

Preface

The Top 23 Reasons Why Group Visits Will Make You a More Effective Healthcare Provider:

1. Prompt access
2. More time with your patients
3. Increase productivity 200–300% or more
4. Improve revenues, RVUs, and the bottom line
5. Better manage busy, backlogged practices
6. Stop repeating yourself with one patient after another
7. Help of a documenter and multidisciplinary team
8. Eliminate physician downtime due to no-shows
9. Reduce double bookings, patient complaints, and phone calls
10. Grow practice size and get new patients into the system
11. Open up more time for surgeries and procedures
12. Open up practices that are currently closed
13. Max-pack visits and provide patients one-stop healthcare
14. Improve quality metrics and clinical outcomes
15. Increase patient education and disease self-management
16. Better address mind as well as body needs
17. Efficient management of chronic illnesses
18. Improve customer focus of the organization
19. Tool for better handling difficult, time-consuming patients

20. Reach out to the poor and underserved cost-effectively
21. Improved patient–physician relationships
22. Greater patient satisfaction
23. Improve physician morale—group visits can be fun!

I truly believe that this book can make a major difference not only in doctors' practices and patients' lives, but also in addressing many of today's most important healthcare challenges. Well-run group visits afford patients prompt access and more time with their own provider while simultaneously packing as much medical care as possible and appropriate into every patient visit. They enhance the patient's healing experience while offering high-quality care and integrating the help and support of other patients (plus a multidisciplinary team) into each patient's healthcare experience.

When properly run, group visits can increase efficiencies, grow revenues, and enhance the bottom line (plus accomplish all this while providing an excellent venue for reaching out to the poor and underserved, including Medicaid and Medicare patients). They help busy, backlogged providers to better manage their practices and meet the needs of their chronically ill patients. They can also increase patient as well as physician professional satisfaction—plus, rejuvenate you by bringing some joy back into the practice of medicine.

Why I Developed Two of Today's Three Major Group Visit Models

I am often asked what led me to conceptualize and develop two of today's three major group visit models. This question is frequently posed by individuals concerned that, because I developed the Drop-In Group Medical Appointment (DIGMA) model at a large staff model HMO, my intent was to make physicians work harder and earn the organization more money. Actually, nothing could be further from the truth! To the contrary, it was my life-altering experience as a patient suffering from a serious illness—coupled with my professional experience in working with the psychosocial and emotional needs of thousands of medical patients struggling with advanced chronic diseases—that caused me to dedicate my life to this purpose.

I developed DIGMAs as a seriously ill patient who, despite having the best doctors that anyone could hope to have, was so dissatisfied with our broken healthcare delivery system that I felt

there just had to be a better way. Simply put, I found medical visits to be too inaccessible and too rushed—often waiting months to get an appointment, just to find myself all too frequently waiting an additional hour or more in the lobby and exam room. Too often, I found that my 15 min office visit was actually more like 6–9 mins of direct face-to-face contact time with the doctor—much of which was spent by the physician looking at my medical chart. I often left visits with the unfortunate realization that: “Oh no, I forgot to ask the doctor about”

In addition, the poor doctor (after spending the whole day on the treadmill of individual office visit care that always seemed to be going faster and faster, requiring evermore patients be seen in less time) often entered the exam room looking worse than I felt—and I felt terrible! Eventually, there came a time when I told myself to buck up, quit complaining, and figure out what I wanted most out of my medical visits. My three answers were *prompt access*, *more time* with my own doctor, and the *help and support of others* who could truly understand.

Between 1988 and 1992, I was very ill, eventually being diagnosed with primary pulmonary hypertension due to pulmonary vascular disease with a patent foramen ovale—although, during the ensuing years and for unknown reasons, I began to gradually improve. I was at my sickest in 1990 at only 47 years of age. My highly volatile blood oxygen dropped as low as 43% and, at my worst, I found myself absolutely exhausted and lying in bed for days sweating like I had just run the Boston marathon when I was just struggling to catch my next breath. There were times when my beloved wife, Janet, would have to change my linens and pajamas as many as eight times in a single night because they were so drenched with sweat.

I had begun to episodically go into A-fib for prolonged periods (which sometimes lasted for days), experience deleterious structural changes in my heart and lungs, and feel chronically fatigued—and eventually even had a stroke. For several years, I was fatigued, hypoxic, sweating profusely, short of breath, and hospitalized all too frequently. On top of all this, I was later diagnosed with prostate cancer.

Before 1988, I had been in excellent health, able to run 4 miles in under 25 min, and capable of taking day-long 100 mile bicycle rides in the coastal mountains of California. I was married and the father of 3 cherished young children (4- and 6-year-old sons, Michael and Kenny, and my 5-year-old daughter, Angie). By 1990, I was concerned about



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my rapidly deteriorating health and very worried about what was going to happen to my family. I found myself yearning to talk to someone about my health problems, but did not want to burden my family and friends—most especially my wife, who was already exhausted taking care of 3 little children and her father, who was dying of advanced cardiovascular disease and end-stage prostate cancer.

I found myself waking up with a jolt at 3 o'clock in the morning feeling cheated, worried, alone, and asking "Why me, God?". It dawned on me that I was having the same types of thoughts and feelings as the thousands of patients with advanced diseases of all types that I had worked with during the previous decade and a half as Director of Oncology Counseling and Chronic Illness Services at the Kaiser Permanente Medical Center in Santa Clara, California. Having worked with so many patients experiencing a wide array of serious diseases (and having found that they were struggling with the same types of emotional issues as I now was), I felt that other patients could truly understand.

In fact, these issues (anxiety over an uncertain future, not wanting to be a burden to family and friends, the sense of loss due to being ill, etc.) seemed to be universal and almost independent of the specifics of one's disease. They seem to have more to do with having an illness than to the particulars of the specific illness that one happens to have.

As a result, I felt that other patients (even those who did not happen to have the same illness as I had, which was quite rare and rapid in its progression) who had some sort of medical condition would be able to understand, empathize, and be compassionate. I came to realize first-hand that patients experiencing chronic illnesses had *mind* as

well as *body* needs. I found that these psychosocial needs could often be better met (in a patient-centered and holistic manner) through the help and support of other patients and a skilled multidisciplinary care delivery team integrated into their healthcare experience.

I gradually began to ask myself exactly what *prompt access*, *more time* with my own doctor, and the *help and support of others* would actually look like. First and foremost, I wanted prompt and barrier-free access to high-quality care that involved max-packed visits and a one-stop healthcare experience. In terms of prompt access, I decided that what I really wanted was to be seen within a week whenever I had a medical need—and with no barriers to care whatsoever (meaning that I could even *drop in* if I had a last-minute medical issue).

In addition, I wanted more time with my own doctor, plus a more relaxed pace of care. When I asked myself just how much time I wanted with my doctor, I thought that 90 min would be just about right—which even now causes me to chuckle at the absurdity of the idea!

In terms of the help and support of other patients (as I felt they could really understand), I asked myself: “How many patients?” I thought that 10–15 would be about right—which, from my extensive group experience as a psychologist, seemed to be an ideal group size for a lively, energized, and highly interactive group.

This is how I gradually came to conceptualize the basics of the DIGMA model—90 min weekly sessions with one’s own doctor (where patients could even drop in whenever they had a medical need) held in a supportive group setting with 10–15 of the doctor’s other patients and a multidisciplinary care team. I felt that a highly skilled and specifically trained multidisciplinary care team that focused upon helping both patients and the doctor could be most beneficial in making this model work. It also explains why I am so passionate about group visits—and why my family and I so often choose them over traditional office visits for our own medical care. When properly done, they offer patients a better, more comprehensive, and highly accessible healthcare experience—one that addresses both mind and body needs, provides an additional healthcare choice, and increases both patient and physician professional satisfaction.

From the very beginning, my goals were to: provide prompt access and more time; max-pack visits and create a one-stop healthcare experience; integrate the help and support of other patients into each person’s care experience; and better serve our patients by making their medical visits everything that they could be. I envisioned

that the focus of the DIGMA from start to finish would be upon the physician's efficient delivery of high quality medical care, which would sequentially address the unique medical needs of each patient individually in a supportive group setting—i.e., where all present could listen, interact, share experiences, ask questions, and learn.

I also wanted the multidisciplinary team to off-load as much as possible from the physician's shoulders, including documentation and all nursing duties—so as to free the doctor up to focus on the delivery of high-quality, high-value medical care to each and every patient attending the group. I also wanted a behaviorist, such as a psychologist or clinical social worker, to manage the group and better address patients' psychosocial needs. In short, my goal was to make DIGMAs singularly patient-centered and optimally helpful to myself as well as other patients.

Who Should Read This Book?

Healthcare executives, clinical leaders, administrators, and primary as well as specialty care physicians and allied health providers interested in seeing a properly designed and run group visit program implemented within their own practice or healthcare system will find this book indispensable. Frontline administrative and operations personnel (as well as anyone interested in learning how to become a champion, program coordinator, behaviorist, nurse or MA, documenter, care coordinator, or dedicated scheduler for the group visit program) will find this book to be both essential and a definitive implementation and operational manual on group visits.

The Intent of This Book

The intent of this book is not to convince readers to run group visits in their practices, but rather to present the information they need in order to make their own decision as to whether or not group visits are a good fit for them. For those who do choose to run group visits in their practices, this book provides the information and tools that they need to design, implement, and evaluate them correctly. Furthermore, this implementation manual will enable them to do so while: avoiding

the frustration of making common beginner's mistakes; systematically addressing operational challenges; and maximizing their likelihood of success. In short, the intended mission of this book is to help you to create an effective community of caring for your patients so that they can get better together, feel less fearful and isolated, and experience greater hope, dignity, and empowerment—and to accomplish all of this efficiently and cost-effectively with prompt access and high-quality care.

Additional Resources

Due to the multiple benefits that properly run group visits can offer to patients, physicians, healthcare organizations, insurers, and corporate purchasers alike, the literature on group visits is already quite rich and is rapidly expanding. It is important to note that this book is specifically focused upon how to correctly design, support, implement, run, and evaluate successful group visits in your practice. For those looking for a more comprehensive textbook on group visits, including detailed lists of references and numerous outcomes studies (plus a more in-depth discussion regarding the various group visit models, chronic disease management, and avoiding potential abuses of group visits), please refer to my earlier book, *Running Group Visits In Your Practice*, which was published by Springer in 2009.

It includes an attached DVD with key training videos by the author (for example, a medical grand rounds presentation on group visits, a behaviorist training video, and a *mock DIGMA* that was made just prior to launching one physician's new DIGMA program). In addition, this DVD contains examples of all important forms and promotional materials needed for running a successful group visit program—wall posters, program flyers, announcements, invitations, Patient Packets, statement of work, chart note templates, patient satisfaction forms, confidentiality releases, etc.

This DVD should prove most helpful in assisting readers to expeditiously develop their own group visit forms and promotional materials based upon what other integrated healthcare delivery systems are already using—thus streamlining the entire process, saving countless hours relative to starting from scratch, and enabling them to optimize the quality and effectiveness of their forms and

promotional materials. Also, as a reader, you are invited to my website, www.GroupVisits.com, for ongoing dialog and further information on group visits and how to successfully implement them in your practice. Finally, readers are welcome to contact me by e-mail at TheDIGMAmodel@aol.com.