs of all patients before the group education session which is conducted in the evening at 5:15 p.m.

To date, HIPAA has not addressed the topic of group visits. As patients routinely discuss personal medical conditions openly within the group, however, Noffsinger and Masley recommend that patients sign a release in which they promise not to reveal personal information about other group members outside the group setting[8, 21]. We have not received any patient complaints or voiced concerns regarding privacy and/or confidentiality in our group visit programs.

In our regular practice, we allot 60 minutes for each new patient and 30 minutes for each follow-up visit. Our groups' individualized medical visits on the other hand, last for an average of ten minutes each, with more time allotted for the first visit. Due to the time-intensive nature of our programs, we have maintained but not increased financial productivity (i.e., given similar time periods, we see approximately as many patients during our group visits as we do in individual visits). This is in contrast to the findings of Noffsinger, who discovered that implementation of group visits allowed physicians to see more patients in a given time period, leading to an increase in physician efficiency of approximately 256.4%[7]. Nevertheless, as the caregiving team is dedicated to promoting patient self-management and self-efficacy, the practitioners' satisfaction in providing group visits is high and is continuously boosted by patient appreciation.

CORRESPONDENCE TO

Raja Jaber, M. D. Department of Family Medicine School of Medicine Health Science Center, Level Four SUNY at Stony Brook Stony Brook, New York, 11794-8461 Phone: (631) 444-0687 Fax: (631) 444-7552 E-mail: rjaber@notes.cc.sunysb.edu

References

1. Stange KC, Zyzanski SJ, Jaen CR, Callahan EJ, Kelly RB, Gillanders WR, Shank C, Chao J, Medalie JH, Miller WL, Crabtree BF, Flocke SA, Gilchrist VJ, Langa DM Goodwin MA. Illuminating the "black box": a description of 4,454 patient visits to 138 family physicians. J Fam Pract 1998; 46: 377-89.
2. Alonso J, Ferrer M, Gandek B, Ware JE, Aaronson NK, Mosconi P, Rasmussen NK, Bullinger M, Fukuhara S, Kaasa S Leplège A. Health-related quality of life associated with chronic conditions in eight countries: Results from the International Quality of Life Assessment (IQOLA) Project. Qual Life Res 2004; 13: 283-98.
3. Starfield B, Lemke KW, Bernhardt T, Foldes SS, Forrest CB Weiner JP. Comorbidity: implications for the importance of primary care in 'case' management. Ann Fam Med 2003; 1: 8-14.
4. Zyzanski SJ, Stange KC, Langa D Flocke SA. Trade-offs in high-volume primary care practice. J Fam Pract 1998; 46: 397-402.
5. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE Tarlov AR. Linking primary care performance to outcomes of care. J Fam Pract 1998; 47: 213-20.
6. Scott J Robertson BJ. Kaiser Colorado's Cooperative Health Care Clinic: a group approach to patient care. Manag Care Q 1996; 4: 41-5.
7. Noffsinger EB Atkins TN. Assessing a group medical appointment program: a case study at Sutter Medical Foundation. Group Pract J 2001; 48: 42-9.
8. Noffsinger E, Sawyer DR Scott JC. Group medical visits: a glimpse into the future? (Enhancing Your Practice). Patient Care 2003; 37: 18 - 27.
9. Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G Cowan P. A randomized trial of group outpatient visits for chronically ill older HMO members: the cooperative health care clinic. J Am Geriatr Soc 1997; 45: 543-9.

10. Coleman E, Eilertsen T, Kramer A, Magid D, Beck A Conner D. Reducing emergency visits in older adults with chronic illness: a randomized, controlled trial of group visits. Eff Clin Pract 2001; 4: 49-57.
11. Masley S, Phillips S Copeland JR. Group office visits change dietary habits of patients with coronary artery disease. J Fam Pract 2001; 50: 235-9.
12. Scott JC, Conner DA, Venohr I, Gade G, McKenzie M, Kramer AM, Bryant L Beck A. Effectiveness of a group outpatient visit model for chronically ill older health maintenance organization members: a 2-year randomized trial of the cooperative health care clinic. J Am Geriatr Soc 2004; 52: 1463-70.
13. Trento M, Passera P, Bajardi M, Tomalino M, Grassi G, Borgo E, Donnola C, Cavallo F, Bondonio P Porta M. Lifestyle intervention by group care prevents deterioration of type II diabetes: a 4-year randomized controlled clinical trial. Diabetologia 2002; 45: 1231-9.
14. Sadur CN, Moline N, Costa M, Michalik D, Mendlowitz D, Roller S, Watson R, Swain BE, Selby JV Javorski WC. Diabetes management in a health maintenance organization: efficacy of care management using cluster visits. Diabetes Care 1999; 22: 2011.
15. Blumenfeld A Tischio M. Center of excellence for headache care: group model at Kaiser Permanente. Headache 2003; 43: 431-40.
16. Coleman E, Grothaus L, Sandhu N Wagner E. Chronic care clinics: a randomized controlled trial of a new model of primary care for frail older adults. J Am Geriatr Soc 1999; 47: 775-83.
17. Clancy DE, Brown SB, Magruder KM Huang P. Group visits in medically and economically disadvantaged patients with type 2 diabetes and their relationships to clinical outcomes. Top Health Inf Manage 2003; 24: 8-15.
18. Miller D, Zantop V, Hammer H, Faust S Grumbach K. Group medical visits for low-income women with chronic disease: a feasibility study. J Womens Health 2004; 13: 217-25.
19. Wagner E, Grothaus L Sandhu N. Chronic care clinics for diabetes in primary care. Diabetes Care 2001; 25: 695 - 700.
20. Holman H. Chronic disease: the need for a new clinical education. JAMA 2004; 292: 1057-9.
21. Masley S. Group visit templates for osteoporosis, asthma and hypertension. Society of Teachers of Family Medicine Preconference on Patient Education. Rye, NY, 2004.

Author Information

Raja Jaber, M.D.
Department of Family Medicine, School of Medicine, Health Science Center, SUNY at Stony Brook

Amy Braksmajer, M.P.H.
Department of Family Medicine, School of Medicine, Health Science Center, SUNY at Stony Brook

Jeffrey Trilling, M.D.
Department of Family Medicine, School of Medicine, Health Science Center, SUNY at Stony Brook