



Will Drop-In Group Medical Appointments (DIGMAs) Work In Practice?

Use of Drop-In Group Medical Appointments (DIGMAs) at our San Jose Medical Center has substantially leveraged physician time; improved accessibility at both the individual physician and the departmental levels; increased quality of care by better addressing patients' mind-body needs and improving follow-up care; achieved high levels of patient and physician professional satisfaction; and reduced cost to the organization by leveraging existing staffing resources. This article discusses the DIGMA model and suggests how it can be usefully implemented at other health care facilities.

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Introduction

In this era of cost containment and managed care, specialists and primary care providers encounter ever-increasing pressure to efficiently see more patients in less time while simultaneously meeting competitive market demands for service and quality care. Optimal value, service, and quality of care will be achieved in today's fast-paced health care environment only by providing the best possible mix of cost-effective group appointments and traditional individual appointments.

Because they are specifically designed to improve specialty and primary care access through use of existing resources, Drop-In Group Medical Appointments (DIGMAs)¹⁻¹¹ enable physicians to "work smarter, not harder." DIGMAs enable physicians to see dramatically more patients in the same amount of time but in a way that increases patients' satisfaction with their health care and physicians' professional satisfaction while improving service and quality of care. DIGMAs offer an extended medical appointment with the patient's own doctor in a group visit setting that enhances the patient's care experience. The increased efficiency that DIGMAs provide can be used both to enable physicians to better manage their large practices and to improve the customer focus of the organization. Although still quite new, the DIGMA concept is already beginning to gain attention and recognition.^{12,13}

While incorporating most aspects of a traditional individual medical appointment, DIGMAs provide more integrated or holistic care by also dealing with patients' psychological and behavioral health

needs—needs which drive a large proportion of medical visits¹⁴⁻¹⁶ and which typically cannot be adequately addressed during the brief time span of an individual appointment.

Origin and need for the DIGMA concept

In 1996, I transferred to the Kaiser Permanente (KP) San Jose Medical Center from the KP Santa Clara Medical Center, where I had been Director of Oncology Counseling and Chronic Illness Services for more than a decade. At KP Santa Clara, I had specialized in designing and implementing large multidisciplinary group treatment programs for high-risk medical patients and their families. During my 23 years at KP Santa Clara, I worked closely with primary and specialty care physicians to provide integrated mind-body care to more than 10,000 medical patients. Through this work, I became familiar with the growing workload and the challenges that increasingly large patient panels presented to our physicians. I also encountered the demands of a rapidly changing health care environment where, increasingly, more must be done with less.

As a senior health psychologist in the Psychiatry Department put on long-term loan to the Division of Behavioral Medicine at the KP San Jose Medical Center, I had the responsibility of expanding the small Behavioral Medicine Department into the major medical illness arena by establishing such large integrated interdepartmental group programs as Cancer, Stroke, Major Medical Illness, Caregivers, Bereavement, Extra Care Group (for inappropriately high utilizers), etc. I also participated regionally and locally to help primary care and assist in the rollout of KP's Adult Primary Care Redesign. All these activities caused me to reflect on how I might help specialty and primary care physicians to better manage their large and expanding practices.

Thus, my first priority at KP San Jose was to conduct a thorough primary care needs assessment by personally meeting with more than 50 internists, family practitioners, and administrators. Physicians at KP San Jose were struggling with many of the same problems as at KP Santa Clara: deteriorating access, substantially increased workloads, growing patient demands and expectations, morale issues, and managing increasingly large patient panels. Physicians felt that they scarcely had enough time during rou-

"I also encountered the demands of a rapidly changing health care environment where, increasingly, more must be done with less."



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tine office visits to attend adequately to patients' physical medical needs. Little if any time remained, either for dealing with the psychosocial needs of medical patients or for enriching the physician-patient relationship which, like physician professional satisfaction, was suffering as a result of these systemwide stresses.

Clearly, the system did not have sufficient resources—money or physicians—to solve these access and panel management problems solely by traditional means, ie, by simply increasing the total number of individual office visits available. A tool was needed that would work equally well in primary and specialty care settings to enable physicians to see dramatically more patients in the same amount of time, but do this in such a way that both patient and physician professional satisfaction were improved while access, service, and quality of care were simultaneously increased. On the surface, these objectives seemed mutually exclusive. It appeared to be impossible to simultaneously satisfy organizational needs (improved access, increased efficiency, and enhanced productivity by utilizing existing resources alone), patients' needs (better access and more time with their doctor, increased quality of care, and improved patient satisfaction), and physicians' needs (increased professional satisfaction and better management of large patient panels).

Of these three sets of needs, physician professional satisfaction seemed to present the greatest challenge, given the economic reality and rapid pace of change in today's health care environment. During these early months, many models of care were conceptualized that would leverage physician time and increase productivity while simultaneously increasing patient satisfaction; however, the challenge was to achieve this while also increasing physician professional satisfaction. In 1996, the DIGMA model began to take shape and emerge as a viable means of meeting these seemingly conflicting demands of patients, physicians, and the organization and of providing a "win-win-win" situation for all three.

Structure and Types of DIGMAs

DIGMAs may be defined as group-setting medical visits which give patients an extended medical appointment with their own physician and the more relaxed pace of an effective support group with the behavioral health professional and other patients experiencing similar issues. To date, more than 8000 DIGMA patient visits have been made in 12 different

specialty and primary care DIGMAs which I have co-lead during the past two years in oncology, nephrology, endocrinology, rheumatology, neurology, and primary care at the KP San Jose Medical Center. Customized with heterogeneous, homogeneous, and mixed designs,¹ DIGMAs are structured to respond to the particular needs, practice style, and patient panel constituency of the individual physician. DIGMAs are open to the physician's entire patient panel, may be attended only by the physician's own patients (and their support persons), and are typically held weekly for 90 minutes (Figure 1). They are co-lead by the specialty or primary care provider and a specifically trained behaviorist (eg, psychologist, social worker, health educator, nurse) and are typically supported by a medical assistant and a scheduler.

The group typically consists of 10 to 20 patients, three to six family members or other caregivers, the behaviorist, and the physician.

Patients who are directly booked into the DIGMA in lieu of an individual visit enter from three sources: 1) by physician invitation during routine office visits to have their next visit be a DIGMA visit; 2) by the scheduler telephoning appropriate patients each week from the physician's panel or waiting list and inviting them to attend; and 3) by patients attending the group on an unscheduled basis (often instead of scheduling an individual office visit or telephoning) when they have a medical need or question. Just as no one would expect a physician's individual appointment schedule for the day to be fully booked without patients having been called and scheduled beforehand, a preassigned scheduler with adequate time dedicated for telephoning patients each week needs to be attached to most DIGMAs.

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Figure 1. Drop-In Group Medical Appointment in progress



Thomas Abel, MD

"I have heard only positive and enthusiastic comments from my patients, and attendance has been consistently excellent.

Patients do not feel that they are relegated to a distant future appointment.

Personally, my DIGMA has given me an alternative method of caring for my practice. I believe it is more efficient, can save time, and augments my ability to meet the medical needs of my patients."



C. Gregory Culberson, MD

"My neurology DIGMA has been the most satisfying new innovation brought to my practice during my 20 years with The Permanente Medical Group in San Jose ... Patient satisfaction is high because patients and their caregivers leave with the knowledge that their medical issues have been addressed comprehensively, and without the time pressure that sometimes intrudes into the routine office visit.

The results have easily surpassed my expectations. Patients' acceptance has been gratifying, both because of their expanded access to me as their neurologist and because of their positive experiences within the group.

Many patients have commented that the availability of my weekly group has given them the message that we are here for them and that they need not worry about receiving insufficient attention or about being a bother!"



Monica Donovan, MD

"Patients seem very happy with the experience, and responses to anonymous patient satisfaction questionnaires confirm this impression.

I certainly believe that DIGMAs can better address psychological issues as well as issues common among group members with similar diagnosis. Patients can learn from each other and gain a great deal of information and emotional support from the group.

I believe that attending the group sessions can help people to build on their strengths, to pay closer attention to the positive aspects of their lives, and to make their medical care a more pleasant experience.

I find it important to get the word out to my patients about my group by routinely spending 15-30 seconds during every office visit telling patients briefly about the group and some of its advantages, inviting them to have their next visit be a group visit, and giving them a flyer describing my DIGMA."

Much of the economic and productivity gain of DIGMAs arises from the direct booking component: appropriately selected patients who agree to attend are scheduled directly into a DIGMA session instead of being scheduled into an individual office visit. However, much of the continuity of DIGMAs, as well as their warm and caring side, is provided by their spontaneous "drop-in" component.

A great amount of medical care can be provided during a DIGMA visit: vitals signs can be measured; medical charts can be reviewed and progress notes entered on each patient; questions can be answered; treatment options and medication side effects can be discussed; prescriptions can be changed or refilled; tests can be ordered and test results discussed; and brief private physical examinations or private discussions can be provided as needed during the last 10 to 20 minutes of group time in an adjacent examination room while the behaviorist leads the group, focusing on psychosocial, emotional, and healthy lifestyle issues of common interest to group members.

DIGMAs enable physicians to address in detail many issues of mutual interest to patients in a warm and supportive group setting where all can listen and learn—eg, the information and misinformation that patients glean from the media, Internet, friends, and direct advertising by pharmaceutical companies. Instead of repeating the same information to different patients with similar conditions—as is done during individual office visits—physicians can address an entire DIGMA group at once, often in greater detail because of the increased amount of time available. Similarly, the entire group can benefit simultaneously from the physician's answer to one patient's medical question, and further discussion is often stimulated. Patients often remark that in group they often get answers to important questions that they did not even know to ask. Patients clearly support one another and enjoy learning from each other's experiences. Patients help other patients in group by sharing helpful information, encouragement, support, effective coping strategies, and disease self-management skills. Everyone leaves the group with the realization that things could be worse and that they are not alone.

Unique Features of the DIGMA Model

DIGMAs differ from other group visit models such as the CHCC model and the CHCC Specialty model developed by Dr. John Scott and his colleagues at the Cooperative Health Care Clinic (CHCC) of the Kaiser

Permanente Colorado Medical Group.^{17,18} Both CHCC models focus on patient populations, either by utilization behavior (eg, the CHCC model for high-utilizing geriatric patients) or by diagnosis (eg, the CHCC Specialty model for high-risk patient populations with conditions such as hypertension, diabetes, hyperlipidemia, asthma, congestive heart failure, irritable bowel syndrome, depression, anxiety, and fibromyalgia).

In contrast, the DIGMA model focuses not on patient populations (either by diagnosis or by utilization behavior) but on the entire patient panel of the individual physician. This conceptual difference results in benefits specific to the DIGMA model. Because DIGMAs focus on improving access and helping physicians to better manage their entire large patient panels, physicians and their patients are the ones who directly benefit from DIGMAs. DIGMAs win physicians over out of self-interest, which ultimately leads to a high level of physician ownership and acceptance of the model.

How Patients Benefit from Participating in a DIGMA

Patient Satisfaction is High

Patients have accepted DIGMAs well and have consistently been highly satisfied with them. Many patients report that they actually prefer DIGMAs to traditional office visits. DIGMAs empower patients by giving them choice while giving assurance that individual appointments can also be scheduled as before.

Surveys have shown that patient satisfaction with DIGMAs is extremely high because the model gives patients what they most want: prompt access to high-quality care that attends to mind as well as body needs and gives patients more time with their own doctor. DIGMAs also release patients from the isolation of the individual office visit by having the help and support of other patients become an integral part of their medical care. These benefits of DIGMAs have inspired some patients to describe DIGMAs as "Dr Welby Care."

Patients Help Other Patients

Patients attending the DIGMA provide encouragement and information to one another and are a source of realistic hope. Patients feel less isolated with their illness and gain a more balanced perspective about their situation because of the information and emotional support provided by other patients, including many who are seen as being worse off. Patients enjoy closer follow-up care because they can simply drop into the DIGMA any



Rajan Bbandari, MD

"From a professional standpoint, I feel more satisfied in being able to meet both the medical and psychosocial needs of my patients in a very warm and relaxed environment. Having the drop-in format empowers patients by giving them freedom of choice."



Lynn A. Dowdell, MD

"The health psychologist and the encouragement, support, and gentle confrontation of other patients in the group with similar conditions are invaluable for breaking through denial and persuading patients to comply with recommended medical advice.

Overall, I have found my DIGMA group a valuable addition to my practice both by giving my patients more accessibility to me and by enabling me to deliver better service and follow-up care.

Because more time is available and the setting is more relaxed, my DIGMA lets me answer questions more fully and for many of my patients at once.

After individual consultations, I frequently use my DIGMA as a follow-up visit to discuss with patients the results of lab tests that I have ordered, to more closely monitor patients in a timely way, to order future tests, or to change medications as needed."



David Granovetter, MD

"Simply put, it's better care!

The groups have a wonderful healing energy about them that is not only helpful to patients, but also gives me hope in general for our ailing health care system."



Joseph E. Mason Jr, MD

"One of the biggest and most pleasant surprises of my medical career has been my experience with my Cancer DIGMA, which has provided a totally new type of service for my cancer patients.

It is very popular among my patients, who receive a kind of support and education not easily possible within the confines of an examination room and brief individual visit.

My patients routinely report to me their great satisfaction with the experience.

As you can see, my DIGMA benefits my cancer patients in many ways. It improves their access to me by providing a weekly time when no barriers exist (not even a phone call) between them and me. It also gives my patients an opportunity to share their experiences and validate their predicament."



William Peters, MD

"I believe that this model brings the human element back into health care. By providing a type of psychological management of medical illness that has not previously been available to physicians in traditional one-to-one office visits, the DIGMA more efficiently addresses psychological issues such as denial and noncompliance."



“The DIGMA program must be allowed to evolve and develop among physicians at the grassroots level.”

week they have a question or medical need and spend a great deal of time with their own doctor (which enhances the physician-patient relationship) and other patients. Patients often remark that the presence of others in the group lets them feel safe enough to ask questions they were not comfortable asking during routine individual office visits.

The greater amount of time available—together with the presence of the behavioral health professional, the physician, and other group members—enables mind as well as body needs to be attended to. The emotional support and occasional confrontation from other patients who have already undergone the recommended treatment regimen with benefit or who have been dealing for a longer time with the same illness that the patient has can be extremely helpful in increasing medical compliance. Patients also benefit from presence of family members and other caregivers at the DIGMA and from their issues also being addressed.

In addition, because of the prompt, barrier-free access that DIGMAs offer, patients who otherwise might not have bothered to schedule an individual office visit (especially patients who deny or minimize the severity of their symptoms) sometimes drop into a DIGMA session where their medical condition—which might even be life-threatening—can be detected and appropriate care delivered (including referral to the emergency department in severe cases). Discussion of specific benefits that DIGMAs offer to patients is more fully developed elsewhere.³

Even patients who chose not to participate in a DIGMA can benefit from the fact that their physician has a DIGMA program for his or her practice. This indirect benefit is improved access: by converting many individual visits appropriately into DIGMA group visits, DIGMAs increase the availability of individual office visits for patients needing or preferring them.

Essential Steps for Developing a Successful DIGMA Program

As is the case for all group visit programs, DIGMAs have certain specific requirements that must be met. Although these demands are reasonable and small compared with the multiple benefits that DIGMAs can offer, they are nonetheless real and critical to success. Failure to fulfill these nominal requirements will jeopardize the entire DIGMA program. Although this question is more fully developed elsewhere,^{4,8,9} I will summarize the essential steps here.

Securing Administrative Support

Formation of a successful DIGMA program requires early and adequate administrative support. For larger group practices, where multiple DIGMAs are to be established, the right person must be carefully selected to be the DIGMA champion. The champion, who must be very knowledgeable about all aspects of the DIGMA model, assumes primary responsibility for the entire DIGMA program, including its development and implementation throughout the medical facility.⁴ The champion serves as “point person” for attending to the myriad details necessary to ensure success. The champion must also inform physicians about the DIGMA model¹ and its many benefits,³ address physicians’ questions and concerns,² and encourage physicians to start a DIGMA for their practice. The champion customizes the structure and design of the DIGMA around the particular needs, goals, practice style, and patient panel constituency of each individual physician who chooses to add a DIGMA to their medical practice.

Securing Patient Buy-In

Formation of a successful DIGMA program requires support from patients. Because patients have grown to expect a traditional one-on-one office visit with their doctor, successful introduction of this radically different concept of group medical care has certain requirements for marketing the program. For example, all marketing materials directed at introducing patients to the DIGMA concept (eg, wall posters, fliers, announcements, follow-up letters to patients) must have a professional appearance that accurately portrays the high-quality medical care DIGMAs provide. In addition, physicians will need to take 15 to 30 seconds during every office visit to briefly explain some of the benefits that the DIGMA offers to patients, to hand patients a flier describing their DIGMA group, and to personally invite patients (as appropriate) to have their next visit be a DIGMA visit.

Securing Physician Buy-In

The DIGMA program must be allowed to evolve and develop among physicians at the grassroots level. Indeed, critical to the ultimate success of any DIGMA program is physician acceptance and buy-in, which can only be achieved by promptly and thoroughly addressing the concerns physicians raise. Resolution of these concerns will greatly facilitate physicians’ willingness to start a DIGMA for their own practice. I discussed elsewhere² some common concerns ex-



pressed by physicians about DIGMAs: “It won’t work for my practice”; “I’m too busy to start a DIGMA”; “I’m not comfortable delivering medical care in a group”; “I still need individual appointments with my patients”; “What if I lose control of the group?”; “Is this increased quality of care or just more HMO cost-cutting?”; “It’s ‘meat market’ care”; “Groups strip away my easiest patients”; “I have some ethical concerns”; and “I’m concerned about confidentiality.” The DIGMA model addresses these concerns very well, so that they can either be resolved promptly or soon after the DIGMA is started.

Physicians who are concerned about confidentiality may wish to use a brief disclosure or informed consent form to be signed by all patients at the beginning of each DIGMA visit. I initially did this myself. However, it has been my experience that concerns about confidentiality have rarely, if ever, been expressed by patients attending DIGMAs and that any initial concerns regarding patients’ needs for confidentiality and possible unwillingness to discuss their medical issues in a group setting have proved unfounded. In general, patients feel safe and comfortable in a well-run DIGMA group and are surprisingly open and candid—a finding also reported elsewhere.¹⁷

One concern in particular is frequently expressed by physicians: “Why should I start a DIGMA for my practice if the net long-term effect will only be 1000 more patients added to my panel?” This physician concern is the only one the DIGMA model itself does not solve, and the potential for long-term abuse in this area is real. Physicians are concerned that running DIGMAs for their practices will only produce a substantial net long-term increase in patient panel size that would completely nullify any net gain in efficiency the DIGMA would otherwise provide.

To create a “win-win-win” situation, physicians too (ie, not only patients and the organization) must derive substantial net long-term benefit from the increased efficiency provided by their DIGMAs. Physicians view this matter as one of fairness and trust. Managed care organizations that seek to capitalize on the many patient, physician, and organizational benefits offered by DIGMAs must adopt long-term business policies that build physicians’ trust and provide benefits to them as well as to patients and to the organization. Physicians need reassurance from administrators that, as a result of implementing a DIGMA for their practice, some meaningful net benefit will accrue to them. Physicians must be assured that any

future increase in panel size based on the increased efficiency that DIGMAs provide will be reasonable, so that they will be left with a substantial net gain for their efforts.

Assigning a Scheduler and Medical Assistant to the DIGMA

In most cases, a medical assistant and a scheduler must both be assigned to the DIGMA group. The scheduler must have enough dedicated time each week to telephone patients from the physician’s panel or waiting list (who have been approved by the physician as appropriate for the DIGMA) to invite them to attend the next DIGMA session.

The scheduler must be trained regarding the scripted telephone message to be used for inviting patients to the next DIGMA session and in how to answer patient questions about the DIGMA program. The scheduler must also be trained to send the personalized, computer-generated follow-up letter that includes all necessary information about the DIGMA and that incorporates the physician’s signature. The scheduler’s function is a clerical one that represents one of the least expensive personnel resources in the medical center; nonetheless, this function is a predictable, important expense that planners must include in the DIGMA budget.

The medical assistant assigned to the group must be trained to work with the increased patient volume that DIGMAs involve and the expanded responsibilities of this role, which includes not only taking vital signs but also performing many special duties, such as obtaining fingerstick blood glucose measurements for diabetic patients. Other special duties include reviewing all prompts on the registration forms for tests and medical services due, retrieving referral and testing forms, and completing as much patient information as possible before attaching the forms to the medical charts and returning them to the group, where the physician can efficiently order indicated tests and referrals during group time.

All personnel associated with the DIGMA—from the receptionists, medical assistant, and scheduler to the physician and behavioral health provider—must be well-trained, empathetic, and courteous. Accordingly, the medical assistant attached to the DIGMA should be selected on the basis of skill, pleasantness with patients, and a willingness to work hard and welcome the expanded role and responsibility that the DIGMA offers to medical assistants. Any medical assistant who complains about the workload and pace

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of care would be a poor choice for the DIGMA program. Try to select a medical assistant who is motivated to work with the DIGMA and perceives the added responsibility as an opportunity to gain experience and develop professionally.

Choosing the Right DIGMA Champion

Thoughtful, careful selection of the DIGMA champion is an important step for developing a successful DIGMA program. The champion's clinical skills and knowledge of the DIGMA model are the foundation on which rests the success of the entire program, especially in its early stages. The champion must not only be skilled and experienced in working closely with both medical patients and physicians but also must engender a high level of physician confidence and respect—so much so that physicians will be willing, by working with the champion, to entrust delivery of medical care in the dramatically different format of a DIGMA group visit.

Physicians need much help from the champion when starting their DIGMA. The champion is responsible for implementing the entire DIGMA program at the facility. The champion should be a behavioral health professional who has adequate dedicated time and detailed knowledge about starting and running a successful DIGMA program; is comfortable working closely with physicians and hospital administrators; has experience in handling group dynamics and in leading large group programs; is compassionate toward the medically ill and is aware of their psychosocial needs; and can train other behavioral health professionals to lead DIGMAs which the champion has established—after which, the champion moves on to starting other DIGMAs with other physicians.

In addition to helping the physician to customize the design of the DIGMA to best meet the physician's needs, the champion helps to develop the program description fliers and progress note (which is mostly preprinted in checklist form for quick charting) and takes the lead in getting the DIGMA program started. Whenever possible, the champion should start the DIGMA program with the physician and then remain with the group for a couple of months until it is running smoothly, all system problems (eg, medical charts not arriving on time) are solved, and the physician has become comfortable with the DIGMA model. The champion may also help the physician to learn how best to select and invite patients seen during routine office visits to have their next visit be a DIGMA visit. The champion can also advise physicians on how to

best use DIGMAs to meet their stated goals and objectives, which continuously evolve as needs change.

The champion must also train different behavioral health professionals as replacements to assume the champion's co-leadership of all DIGMAs established by the champion. Because they will be working closely together and need to be compatible, considerable care must be taken in selecting the best behavioral health professional for each DIGMA in order to ensure that this replacement is well matched to both the physician and the group.

Choosing a Behavioral Health Professional for the DIGMA

The behavioral health professional must be selected on the basis of skill set, scope of practice under licensure, and being well matched to the group and the physician (and not simply on the basis of lowest personnel expense). A poor choice of behaviorist is likely to reduce the productivity of the DIGMA and may even cause the group to fail.

The behavioral health provider introduces the group, manages group dynamics, addresses emotional and psychosocial issues, provides behavioral health evaluations and interventions, responds to any psychiatric emergencies, and helps to keep the DIGMA running smoothly and on time. In addition, the behaviorist helps the physician to resolve patient hostility or other negative emotions and leads the group alone (focusing on psychosocial issues) when the physician leaves the room to conduct brief private examinations or is otherwise absent. This arrangement enables physicians to focus on delivering quality medical care instead of worrying about group dynamic and psychosocial issues that require special expertise.

The behavioral health professional must be skilled in running groups; compassionate toward the chronically ill; knowledgeable about the psychosocial needs of medical patients; and have sufficient experience, training, and scope of practice under their license to handle all of the responsibilities that are likely to occur in the DIGMA. It is for these reasons that I particularly recommend using health psychologists in nephrology, oncology, and rheumatology DIGMAs, where anxiety, depression, and suicide are more likely to be major issues.

Developing Effective Promotional Tools

Well-designed wall posters (for the physician's lobby and examination rooms) and descriptive fliers about the DIGMA program represent an im-



portant but relatively small, one-time expense incurred at the beginning of each DIGMA program. Although small, considerable lead time should be allocated to this expense, which must be built into the DIGMA budget. Failure to obtain these important promotional tools will negatively impact the entire program.

Maintaining Predetermined Minimum Census Levels

I cannot overstate the importance of establishing and consistently maintaining a minimum patient census level for each DIGMA: Adequate census is the key to leveraging physician time and to attaining the levels of increased productivity and efficiency that well-run DIGMAs can achieve. Failure to consistently meet minimum census requirements would not only reduce efficiency and productivity, but could also jeopardize the entire DIGMA program.

Moreover, in contrast to the way the DIGMA model swiftly resolves most concerns, the concern around establishing and maintaining a minimum level of census is as real and important after a year or two as it was at the first DIGMA session. The minimum census level must be set high enough to meet the targeted goals for increasing physician productivity; at the same time, the minimum census level must not be set so high as to create an onerous workload or to reduce patient bonding. Experience has shown that the ideal census for most DIGMAs is between 10 and 16 patients plus an additional three to six family members and caregivers.

Maintaining census is critical to the success of each DIGMA and requires continuous vigilance. In addition, not only must a certain number of patients attend group each week; they must be the right patients (ie, patients whom the physician has specifically selected for inclusion and especially those who attend the DIGMA in lieu of an individual visit). Maintaining census converts individual visits into group visits, leverages physician time, improves accessibility, and achieves the goals for which the DIGMA model was originally designed.

The behavioral health professional has the responsibility of monitoring the group census each week and of notifying both the physician and the scheduler if census starts to drop or fails to meet the established minimum census level so that they can increase their efforts for inviting patients. In this way, the DIGMA census can be fine-tuned and maintained so that the DIGMA program's desired objectives continue to be met.

Implementing DIGMAs Throughout the Organization

Larger group practices and managed care organizations may wish to first establish and evaluate the effectiveness of DIGMAs at a pilot site before disseminating the DIGMA model to facilities throughout the organization. Ultimately, full-scale implementation in both primary and specialty care settings is likely to be the organizational goal; this process is discussed in detail elsewhere,⁴ as are important keys to success⁸—and pitfalls to avoid⁹—when developing a DIGMA program throughout the organization.

Barriers to Development of a Successful DIGMA Program

The difficulties that I faced as DIGMA champion at the KP San Jose Medical Center should serve as a lesson for others and can be prevented by following the steps described in this article. Initially, primary care physicians were not easily convinced to try DIGMAs for their practices; I therefore started with specialists, and interest soon evolved among primary care practitioners. I also had difficulty obtaining funding for the three sets of framed wall posters and accompanying DIGMA program description fliers for the physicians' lobby and for two examination rooms. In addition, there were sometimes difficulties reserving a group room that was adequately sized, comfortable, and with a well-stocked examination room nearby. Overcoming these difficulties often required improvisation, ingenuity, and persistence.

Due to lack of funding, we did not have a scheduler assigned to most DIGMAs with sufficient time dedicated each week (as much as four hours were needed in some weeks) to telephone patients and send follow-up letters. As a result, the census was sometimes below targeted levels, and the degree to which productivity was increased was correspondingly less than optimal.

Any perception by frontline physicians that the DIGMA model is being dictated "from the top down" is likely to engender physician resistance and resentment. Instead, managed care organizations should recognize that DIGMAs have the remarkable ability to win physicians over at the grassroots level out of self-interest and through word-of-mouth recommendations from colleagues already successfully running DIGMAs for their practices. By thus achieving high levels of physician "buy-in," DIGMAs can create for HMOs, group practices, and managed care organizations a special opportunity to initiate system reform

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“Physicians who use DIGMAs effectively can achieve tremendous results in their practices.”

that increases physicians' productivity from the “bottom up” rather than being imposed “top down.” Instead, it is recommended that administrators simply provide the necessary support, carefully select the best possible candidate to be the DIGMA champion, and then allow the DIGMA program to develop and evolve among primary and specialty care physicians.

Conclusions

DIGMAs Help to Optimize Value

The DIGMA model offers an exciting new dimension to cost-effective delivery of high-quality health care. The extraordinary national response I have received to my published articles on the DIGMA model¹⁻⁵ shows that the model is attractive to administrators and physicians alike. Because DIGMAs strike an optimal balance between economy and the needs of patients, physicians, and health care organizations, DIGMAs provide a “win-win-win” situation and can be expected to play an increasingly important role in the future of health care delivery.

Group Visits Complement Traditional Office Visits

DIGMAs work well in conjunction with the judicious complementary use of individual appointments. Both types of appointments have an important role in today's health care environment; each has its own advantages and disadvantages, and neither is best for everyone in every situation. Physicians who use DIGMAs effectively can achieve tremendous results in their practices. DIGMAs excel at containing costs by making individual appointments more available for patients who need them most, by leveraging physicians' time, by using existing staff resources more efficiently, by reducing return patient backlogs, and by increasing accessibility and therefore service. By addressing mind as well as body needs and by providing better follow-up care, DIGMAs enhance quality of care while improving patients' and physicians' satisfaction with the total health care experience.

DIGMAs function most effectively when used to replace or supplement routine return appointments for relatively stable chronic illnesses, the worried well, patients with extensive informational and psychosocial needs, and patients who require much contact with their physician and a lot of professional handholding. Individual appointments are best used for initial evaluations, lengthy individual examinations, one-time consultations, most medical procedures, acute illnesses, urgent medical situations, and for patients who refuse to try group visits.

Why Physicians Like DIGMAs

Physician professional satisfaction has been consistently shown to increase with DIGMAs as a result of reduced backlogs and waiting lists, fewer patient phone calls and force bookings, less complaints about access, and more rewarding interactions with patients and their support persons. Physicians report that DIGMAs enable them to regain a sense of control over their practice by better managing their burgeoning panel sizes, delivering a more satisfying level of care, and enjoying improved physician-patient relationships. DIGMAs also offer physicians other benefits:

- A regular reprieve from the fast-paced treadmill of individual care;
- More time with the patient so that mind as well as body care can be provided, including addressing the psychosocial and behavioral health issues known to drive a large percentage of all medical visits;¹⁴⁻¹⁶
- An opportunity to try something new and different that provides an interesting learning experience;
- Improved access and a way to “work smarter, not harder”;
- Less need to repeat information;
- Collegial interaction with the behavioral health professional;
- More compliant patients;
- A way to get back on schedule, even if the physician enters the group late;
- The ability to respond effectively to angry or demanding patients;
- The benefit of helpful assistance from both the behavioral health professional and the group itself.

Will DIGMAs Work in Practice?

Would the DIGMA model work in actual practice? After three years of development, over 8000 DIGMA patient visits, and experience with 12 specialty and primary care DIGMAs in three different phases, I can unequivocally answer this question in the affirmative: Carefully designed, properly run, and adequately supported DIGMAs can consistently work well in actual practice to achieve all of the goals for which the DIGMA model was originally designed. All 12 DIGMAs implemented to date have successfully met the goals for which they were designed.



DIGMAs Increase Access to Care

DIGMAs have been demonstrated to be extremely effective in solving individual physician⁶ as well as departmental⁷ access problems by converting many individual visits into more efficient, cost-effective group visits. DIGMAs work especially well for patients who are noncompliant, anxious, depressed, angry, distrustful of medical care, or have extensive psychosocial needs that require much time and emotional support. Physicians consistently remark how much easier it is to gain trust and medical compliance, even among resistant and noncompliant patients, when their treatment recommendations are reinforced by other patients in the group who have already received benefit from the recommended treatment.

DIGMAs excel in addressing the behavioral health, emotional, and psychosocial needs that are known to drive a large percentage of all medical visits,^{14,15,16} and this result can substantially reduce the demand for individual visits. Because DIGMAs can so effectively meet the medical needs of the relatively stable chronically ill, the worried well, and the psychologically needy, they can free up numerous individual office visits for rapidly evolving medical conditions, procedures, lengthy examinations, and patients truly needing an individual appointment.

DIGMAs Increase Patient and Physician Satisfaction

As important as any other benefit provided by DIGMAs, this model of health care delivery has been shown to increase the satisfaction of patients as well as physicians. DIGMAs reduce or eliminate appointment waiting lists and extra appointments force booked into already full schedules, decrease the need for patients to phone physicians' offices, increase access to medical care, and facilitate more rewarding interactions between physicians, patients, and patients' support persons. ♦

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