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Understanding Today's Group Visit Models

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Introduction

With its increasing patient demands for expanded services at reduced rates, today's rapidly changing and highly competitive health care environment requires health care organizations to look for innovative ways to improve level of service and quality of care while reducing costs. Group visit models have been developed to achieve these complex objectives effectively and simultaneously through use of existing resources. As developers of today's group visit models, the authors realize that much confusion unfortunately exists as to what defines these group visit models, how they differ, and how they can work together. Nonetheless, experience with group visits to date has been exciting and encouraging. This article discusses the features, advantages, and disadvantages of the basic models of group medical visits, what their future looks like, and how they might best work together to produce even greater efficiencies than any one model alone or individual office visits could provide.

We invite physicians, administrators, and health care organizations to take a closer look at using group medical visits for their own practices. Many physicians and administrators are concluding that the current paradigm—individual office visits only—is economically unsustainable. There simply isn't enough money in the system to allocate enough physicians to solve current access, service, and quality-of-care problems through traditional means. We need a tool for leveraging physician time and for increasing both efficiency and production while improving service and quality of care. The authors feel strongly that properly run and adequately supported group medical visits can provide this much-needed tool.

The Need for New Models of Delivering Care

The physician-patient relationship, widely believed to be the bedrock of medical care, is being eroded to the detriment not only of both those parties but also to the detriment of those who would manage that care. The glue that cements the physician-patient relationship and that ought to cement the physician-management relationship is trust; indeed, erosion of trust is the key issue. It is pointless to try to assign blame for this erosion, which is a product of complex changes in the world—everything from the business imperatives of a global economy to the impact of technology on both patient and provider in the information age.

Physicians must master a huge and growing body of scientific and technical information. This learning process often requires a decade of formal training and must be ongoing. Discussing the applicable pieces of this technical knowledge and translating it into meaningful, individualized decisions requires spending more time with patients than in the era when there were only a half dozen antibiotics and only two imaging techniques available (ie, x-ray films and laparotomy). The emerging guidelines and checklists of evidence-based medicine compete with time available for seeing patients. The medical record has become an instrument of reimbursement instead of a record of medical decision-making. Data entry further competes with time available for seeing patients.

Patients, too, are overwhelmed with information and with expectations of accountability. Some are able to extract the information they need for their medical care directly from the Internet, but most are swayed by the mass media urging them to "ask your doctor about ...." Sound bytes on advertisements rarely discuss the complexities of false-positive and false-negative test results and risk-benefit analyses. Thus, patients often bring a great deal of information, but frequently much less knowledge, along with many sets of questions and expectations that also must be addressed in the limited time allotted for the doctor office visit. The general movement toward more patient empowerment lends validity to these questions and expectations.

Managers of the time allotted for doctor office visits are not unaware of the above issues and are acutely aware that patient satisfaction is the key to success. Nonetheless, these managers must focus on access and cost as primary issues. The almost universal response to these twin pressures is to see more patients. Because clinicians' capacity for late hours and weekend clinics has already been stretched to maximum tolerance, the result is generally less time for the doctor office visit—less time for the patient to communicate fears, expectations, and even critical symptoms. The physician has less time to discuss diagnostic or treatment options along with their risks and benefits and has virtually no time to address the psychosocial issues which often drive medical visits and which result in different outcomes from the same process of care. Unanswered questions and inadequate explanations generate more anxiety and thus more utilization—and the spiral continues.

Eventually, patients feel that the physician is not listening or doesn't have the needed answers. Trust

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is eroded. Physicians begin to categorize their patients' concerns as either appropriate or inappropriate and to communicate the verdict through body language. Effective communication is difficult, and administrators bemoan declining patient satisfaction. For their part, patients frequently turn to alternative medicine, which emphasizes the humanistic instead of the scientific and technical aspects of medical care.

What is the answer? Better communication, addressing fears and anxieties, focusing more on psychosocial issues, active listening, increasing access to care, and lowering costs are some obvious answers which would satisfy everyone concerned. Unfortunately, these answers are impossible to achieve within budget through the current physician-patient dyad, the individual doctor office visit.

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Advantages of Group Visits

Many physicians feel that the traditional individual office-visit model for which they have been trained and with which they have been practicing is the best form of care; they would therefore like to maintain the status quo. Unfortunately, patient panel sizes are now so large that schedules are backlogged, waiting lists are common, patients have difficulty obtaining timely appointments, and the level of accessibility is not commensurate with good care. A tool is needed to enable physicians to leverage their time and to "work smarter, not harder." Group visits can be such a tool.

We invite the reader to consider the benefits that group visits offer. For example, by integrating into medical care the encouragement and support of other patients, group visits reduce the sense of isolation that medical patients often feel. Not only do patients no longer feel alone, but they also gain a more balanced perspective because they leave group visits realizing that many others are much worse off. Patients often comment that attending group sessions relieved them of the "woe is me" type of thinking and caused them to realize three things: that their situation could be worse, that they can still do much which others cannot do, and that they can build on their strengths without merely perseverating on their illness and disability.

Unlike individual office visits, where physicians must do everything themselves, group visits provide the help of other patients and support staff (eg, the behavioral health professional in the DIGMA model and the nurse, pharmacist, and health educator in the CHCC model). In group visits, patients teach patients by discussing successful coping strategies, by sharing personal experiences, and by providing helpful information. Unlike rushed individual visits, the pace of group visits is generally more relaxed because of the greater amount of time available.

For many patients, group visits reduce the stigma of illness through the emotional support of others, including those who are similarly afflicted. Often, patients state how much they have been wanting to talk to someone else experiencing the same health problems but that they never knew such a person until they attended the group. After attending a group visit, they comment upon how much they appreciated the opportunity to finally meet and talk to such a person.

Group visits are meant to work in conjunction with the judicious use of individual office visits—not to completely replace them. Group and individual appointments both have their own advantages and disadvantages, and neither is best for all situations and circumstances. In this article, we discuss the advantages and disadvantages of major group visit models and how they can work together with individual office visits to provide optimal value through both reduced cost and improved, integrated care.

Types of Group-Visit Models

Two major group visit models have been developed—one that is patient-focused and another that is physician-focused. The first—the result of pioneering work begun in 1990 in the Cooperative Health Care Clinic (CHCC) at The Permanente Medical Group in Colorado[1-4] (Beck A, PhD, unpublished data)[a]—focuses on patient populations. Although the CHCC model initially focused on specific patient populations categorized by their utilization behavior (ie, high-utilizing geriatric patients), the model was later extended to focus on various specific patient populations categorized by their diagnosis (ie, Specialty CHCC groups). The Specialty CHCC model serves as the foundation on which high-risk patient population management programs can be based (eg, for management of diabetes, asthma, hypertension, hyperlipidemia, congestive heart failure, depression, anxiety, irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia, and headache). The CHCC model was designed to provide adequate time to deliver the quality of care that all physicians know they should deliver. The therapeutic benefit of the group dynamic; enhanced physician and patient satisfaction; better patient outcomes with reduced utilization of the hospital, emergency department, and

nursing facilities; and lower costs were positive consequences of well-trained physicians having adequate time to practice their art.

The second major group visit model, the Drop-in Group Medical Appointment (or DIGMA) model, was originated by Dr Noffsinger in 1996 at the Kaiser Permanente San Jose Medical Center.[5-15] The DIGMA model has an entirely different focus than that of the CHCC model. Instead of focusing on patient populations categorized either by utilization behavior or by diagnosis, the DIGMA model focuses on the entire patient panel of an individual physician and includes only patients from the physician's own panel. The DIGMA model has been effectively achieving all the goals for which it was originally designed: to improve access for patients on the physician's panel; to leverage the physician's time and increase productivity so that the physician is better able to manage an increasingly large patient panel; to improve quality of care, both by providing closer follow-up care and by better attending to the mind as well as body needs that patients bring to the medical visit; and to simultaneously increase patient satisfaction and physician professional satisfaction.

In this article, we propose alternative delivery models that use group office visits of various types for specific patient populations as well as for the physician's entire patient panel. Evidence shows not only that these models work but that they actually work better for a large percentage of patients than the current dyad paradigm. We will present three group visit models of care that have been shown to increase patient and physician satisfaction, enhance quality of care, improve access, and cost less than the current individual office visit model. These models include the CHCC (Cooperative Health Care Clinic) model, the Specialty CHCC model, and the DIGMA (Drop-in Group Medical Appointment) model.

Although each model is directly concerned with patient care, each has a slightly different philosophical basis. The CHCC model is designed primarily for the benefit of the patient, whereas the DIGMA's primary goal is to improve access and to help physicians better manage their large patient panels. The Specialty CHCC model is designed primarily for the benefit of the organization as a whole.

Description of the CHCC Model

This model is designed to serve high-utilizing seniors who have contact with the system twice a month or more. They are over age 65 years and therefore usually have multiple medical conditions. Patients are identified by administrative data and are grouped by their physician. If the physician is willing to implement the CHCC model, invitations explaining the CHCC concept and process are sent to the target population.

Nine years of consistent experience has taught us that 40% of these patients accept the invitation enthusiastically, 20% equivocate, and 40% decline to participate. A recent two-year, randomized, controlled clinical trial sponsored by the Robert Wood Johnson Foundation clearly showed that the target population consists of the 40% who unequivocally accept the invitation.[1-4] Optimal group size is set at 20 to 25 participants. Participating physicians were surveyed on the issue of group size, and their consensus opinion was that groups with more than 25 people lose the group dynamic and personal interaction which are key to their success; and that groups with fewer than 15 people require too much energy from the physician and nurse to keep discussions lively. In addition, groups with fewer than 15 people start to lose the up-front cost benefit to the organization.

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Groups should meet once a month on a regular basis at the same time and in the same place. The same patients are invited to attend each month, although new patients are added as group members move, change health plans, or die. Daylight hours are essential for geriatric patients because most have problems with driving in the dark. Two-and-one-half hours are set aside for each CHCC model session: a 90-minute period of group time is followed by one hour for one-to-one patient-physician visits, as needed. On average, six or seven patients are seen after each group session in this model.

In the CHCC model, each group session has five key components: socialization time, education time, the break, question-and-answer time, and one-to-one physician-patient time.

Socialization Time

Each session begins with 10-15 minutes of either organized or spontaneous socialization. In the first few sessions, reminiscence therapy techniques are used to help build the cohesiveness of the groups. Questions like "What was Christmas Day like when you were ten years old?" or "What was your most memorable trip?" are passed around the U-shaped seating arrangement for optional responses. The commonality of experiences that this process elicits helps build the foundation for communication about specific diseases and coping skills, as well as the

emotional support that evolves quickly in every group. As time goes on, the socialization time becomes more informal, eg, vacation stories or even jokes are told. Formal or informal, the focused group interviews done after seven years of CHCC experience show how important this process really is. Patients describe the group as a stronger support system than even their own families.

Education Time

The next half hour of group time is allotted for education. During the first year, certain core topics are delivered in every group. These topics include advance directives, health maintenance requirements, use of the emergency system, Medicare coverage, and long-term care. Later, topics are selected by the group and range from safety at home to cardiovascular signs and symptoms among the elderly. Educational sessions are interactive and not didactic. For example, the physician might ask, "Has anyone in the group ever had a heart pain?" Usually three or four hands are raised and those folks are asked, "What was it like?" or "What did you do?" After several descriptions, the physician elaborates on key points or fills in the blanks. Not only is information conveyed, but also the patients are validated as reliable sources of information for each other.

Confidentiality, although available in the one-to-one time, is a "nonissue" because patients feel that the support group function of CHCC is "stronger than family."

The Break

Next comes the most active and most essential part of the group session, inappropriately referred to as "the break." During this 15-20 minute segment, the physician and nurse position themselves at opposite sides of the U-shaped seating arrangement and address multiple issues presented by members of the group. Blood pressure levels are monitored, prescriptions are refilled, forms are filled out for everything from durable medical equipment to parking stickers, immunizations are given as needed, and "Oh, by the way, doc" issues are addressed. Everyone gets an opportunity for one-to-one contact with both the physician and the nurse. Patients who are not actively engaged with the provider interact with each other while enjoying the snacks that designated group members provide for each session.

Question-and-Answer Time

The working break is followed by a question-and-answer period that is also highly interactive and that may range from topics presented on that day to the latest media medical stories. Often one question triggers a series of questions and leads to discussion of multiple facets of complex medical issues.

One-to-One Physician-Patient Time

It is critical in describing the CHCC model to include the one-to-one physician-patient time that follows the group visit time. Six or seven patients are seen after each session—about half for intervening illness or flares in chronic conditions and about half for health maintenance (eg, physical examinations, routine checks for diabetes or heart disease). On average, each patient is seen about four times a year in this individualized setting.

Advantages of the CHCC Model

CHCC is a health care delivery system that is entirely voluntary for both patients and staff. It efficiently and effectively enhances quality of care and the satisfaction of the professional staff and patients who participate. In focus group interviews, patients tell us that this format improves the doctor-patient relationship, is far superior to the usual patient education formats, gives them an opportunity to get all their questions and issues addressed, and helps them to feel capable of coping with their various medical issues. Confidentiality, although available in the one-to-one time, is a "nonissue" because patients feel that the support group function of CHCC is "stronger than family."

This patient satisfaction and commitment to CHCC translates into membership retention that is more than double that of seniors who do not attend CHCC sessions. This format is not only good medicine—it is good business.

Perhaps the greatest strength of the CHCC model is that it is evidence-based. The outcomes—improved independence and functional ability, improved perception of quality of life, fewer hospital days, and less need to use ambulance and emergency department facilities—are important[1-3] and reproducible[4] (Beck A, PhD, unpublished data).[a] In these days of cost-conscious medical care, the cost-effectiveness of CHCC cannot be overemphasized.

Disadvantages of the CHCC Model

Despite its strengths, the CHCC model has four major disadvantages.

First, the financial success of the CHCC model depends upon major savings in "big-ticket" items such as hospitalization and emergency department use. The model is dramatically economically successful

only in an integrated system of care—at least in the world of medicine as it is currently constituted.

Second, the CHCC model requires constant monitoring and coaching to be sure that it remains an interactive care delivery process and does not become "a class," ie, purely educational. We have found that even well-intentioned physicians left to their own devices often slip into the role of authority figure and professor—roles that can be much more comfortable than the role of facilitator in an interactive process.

Third, to use the CHCC model most effectively may require more up-front skill building in the group process than we have been able to provide. As mentioned above, the model requires coaching and monitoring. One person could provide these services for a minimum of 40 groups (our experience) and perhaps for as many as 100 groups.

A fourth—and major—hurdle for CHCC 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 as they provide 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 issues of same-day access, unscheduled walk-in patients, and emergency care. Although aware of the long-term favorable results of the CHCC model, staff are frequently diverted to more visible demands. High-level administrative support for the CHCC model, even when present, is not enough; dedicated nurse support is a necessity.

Future of the CHCC Model

The future for the CHCC model looks bright. Reflect at first only on the geriatric population. This population, currently about 12% of the whole, will double in the next two or three decades. It does and will control the majority of wealth in the country and thus, for better or worse, will influence federal health care policy. Medicare will not be allowed to languish, and 7 1/2-minute doctor office visits—(long predicted, currently not uncommon, and surely the scourge of the future) will not be tolerated, even under the rubric of "computer-assisted quality time" or "institutional memory." People want to talk to doctors about aging, death, and dying. WWW.DEATH.com will not suffice—not for today's elderly population nor for their children and grandchildren.

The same is true for virtually every chronic disease in every age group. People's thoughts, beliefs, fears, and expectations about their medical issues cannot be bundled into simple guidelines and checklists. Human reactions to illness are often the major determinants of outcomes, regardless of prescribed interventions. It takes time to address these issues, and the CHCC model provides both the time and the environment to do this. The current one-to-one doctor-patient paradigm is not only economically unsustainable as a sole delivery system but lacks the power and the therapeutic benefit of the group dynamic.[16]

Two challenges loom for the CHCC model. The first is data entry and retrieval in the computer age. The current CHCC model features patients sitting with their medical chart in front of them. Notations are made in the chart both during and after the group session. Transition to a fully computerized medical record will require new formats for transfer of information. The second challenge for the CHCC model is to secure a CPT code—a process which can be long and arduous and which must include safeguards against abuse.

Description of the Specialty CHCC Model

The CHCC model of care is adaptable to a large number of diseases and patient populations. In some instances, the emotional support provided is less important than the education component. Thus, hypertension groups for working-age adults meet only twice a year, whereas diabetic groups might meet for four to six intense educational sessions followed by two to three meetings a year for routine maintenance care. Although the frequency, content, and duration may vary considerably (ie, from the original geriatric model to pediatric groups for attention deficit disorder and well-baby care), the basic elements remain the same: sufficient time for interactive care delivery with multidisciplinary assistance as needed. Thus, the CHCC model can be used as a foundation for all population management programs designed for high-risk patient populations.

Specialists find the CHCC model useful for addressing diseases associated with significant psychosocial issues. The list of such diseases is long, but successful pilot groups have been done for rheumatology (fibromyalgia), gastroenterology (functional bowel disorder), cardiology (congestive heart failure), and pulmonary medicine (chronic obstructive pulmonary disease). Specialists emphasize efficiency in caring for time-consuming patients who do not require any medical procedures. This same focus has recently been brought to orthopedics where group preoperative and postoperative visits are viewed as poten-

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tially freeing up more operating suite time. From the administration's point of view, the cost-benefit of this availability is obvious; and, of course, working in the operating suite is essential for the surgeons.

Quality assurance is another mandatory consideration for health plan administrators. Guidelines for managing specific diseases and patient populations are proliferating faster than providers can read them, let alone implement the details. Reporting requirements are likewise proliferating, with HEDIS being the most prominent of these to date. The Specialty CHCC model, either run by or including specialists as guest speakers, is the ideal forum for implementing guidelines and enlisting patients in monitoring their own compliance.

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Description of the DIGMA Model

This section discusses the DIGMA model: what it is; how it looks; what it can achieve; how it is different from other group medical appointment models; what its strengths and weaknesses are; and how DIGMAs can positively impact service, quality of care, and the bottom line.

The DIGMA model was created in 1996 to improve access to care and to enable physicians to better manage their large patient panels by seeing dramatically more patients in the same amount of time while increasing patient and physician professional satisfaction as well as improving access to care, level of service, and quality of care.[5-15] DIGMAs enable physicians to "work smarter, not harder" and simultaneously provide patients with more integrated, holistic care that addresses not only physical medical needs but also their psychological and behavioral health needs—needs that typically cannot be adequately addressed during the brief timespan of an individual office visit.

DIGMAs are customized to the needs, goals, practice style, and patient panel constituency of the individual physician. Open only to the physician's own patients (ie, they are not drawn from elsewhere in the medical center), DIGMAs are designed to encompass most or all of the physician's own patient panel. DIGMAs combine an extended medical appointment with the patient's own physician and an effective support group consisting of the physician, a behavioral health professional, and other patients from the physician's panel. Surveys have consistently shown that patients are highly satisfied with DIGMAs because DIGMAs provide what patients most want: better access, high-quality health care in which both mind and body needs are addressed, and more time with their own doctor.

Co-led by the physician and a behavioral health professional (such as a health psychologist, social worker, marriage and family therapist, nurse, or health educator), both of whom are present throughout each DIGMA session, DIGMAs are typically held for 60, 90 or 120 minutes weekly or biweekly. Most current DIGMAs are 90 minutes long, are held weekly, and are supported by a medical assistant and a scheduler. DIGMAs are typically attended by 10 to 16 patients plus two to six support persons (most frequently the spouse, family members, friends, or the caregiver), bringing the total DIGMA group size to between 12 and 22 group members. Different patients attend each week, typically whenever they have a question or medical need. Patients help other patients in the group by sharing information, encouragement, support, effective coping strategies, and disease management skills.

The behavioral health provider plays a very active role throughout each DIGMA session by introducing the DIGMA group concept and discussing procedural items at the beginning of each session; by handling group dynamic issues; by keeping the group running smoothly and on time; by addressing emotional and psychosocial issues; by dealing with psychiatric emergencies; by providing behavioral health evaluations and interventions; by seeing that each patient's mind and body needs are met during each session; by doing whatever is necessary both during and outside of the group to assist the physician in running the DIGMA; and by conducting the group alone when the physician is late or leaves the room to deliver brief private examinations near the end of the group session. The behavioral health professional then focuses on psychosocial issues of common interest which have been brought up by patients attending the DIGMA session. Fulfillment of this role of behavioral health professional frees the physician to focus on delivering high-quality, high-value medical care in the warm, supportive DIGMA group setting enjoyed by patients and physicians alike.

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Patients enter DIGMAs either by being directly booked into the DIGMA in lieu of an individual appointment (which provides much of their economic benefit) or by simply attending whenever they have

a question or medical need. Allowing patients to drop in often avoids the need to schedule an individual visit, improves accessibility, increases efficiency, adds continuity to the DIGMA, and provides a warm and compassionate side to medical care. Patients can be directly booked into DIGMAs in two ways: 1) by physician invitation during routine office visits, when the physician invites appropriate patients to have their next visit be a DIGMA group visit in lieu of an individual appointment; or 2) by a scheduler who telephones patients approved by the physician from their panel or waiting list who are either due or past due for a return visit, inviting them through a scripted message and follow-up letter to have their next visit be a DIGMA visit.

More than 9000 DIGMA patient visits have been recorded to date for the 32 DIGMAs co-led by the author with 31 specialty and primary care physicians at the Kaiser Permanente San Jose Medical Center and elsewhere around the nation. DIGMAs in oncology, nephrology, endocrinology (one endocrinologist had two DIGMAs), rheumatology, neurology, physiatry, obstetrics, gynecology (women's health), pediatrics, cardiology, family practice, and internal medicine have consistently worked well in actual practice during the past four years. The results have shown that DIGMAs work equally well in both primary and specialty care settings.

Because a DIGMA is primarily an extended medical appointment with one's own doctor held in a warm and supportive group setting, extensive medical care is provided during every DIGMA session: charts are reviewed; visits are documented through a progress note on each patient (which is largely preprinted and partially in check-off form so as to minimize charting time); vital signs are monitored; prescriptions are changed or refilled; medications and side effects are discussed; tests and procedures are ordered, and the results are discussed; referrals are made; medical questions are answered; treatment options are explained; routine health maintenance issues are addressed, and, when appropriate, brief private examinations and discussions are provided by the physician toward the end of the group session. Medical care is the central focus of DIGMA visits, and the physician plays an active role throughout the session.

DIGMAs are not meant to completely replace individual appointments, but instead to complement the judicious use of traditional office visits in order to achieve maximum value. In this way, patients such as the relatively stable, chronically ill and the "worried well," all of whom can be appropriately seen in a group visit, will be seen in a cost-effective and highly accessible DIGMA group visit. Conversely, patients needing individual visits can be seen individually, which should now be more accessible as a result of off-loading numerous individual office visits onto more efficient and cost-effective DIGMA group visits. Patients should always be reminded that participation in DIGMAs is completely voluntary and that it is meant to offer them freedom of choice. Patients are always welcome to have individual appointments, as before, even after they have attended a DIGMA session.

Profile of a Typical Digma Session

If you were to first walk into a typical CHCC group visit and then into a typical DIGMA session, you would immediately notice substantial differences. Although a DIGMA session usually begins with brief introductory comments by the behavioral health professional about the purpose of the group, its intended benefits to patients, and the importance of telephoning and preregistering a day or two before dropping into the group session, the focus then immediately shifts to the delivery of medical care—a focus which is maintained throughout the remainder of the group session. Initial socialization or education components can be present but typically aren't.

Because DIGMAs typically meet weekly and are only 90 minutes (including a few minutes for introductions and 10 to 15 minutes at the end of each group session for individual examinations), most of the group session is used for delivery of comprehensive mind-body medical care to all patients present. For this reason and because the physician and behavioral health provider are typically present throughout each DIGMA session, DIGMAs far more closely resemble a traditional individual office visit than a health education class, behavioral medicine program, or psychiatry group. Patients never confuse a DIGMA with a class or psychotherapy group.

Upon entering a representative DIGMA session, an observer would see a group of 12 to 22 members seated in a circular arrangement, along with the physician and the behavioral health professional, who typically sit together with a small table between them upon which medical charts, forms, and any handouts are stacked. The medical assistant or nurse, who arrives 15 minutes early, would be calling patients out of the group one at a time at the beginning of

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the session in order to take vital signs and perform other important duties—such as pulling and partially completing the patient information section of lab slips and referral forms for preventive tests and medical services which are due or past due (this tactic minimizes the amount of physician time required during group to complete the forms and make these referrals). Although DIGMAs can be designed as heterogeneous, mixed, or homogeneous models,[2] they are typically attended by a heterogeneous mix of patients in terms of age, sex, diagnosis, marital status, race, utilization behavior, etc. (although they would be relatively homogeneous as to diagnosis in the mixed and homogeneous DIGMA models).

Introductory comments about the group are followed by a request for patients to introduce themselves one at a time with each saying whatever they would like by way of introducing themselves, starting with patients who have to leave early. However, everyone is asked to state what their medical condition is and what specific information or assistance, if any, they hope to obtain from their doctor today. They are assured that their doctor will answer all medical questions and will deliver most of the medical services normally provided during routine office visits, only at a more relaxed pace because more time is available in the group setting, where all can listen and learn. All present are invited to actively participate in this highly interactive format. A patient who volunteers to speak first starts the group, and the focus shifts sequentially from one patient to another in either a clockwise or counterclockwise direction. The physician might prefer to address patients in clusters according to diagnoses (eg, a neurologist might ask Parkinson's disease patients to speak first, followed in turn by patients with headache, seizure disorder, and stroke). When every patient in the room has spoken, a process which typically uses all but the last 10 to 15 minutes of group time, the physician leaves to provide brief private examinations while the behaviorist takes over nursing the group.

The DIGMA group consistently provides a highly interactive experience so that the physician, behavioral health professional, and others present in the group all actively help the patient being focused on at any given moment. The physician spends much of the time in group answering patients' medical questions, occasionally walking over to give a prescription refill to a patient, to provide a referral (ie, for a laboratory test, procedure, or medical service), or to perform a brief examination which can be appropriately conducted in group (eg, examination of thyroid, arthritic hand or wrist, swollen ankle, growth on the face, tennis elbow, skin rash on the arm or leg, or sore on the foot). Meanwhile, other patients offer encouragement and support, provide gentle confrontation when needed for noncompliant patients, and share relevant information and personal experiences—all of which can be helpful to the patient being focused upon.

This high degree of interaction between each patient and the physician, behavioral health professional, and other group members, combined with delivery of comprehensive mind-body health care, is a characteristic feature of the DIGMA model. Activities which can be appropriately conducted in the group setting are conducted during the DIGMA so that all patients can listen, learn, and respond. Issues of confidentiality are rarely, if ever, mentioned by patients, but any physician concerned about confidentiality could consider having patients sign at the beginning of each DIGMA session a full-disclosure consent form encompassing confidentiality.

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Patients and staff alike consistently report that they find DIGMA sessions lively, interesting, helpful, and a wonderful learning opportunity. Physicians report learning things about their patients that they never knew, despite often having seen them previously for years during individual office visits. Patients learn from the physician, the behavioral health professional, and other patients—often stating that they even learned answers to relevant questions that they did not know to ask because somebody else did ask.

The number of patients actually requiring an individual examination at the end of group is surprisingly small—typically one or two, and occasionally three or four. This finding supports the claim of various authors that most medical visits are driven by psychosocial and behavioral health issues rather than by medical need.[13-15] The reason that only a small percentage of patients require an individual examination at the end of group is that after their questions are answered and their various mind and body needs which can appropriately be attended to during the group setting are addressed, very few patients are left who actually need an individual examination.

Occasionally during the DIGMA session the physician spots a medical condition requiring a traditional individual office visit, which is then scheduled. When this referral occurs, the good news is that the office visit should be readily accessible because DIGMAs

permit many appropriate individual visits to be off-loaded onto DIGMA group visits, so that individual office visits eventually become more accessible to those who need them.

A goal of every DIGMA session is to end on time with all of the physician's duties completed. This includes writing a progress note for each patient present in the group, which is typically done in group as each patient is being focused upon. Accomplishing this end requires discipline, coordination between the physician and the behavioral health provider, and a certain amount of experience in running the DIGMA. In so doing, the physician leaves the DIGMA session back on schedule, even if the physician entered the group late—which is but one of the many physician benefits that a well-run DIGMA can offer.[7]

How DIGMAs Provide Cost Savings

The CHCC and DIGMA group visit models have been shown to provide substantial cost savings. Because of the different focuses of these two group visit models, their financial benefits to the health care organization have been correspondingly evaluated in different ways.

Some of the financial benefits provided by the DIGMA model can be measured directly by evaluating the degree to which the model leverages existing staffing resources, a strategy which can solve access problems without hiring additional staff. The DIGMA model has been shown to dramatically leverage physicians' time,[12,13] and its implementation can be converted to cost savings based upon the lower staffing levels required to provide good service and care. In addition to off-loading many individual appointments onto more cost-effective group visits, DIGMAs also excel in addressing the behavioral health and psychosocial issues which drive such a large percentage of all medical visits.[17-19] Addressing mind as well as body needs during a medical visit decreases utilization of medical resources.

Because DIGMAs are readily accessible, patients often drop into a DIGMA any week that they have a question or medical need instead of scheduling an individual office visit, demanding an urgent work-in appointment, complaining about poor access, or telephoning with a question. This practice saves money through both reduced individual office visits and decreased phone call volume. In addition, patients can be taught during DIGMAs by the physician, the behavioral health professional, and other patients to more appropriately use the emergency department and other inpatient and outpatient services. Because DIGMAs are specifically designed to handle many of the most difficult, time-consuming, psychosocially needy, and inappropriately high-utilizing patients in the physician's practice, such patients can often be better treated and with less cost in the more effective format of a DIGMA group visit, where mind as well as body needs can be met.

DIGMAs represent best use of staff and budget. They increase physician productivity and efficiency, provide many economic and patient care benefits, offer the competitive advantage of a new service which is much appreciated by patient-customers, and reduce costs by leveraging existing staffing. A properly run and adequately supported DIGMA program can substantially and positively impact a health care organization's bottom line while simultaneously creating happier patients and physicians. Happier patients and physicians translates into better retention of both patients and staff—an additional cost savings. DIGMAs increase value by providing high-quality medical care with excellent access and service at reasonable cost in a warm, supportive group atmosphere which is enjoyed by patients and physicians alike. Because they optimally balance the needs of patients, physicians, and health care organizations, DIGMAs provide a "win-win-win" situation and, as a result, are expected to play an increasingly important role in the future of health care delivery.

The DIGMA model has been shown to dramatically leverage physicians' time ...

Advantages of the DIGMA Model

DIGMAs are specifically focused upon improving primary and specialty care access through the use of existing resources and upon enabling physicians to better manage their large patient panels. Access has become a national problem. Physicians are already working as hard and efficiently as is possible, so that this access problem cannot be solved by simply having physicians work longer or harder—any "fat" which may have existed here has long since been removed. What is needed is a tool which will enable physicians to substantially leverage their time so that they can see dramatically more patients in the same amount of time while also providing excellent service and high-quality medical care which is satisfying to patients and physicians alike. The DIGMA model provides precisely the right tool for this purpose. DIGMAs have been shown to use existing resources to improve access by rapidly reducing return appointment backlogs at both the individual physician[10] and the departmental[11] levels.

Because they provide patients with the prompt access, quality health care, and increased time they want with their own doctor, DIGMAs increase both patient satisfaction and patients' perception of quality of care. Patients appreciate the fact that DIGMAs comprehensively address the totality of mind-body needs they bring to the medical visit. This view contrasts with that engendered by individual office visits, which often make patients feel rushed and which might not provide enough time to address a patient's physical medical needs, let alone psychosocial needs. One indication of the degree to which DIGMAs have been meeting patients' needs occurred shortly after both rheumatologists at the Kaiser Permanente San Jose Medical Center started their Rheumatology DIGMAs, when a previously successful fibromyalgia and chronic fatigue syndrome program in the Division of Behavioral Medicine failed due to a complete loss of census. The reason given was that these patients preferred attending their rheumatologist's DIGMA whenever they had a question or medical need.

Consider the noncompliant patient, whose needs are often poorly addressed during traditional, individual office visits. The information, encouragement, support, and gentle confrontation provided by other members in the group and by the behavioral health professional increases patient compliance with recommended treatment regimens. It is amazing how influential another patient who has already benefited from the recommended treatment or lifestyle change (dietary compliance, initiating insulin, undergoing chemotherapy, starting dialysis, smoking cessation, etc) can be in relieving the noncompliant patient's anxiety about the treatment and in persuading the resistant patient to comply with recommended treatment by confronting them with the long-term consequences of noncompliance.

Individual appointments need no longer be largely occupied by either worried well or relatively stable, chronically ill medical patients requiring much professional hand-holding and contact with the physician. Such patients can be more efficiently and cost-effectively handled through DIGMA group visits and with better care because both mind and body issues are effectively addressed and closer follow-up care is made available. Because of the added help from the behavioral health professional and the group itself, DIGMAs provide an efficient and effective means of dealing with many of the physician's most problematic patients, all of whom the physician is encouraged to invite to the DIGMA. This includes patients who are difficult and time-consuming; noncompliant; inappropriately high utilizers of health care services; angry, depressed, or anxious; demanding or distrusting of their health care; experiencing extensive psychosocial needs; lonely or lacking social support; or having excessive needs for information, reassurance, or contact with their physician.

DIGMAs represent a biopsychosocial model[20,21] for treating both mind and body needs, including anxiety and depression, which are known to be underdiagnosed in medical settings.[22] DIGMAs excel in treating the behavioral health and psychosocial issues known to drive such a large percentage of all medical visits (with estimates running as high as 60% and more).[17-19] DIGMAs also treat caregiver and family issues: Family members and caregivers are invited to accompany patients to DIGMA visits because illness impacts loved ones as well as patients.

Improved access as well as increased patient and physician professional satisfaction are certainly among the great strengths of the DIGMA model which have been consistently demonstrated in actual practice.

Improved access as well as increased patient and physician professional satisfaction are certainly among the great strengths of the DIGMA model which have been consistently demonstrated in actual practice. DIGMAs which are carefully designed, properly run, and adequately supported result not only in high levels of patient satisfaction but also in increased physician professional satisfaction as each DIGMA is customized to the particular needs, goals, practice style, and patient panel constituency of the individual physician.

Physicians appreciate being able to better manage their burgeoning panel sizes and to regain control over their practices while delivering a more satisfying level of care and enjoying improved relationships with their patients. They like the more relaxed pace of DIGMAs, the reduction in repetition of information, the opportunity to try something interesting and different, and the collegial interaction with the behavioral health professional. Physicians also appreciate the ability to respond effectively in DIGMAs to angry or demanding patients and to have more compliant patients. Because of the many benefits DIGMAs offer, they are already beginning to gain acceptance and recognition for the role that they can play in delivering health care.[23-26]

The physician and his or her panel of patients directly benefit from the increased efficiency and quality of care that DIGMAs offer. Because DIGMAs enable physicians to better manage their large patient panels and offer many other physician benefits,[8] DIGMAs are "owned" by the physicians running them. DIGMAs ensure that no invisible or orphan program exists without strong physician ownership and sup-

port, as could be the case for some group programs (such as for hypertension, diabetes, asthma, irritable bowel, etc), where only a comparatively small percentage of the physician's panel is covered (often their easier patients, whom physicians may prefer to see individually for that very reason).

Additional strengths of DIGMAs include the following:

- Instead of repeating the same information with different patients as is done in individual office visits, the physician can address the entire group at once (and in greater detail because of the greater time available). They all can listen and learn, focusing on such issues of common interest as the information and misinformation which patients glean from the media, the Internet, friends, and direct advertising by pharmaceutical companies.
- DIGMAs improve not only patient and physician professional satisfaction but also physician-patient relationships. Patients can see their physician be more relaxed—they even joke and laugh together—and physicians get to know their patients better as people and not just as patients.

The prompt access without barriers which DIGMAs provide, when coupled with the relaxed pace and support of other group members (which makes the group feel safe to patients), sometimes results in patients opening up more in group than in office visits. The result is that physicians occasionally detect very serious and even life-threatening conditions which would otherwise have gone unnoticed. This detection often happens because the patient is minimizing or denying their symptoms. Consider the patient who dropped into an endocrinology DIGMA requesting a prescription for glasses, almost apologizing for being there and stating that he would not have bothered to come in if it were not for the fact that he was able to simply drop in without an appointment. Because fingerstick blood glucose levels were routinely measured for all diabetics attending the endocrinology DIGMA, his blood glucose level was discovered to be extremely high (49.9 mmol/L), and he was immediately given emergency care. Another patient, who had been quiet throughout most of the session, spoke up in another DIGMA when other patients were complaining about the fatigue they were experiencing, stating that he needed a pep pill. When asked why, he explained that he became extremely fatigued with even minor exertion and that when he lay down to rest, he felt like an elephant was stepping on his chest. What he received was an urgent cardiac evaluation, not a pep pill!

Disadvantages of the DIGMA Model

One weakness of DIGMAs is that they have some support needs which, while modest, must be met if the DIGMA model is to be successful. Most important is the fact that for larger group practices and managed care organizations, a highly skilled champion who is very knowledgeable of the DIGMA model is needed to move the entire DIGMA program forward throughout the facility. Second, a behavioral health professional trained by the champion is needed to take over each of the DIGMAs the champion has established. In each case, the behavioral health professional must be well matched to both the physician and the patients attending the DIGMA.

Most DIGMAs also require a nurse or medical assistant and a scheduler. The primary requirement for the medical assistant or nurse is willingness to work hard, both in terms of seeing the larger volume of patients which DIGMAs entail and in terms of the expanded responsibilities which need to be assumed. Similarly, a scheduler trained by the champion must be provided for most DIGMAs with adequate dedicated time each week (as much as four hours) to maintain the desired census level by telephoning enough patients selected by the physician with a scripted message and then sending them follow-up letters containing all important details on the DIGMA.

Clearly, any innovative health care delivery program which differs as much as the DIGMA model does from the format of traditional office visits requires a high level of administrative commitment and support. As is the case for all group programs, there are also certain facilities requirements. In particular, DIGMAs require a comfortable group room of sufficient size with an examination room located nearby. In addition, the DIGMA model requires that each physician running a DIGMA for his or her practice take approximately 15 to 30 seconds during routine office visits to invite all their appropriate patients to have their next visit be a DIGMA visit. A small one-time expense must also be budgeted for at the beginning of each DIGMA to provide the professional-appearing framed wall posters and program description flier holders to be mounted on the walls of the physician's lobby and examination rooms. Because DIGMAs differ dramatically from the traditional one-on-one office visits patients have

In each case, the behavioral health professional must be well matched to both the physician and the patients attending the DIGMA.

come to expect, in order to obtain patient buy-in, all marketing materials must be of high quality so as to accurately reflect the quality of care which DIGMAs do in fact provide.

Finally, it is important to note that DIGMAs work best for routine return appointments with the worried well, patients with extensive informational and psychosocial needs, and patients experiencing relatively stable chronic health problems who require mind-body care, more time with their physician, periodic surveillance and monitoring, or closer follow-up care. DIGMAs are not meant for initial evaluations, one-time consultations, inpatients, most medical procedures (although the rheumatologists are considering offering some of their simpler injections toward the end of their Rheumatology DIGMA sessions), highly contagious illnesses, medical emergencies, rapidly evolving medical conditions, lengthy individual examinations, many acute illnesses, or patients refusing to attend group visits.

Many patients report that they actually prefer and get more out of their DIGMA visits than from traditional individual office visits.

With regard to patients refusing to attend DIGMAs, an interesting observation has been repeatedly made. As time passes, patients who initially refuse the DIGMA will often later be persuaded to attend after hearing other patients in the physician's waiting room discuss how much they enjoyed and got out of their recent DIGMA visit. Sometimes patients who initially refuse the invitation to participate will eventually consider attending a DIGMA after being invited several times by their physician during routine office visits. On rare occasion, patients have mistakenly come to a DIGMA session with the misunderstanding that it will be an individual appointment. In this case, they are given the option of staying for the group or being seen immediately by the physician in private in the adjacent examination room. Such patients will often choose to stay out of curiosity to see what the DIGMA is all about. In any case, after a patient does attend a DIGMA session, he or she almost invariably is won over to this new approach and is then open to returning whenever there is a medical need. Many patients report that they actually prefer and get more out of their DIGMA visits than from traditional individual office visits.

How Group-Visit Models Can Work Together

Although the CHCC, Specialty CHCC, and DIGMA models individually offer their own distinct advantages in terms of reduced costs and increased efficiency, productivity, service, quality of care, and both patient and physician professional satisfaction, these models can operate together to provide even greater benefits than they could alone. The authors feel that optimal value can only be achieved in the future delivery of health care when the best possible mix of efficient group visits (using group-visit models which have been demonstrated to be effective in actual practice) and traditional individual visits is offered. Then patients who can appropriately be treated cost-effectively in group visits can be efficiently seen in group while individual visits can be used judiciously for patients truly needing them.

To fully capture the potential economic and patient care benefits which group visits can provide, all group visit programs must be carefully designed, properly run, and adequately supported. If, in the rush to roll out a group visit program, group practices and managed care organizations hurriedly launch poorly planned, inadequately supported DIGMAs or CHCC groups with flawed implementation strategies, their multiple potential benefits will never be completely realized.

As a means of fully achieving the many benefits that the DIGMA, CHCC, and Specialty CHCC models can conjointly offer, consider the following illustrative example of fully integrated care. First of all, every primary and specialty care provider at the group practice or managed care organization who wants a DIGMA would have one for their practice as a means of better managing their patient panel, leveraging their time, solving their access problem, providing comprehensive mind-body care, and increasing both patient and physician professional satisfaction. In addition, the facility would have numerous CHCC and Specialty CHCC group visit programs for managing high-risk patient populations both in terms of utilization behavior (eg, CHCC programs for high-utilizing geriatric patients) and by diagnosis (population management programs based upon the Specialty CHCC model for diabetes, hypertension, asthma, hyperlipidemia, depression, anxiety, fibromyalgia, irritable bowel, congestive heart failure, etc). Then any patient seen in a physician's DIGMA who needed further help for their particular health problem could be efficiently referred to the appropriate CHCC or Specialty CHCC group or to an individual office visit, when appropriate. Conversely, when appropriate, patients seen in CHCC and Specialty CHCC groups could be encouraged to have their next medical visit with their doctor be a DIGMA visit. In this way, all patients who could best be seen in a group visit would be—thus, capturing the in-

creased efficiency, improved service and quality of care, and reduced cost which group visits can offer. In this schema, individual office visits would be reserved for those patients who need them.

This vision for optimizing value in health care delivery through the integration of the various group-visit models with individual office visits would involve substantial alteration in: the long-range business plan; allocation of funding; staffing resources; facilities planning; and the way in which future mainstream medical care will be delivered. Nonetheless, what is being proposed is achievable and can result not only in improved access, dramatic cost savings, and more efficient utilization of existing staffing resources but also in substantially improved service, quality of care, and patient and physician satisfaction.

Concluding Comments

Continuity of care is a recurring theme for most managed care organizations.[27] Its benefits need no elaboration. Continuity presupposes physician retention as well as member retention. Primary care physicians as a whole are not a happy group, and turnover rates in some organizations are alarming. The professional satisfaction derived from a job well done is a major part of physician satisfaction with the CHCC and DIGMA models, yet control issues loom large for physicians in managed care. DIGMAs provide some degree of control in the management of large patient panels, and such increased control in and of itself is a positive development for the physicians. In addition, both group models provide some variety in an often tedious workday. This is especially true in an environment where hospital and emergency department duties have been assumed by dedicated teams of hospitalists and emergentologists. Satisfied physicians create satisfied patients either in the group model or in the traditional dyad. Satisfied physicians and their patients stay in the organization. Continuity is enhanced.

Next, consider panel management. About half of a panel of patients could be candidates for group visits of some type, and this percentage is expected to grow in the future as patients become more familiar with the benefits of group visits. Experience shows that the other half prefers the traditional physician-patient dyad, at least at this time, even though satisfaction with that model is in decline. This situation presents the individual physician with some potentially wonderful options for better managing their panels through group visits. However, in a fully capitated system, a physician's panel size must be fixed for any physician to even consider the benefits of group visits. If the reward for efficiency is a correspondingly larger panel and no commensurate increase in reimbursement (either in time or dollars), then innovation is improbable from the outset. If, however, group visits are appropriately recorded and everyone in the organization participates in some way, then group appointments will increase access and efficiency, improve service and quality of care, enhance patient and physician satisfaction, more efficiently utilize existing resources, and reduce the cost of health care delivery—and all this while providing more time for effective and fulfilling physician-patient relationships.

An effectively integrated system of CHCCs, Specialty CHCCs, DIGMAs, and traditional individual office visits can provide a "win-win-win" for patients, physicians, and managers of health care. CHCCs and DIGMAs provide useful tools in helping to manage the ever-increasing demand for specialty and primary care services through the use of existing resources. We offer them for consideration to group practices and managed care organizations as exceptionally helpful tools for confronting the access, service, quality of care, and economic challenges facing them in today's rapidly evolving and highly competitive health care environment. ❖

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On Being Ill

There is, let us confess it (and illness is the great confessional), a childish outspokenness in illness; things are said, truths blurted out, which the cautious respectability of health conceals.

Virginia Woolf,
On Being Ill, The Moment (1947)