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CONFERENCE ABSTRACT

Group Medical Visits for patients with chronic disease – innovative tool to improve patient's outcomes through inter-patient interaction and inter-patient empowerment

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Introduction: (comprising context and problem statement) The increase of patients affected by multiple chronic conditions requires a shift in health care delivery from acute episodic interactions towards continuous, proactive care. In order to be effective, chronic care needs to put the patients' personal needs, experiences and values are in the center of care delivery. Yet, interventions translating these policies into everyday care delivery are scarce and highly sought after by healthcare policy makers and health practitioners.

One answer to these imperatives are "Group Medical Visits" (GMV). GMVs are an innovative primary care intervention empowering and engaging chronically ill patients not only in their own care delivery. GMV have been recognized to be an effective and efficient tool improving outcomes for chronically ill patients, and to decreasing costs.

Short description of practice change implemented: Out of various GMV models, Cooperative Health Care Clinics (CHCCs), developed at Kaiser Permanente, is the most commonly one used. In CHCC the same 10-12 patients, affected by the same chronic disease, meet bi-monthly in a group session with their GP, instead of seeing him individually in one-on-one visits. Each CHCC session is composed of five phases conducted in the group setting, concluded by optional one-on-one patient-physician-time.

Table 1. Template CHCC model

Phase	Duration
Introduction / Warm up	~ 5-10 Minutes
Patient centered group discussion	~ 20-30 Minutes
Treatment	~ 30-50 Minutes
Questions and Answers	~ 10-15 Minutes
Closing and Planning	~ 5-10 Minutes
Brief one-on-one visits	as necessary

Aim and theory of change: CHCC reside on the facts, that patients have accumulated comprehensive disease specific knowledge and gained a wealth of problem solving skills and personal experience in how to overcome disease related challenges. By providing a supportive, physician guided peer group format for patients to exchange their individual knowledge, their "real-world-tested" coping strategies and their personal experience, CHCC aim to utilize and foster the patients' self-care capabilities and strengthen their health literacy.

Targeted population and stakeholders: Chronically ill patients were targeted to improve their ability to better self-manage and engage in their healthcare. Stakeholders are GPs as well as patients themselves, fostering…

…exchange of problem solving strategies and coping mechanisms for disease specific challenges
…motivation to alter hazard lifestyles
…dealing with psychosocial aspects of chronic care

Timeline:3 years

Highlights: (innovation, impact and outcomes)

Proven CHCCs outcomes:

patient satisfaction

physician satisfaction

quality of care

effectiveness and efficiency in care provision

Comments on sustainability: CHCC constitute an efficient alternative to one-on-one visits, as they require less physician time per patient.

Comments on transferability: Developed by Kaiser Permanente, CHCCs have now been successfully trialed in various integrated and non-integrated healthcare systems.

Conclusions: (comprising key findings) Aiming at supporting chronically ill to manage their conditions, to access and adapt coping strategies via peers affected from the same challenges, has been proven an effective tool. CHCCs…

improve user experience as chronic care is translated from episodic to continuous interactions with the primary care provider in a group setting with peers

improve health of chronically ill, by inter-patient exchange of knowledge and coping strategies

increase the efficiency of primary care provision by replacing one-on-one visit

Discussions: GMVs are not the panacea for chronic care delivery; however they are an instrument every GP should have in his "chronic care toolbox". CHCC support GPs to help patients self-manage effectively, improve health outcomes and avoid inappropriate usage of healthcare resources. They are an instrument to enable patients to make choices of treatment options, to alter hazard lifestyles, and to access coping strategies.

Lessons learned: Implementing GMVs to multiply self-care skills and enhance health literacy for the entire chronically ill patient panel at physician clinics requires change management and project management capabilities, which are not necessarily present in small independent GP practices.

Keywords: chronic care; supporting self-care; improving health literacy; patient empowerment

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