



The CAHPS Ambulatory Care Improvement Guide

Practical Strategies for Improving Patient Experience

Section 6: Strategies for Improving Patient Experience with Ambulatory Care

6.M. Group Visits

To download the Guide's other sections, including descriptions of improvement strategies, go to <https://cahps.ahrq.gov/quality-improvement/improvement-guide/improvement-guide.html>.

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6.M. GROUP VISITS

6.M.1. The Problem

Dissatisfaction with how providers communicate can arise when people need more attention, support, and information from the health system than they are getting. But in a typically brief office visit, clinicians do not have the time to cover everything the patient may need to know or to discuss all of their concerns (including problems with self-management.) As a result, the patient may feel that no one is listening or making the effort to explain things clearly. While the patient may be receiving various services, many of his or her needs are being missed.

This problem is particularly common for patients with chronic conditions, who are often struggling to understand how to control and live with their disease. A frequent consequence is that these patients become “high utilizers” of the health care system, particularly of emergency departments and urgent care centers—which tends to make them even less satisfied with their health care experience and more likely to have poor outcomes. These visits occur in part because the system of care does not provide patients with the tools, support, and information they need to manage their health problems adequately.

6.M.2. The Intervention

Group visits are an important component of the Chronic Care Model. (Read about this model at

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.)

In essence, they are a form of outpatient care that combines medical care, patient education, and patient empowerment in a group setting. In a group visit, patients with a common condition (such as diabetes) meet as a group under the guidance of one or more clinicians; participation in this group becomes part of their regular clinical treatment. This model dates back to at least 1990 when John Scott, M.D., of Kaiser Permanente Denver created the Cooperative Health Care Clinic (CHCC) for groups of 25 chronic care patients, 65 and older, who were high users of health care.¹

6.M.3. Benefits of This Intervention

The benefits associated with group visits include:

- Reduced health care costs
- Greater patient and clinician satisfaction
- Patient empowerment
- Greater patient compliance

¹ Lippman H. Making group visits work. *Hippocrates* 2000;14(7).

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- Reduced repeat hospital admissions
- Fewer emergency room and sub-specialist visits²

As a response to increased pressure for clinician productivity, this format can be an efficient way for patients to have face-to-face contact with their provider, get educational content, and learn from the experiences of fellow patients without overly taxing the clinician's time. These groups provide social and psychological support for the participants and help motivate them to follow their treatment plan and to take more responsibility for their own health.² The clinician is spared the repetition of delivering the same educational message to multiple patients in traditional one-on-one encounters,³ while patients get to share valuable information and insights with one another about self-management and quality of life issues.

6.M.4. Implementation of This Intervention

There are several variations of the group visit concept. For example, in the model known as the drop-in group medical appointment (DIGMA), patients need not make prior appointments.¹

To learn about the various ways in which medical practices conduct group visits, go to <http://www.improvingchroniccare.org/downloads/groupvisitmodelcomparison.pdf>.

The implementation of group visits is not complex, but it does require advance planning and preparation. A few considerations are worth mentioning:

- First, choose an appropriate condition. Group visits are best suited for chronic illnesses, such as asthma, diabetes, arthritis, and obesity.³
- Think carefully about which patients to invite. The goal is to identify patients who seem in need of better care, better advice on self-management, and more support. One way to do this is to focus on high-utilization patients, who can often be identified through pharmacy and billing records.
- Keep the group a manageable size, perhaps 10 to 16 patients.
- Pay attention to who is leading the group visit. Physician-led groups can be more effective at reducing no-shows than groups led by nurses or other mid-level clinicians. Also, it is important to avoid the impression that group visits are a way for physicians to avoid time with the patients.
- Be sure to get the permission of participants to share information about them in the meeting. Also, discuss the confidentiality of personal health information during the meeting itself.

² *Improving Chronic Illness Care (ICIC). Group Visit Starter Kit: ICIC Tools for Improvement. 2002.* Available at: <http://www.improvingchroniccare.org/index.php?p=Toolkits, Manuals & Critical Tools&s=162> . Accessed June 2, 2008.

³ Masley S, Sokoloff J, Hawes C. Planning group visits for high-risk patients. *Fam Pract Manag* 2000;7(6):33-7.

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The meeting might last 2 or more hours and generally follows this format:

- Introductions
- Educational mini-lecture or discussion
- A break during which clinicians conduct clinical work (e.g., review medication refill needs, check blood pressures, and other clinical measures)
- A discussion or question-and-answer period

They often end with clinicians meeting one-on-one with patients who were identified as needing extra follow-up.

Barriers to conducting group visits include privacy concerns, resistance from patients who do not want to participate in a group, and practical issues like adequate meeting space and available personnel. For many practices, the only space large enough to hold a group of people is the waiting room. Some medical groups get around this problem by conducting the group visits in the evenings; other organizations sometimes seek out space in the community that may be more accessible and familiar to their patients.

Learn more in the Improving Chronic Illness Care (ICIC) program's Group Visit Starter Kit, available at

http://www.improvingchroniccare.org/downloads/group_visit_starter_kit_copy1.doc.

6.M.5. The Impact of This Intervention

Evaluations of group visits have found promising results:

- Randomized trials have shown that diabetic patients involved in group visits achieved better HbA_{1c} levels than patients in a control group.⁴ Other studies of group education in diabetes have also found that HbA_{1c} levels in the intervention groups were better than those of control groups; they also found evidence of improvements in patient self-care and satisfaction,⁵ self-efficacy,⁶ and body weight and non-fasting triglyceride levels.⁷
- In a study that compared a control group to a group of high users of HMO medical care who participated in group visits (all aged 65 and older with chronic conditions), the findings indicated that those in the intervention group were

⁴ Trento M, Passera P, Tomalino M, et al. Group visits improve metabolic control in type 2 diabetes: a 2-year follow-up. *Diabetes Care* 2001;24(6): 995-1000.

⁵ Sadur CN, Moline N, Costa M, et al. Diabetes management in a health maintenance organization. Efficacy of care management using cluster visits. *Diabetes Care* 1999;22(12): 2011-7.

⁶ Anderson RM, Funnell MM, Butler PM, et al. Patient empowerment. Results of a randomized controlled trial. *Diabetes Care* 1995;18(7): 943-9.

⁷ Kronsbein P, Jörgens V, Mülhauser I, et al. Evaluation of a structured treatment and teaching programme on non-insulin-dependent diabetes. *Lancet* 1988; 2(8625): 1407-11.

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more satisfied with their care; had lower care costs; and had fewer ER visits, sub-specialist visits, and calls to physicians.

Nurse contact (phone and in person) was higher among the group visit patients. Also, participating physicians were more satisfied with caring for older patients than comparison physicians who relied on standard one-to-one interactions with their patients.⁸

Read More About Group Visits

- Houck S, Kilo C, Scott JC. Group Visits 101. *Fam Pract Manag* 2003 May. Available at <http://www.aafp.org/fpm/20030500/66grou.html>. Accessed June 2, 2008.
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⁸ Beck A, Scott J, Williams P, et al. A randomized trial of group outpatient visits for chronically ill older HMO members: The Cooperative Health Care Clinic. *J Am Geriatr Soc* 1997;45(5):543-9.