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Innovation in delivery of primary health care services for people with chronic disease: provider's perspectives on group medical visits

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Sabrina T. Wong, RN PhD, Josee Lavoie, PhD, Annette Browne, RN, PhD, Lily Farris, MA

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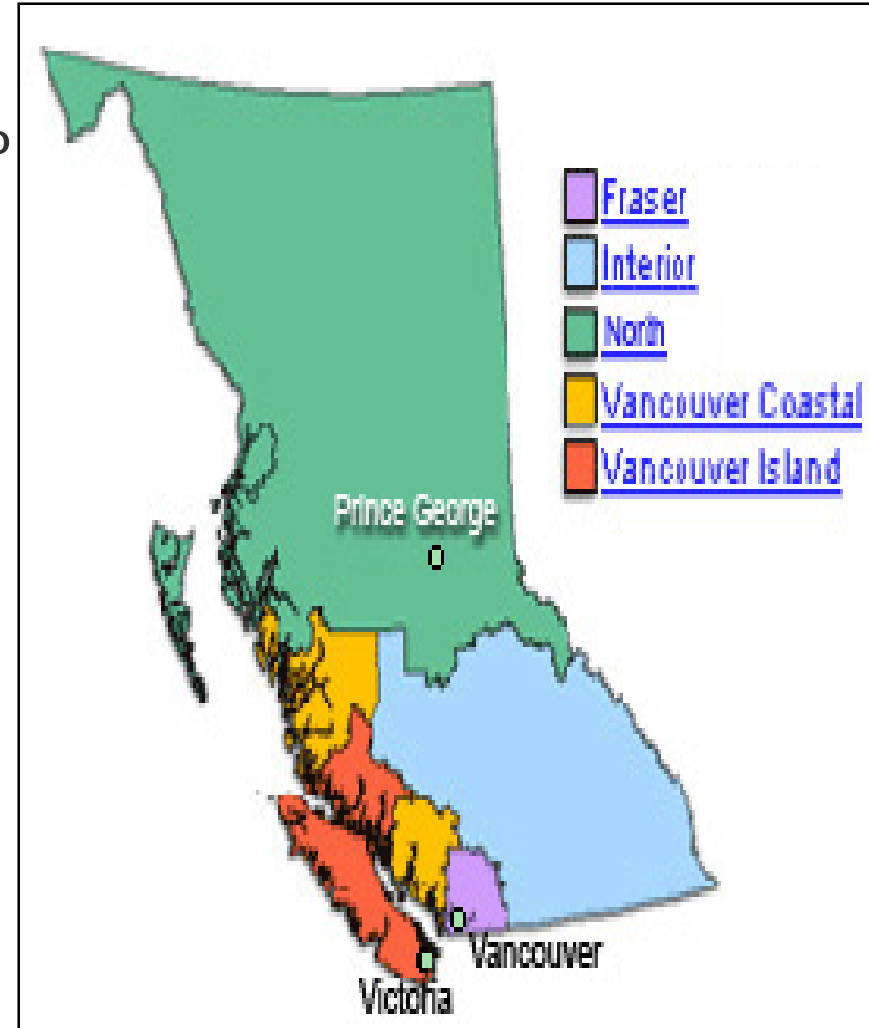
Team Members

- **Academic partners:**
 - UBC: Annette Browne, Lily Farris
 - UNBC: Josée Lavoie, Martha MacLeod
- **Decision-maker partners:**
 - Northern Health Authority: Cathy Ulrich, Dan Horvat
 - Impact BC: Judy Huska
- **Community partners:**
 - Northern primary care practices: Prince George, Fraser Lake, Quesnel, Masset, and Queen Charlotte City
 - First Nation Reserve communities: Skidegate and Old Masset. Stellat'en, Nadleh Whut'en and Nazko are interested.



The BC context

- Population – 4.36 million
 - ~14.2% age 65+ and ~4.0% age 80+
- Approx 4600 GPs, paid mainly through Fee-for-Service
- About 1 in 3 people have at least one chronic disease
- Challenges in maintaining supply and mix of health care professionals



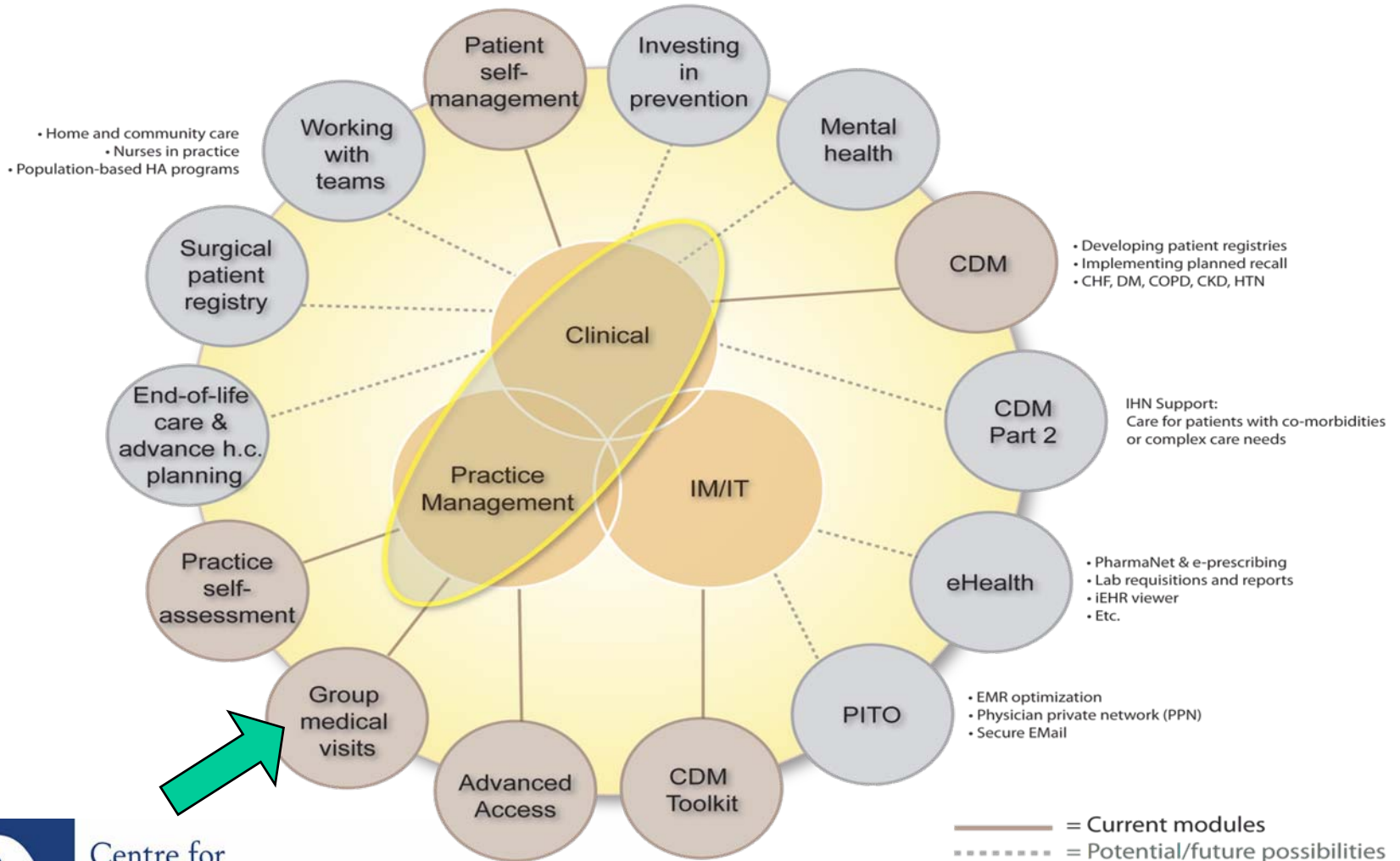
BC Practice Support Program- Primary Care Reform Continues

- ✓ A voluntary training program for GPs and MOAs – both are paid to attend
- ✓ 4 modules currently (Advanced Access, CDM, Group Visits and Patient Self-management)
- ✓ Major support provided by health authority teams in medical offices - working to expand the boundaries of primary care within each health authority.
- ✓ Uses FP and MOA champions to lead the work, network with peers and provide feedback.



Practice Support Program

Local support for GP's, Specialists, IHN's & Beyond



What are group medical visits?



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Methods

- Mixed-methods study, 3 years
 - Phase I: qualitative; in-depth interviews with providers delivering GMVs, patients attending GMVs (recently completed)
 - Phase II: quantitative; patient survey
 - » Patients attending GMVs (approx. 400)
 - » Patients not attending GMVs (approx. 400)



Methods (Phase 1)

- In-depth face-to-face or telephone interviews (60 minutes avg.)
- Recruited from various communities across NH, recommended by decision-maker partners/communities
- Interviews recorded, transcribed, and coded

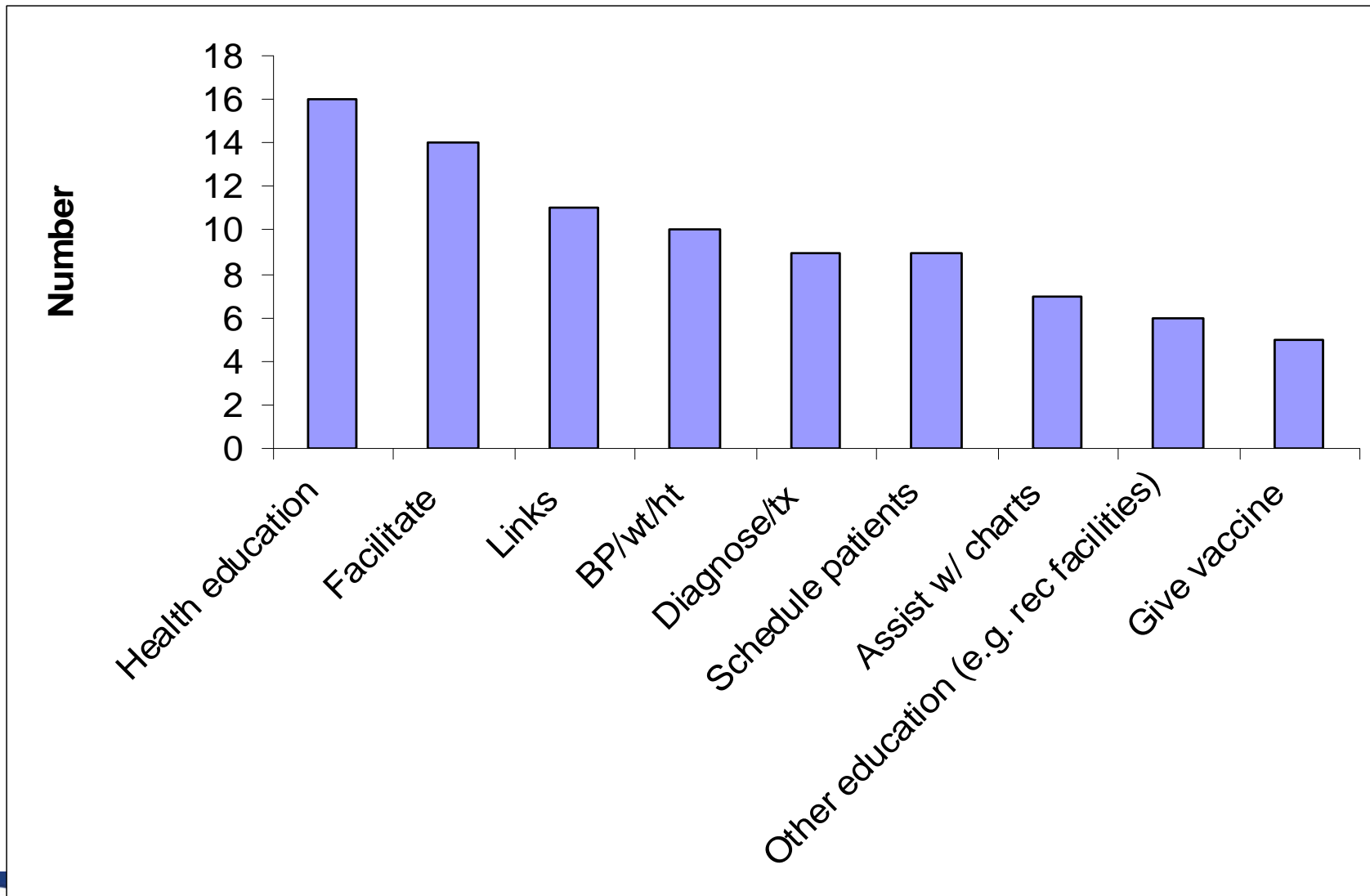


Results

- 30 in-depth interviews with providers
 - Included family physicians (n=10), nurse practitioners (n=2), registered nurses (n=5), PHC coordinators (n=4), and other health professionals (social worker, nutritionist (n=4)) and supportive services (medical office assistant (n=5)).



Results (con't)



Results (con't)

- Types of Group Medical Visits:
 - Shared Physical Appointments
 - Heterogenous (used for advanced access)
 - Homogenous (specific to one type of condition)
 - Diabetes, chronic pain, prenatal, smoking cessation, congestive heart failure



Patients gain additional Information

- “its interesting because sometimes we get two different opinions... one doc was in favor and one was very much against and so it was nice for those patients to hear the two sides of the story” [MD]
- “its gives people the opportunity to tell their story ...they can talk with their peers, other people who have similar problems, maybe look like them....so its gives them more power in that room, because there are more patients than providers” [PHC coordinator]



Providers gain additional information

- **There are things that come up in the group medical visit that would not come up in a one to one visit very easily, especially when I'm focused on completing the services that need to be done to take care of a particular condition. We might not focus so much on what's really going on at home..... a lot more history as well so people will bring up other associated things more readily [PHC coordinator, MD]**



Increased comprehensiveness of care

- “I think there’s been a lot more team work happening.. we talked a little bit about expanding the team to include different skill sets...everyone tries to work to their full scope.” (NP)
- “There’s more of it goes on between us (providers) outside of the group appointment as a result of doing these together” (PHC coordinator).
- “(We) make sure that they’ve got everything that completely addresses (their health concerns), I think it helps to reduce the need for repeat visits, for forgetting, for, you know, trying to book for sub sequential ones to get everything dealt with at once” (PHC coordinator)



“Group Effect” for Patients

- “What’s efficient is that you say it once and it affects all and then you also gather people’s experiences which is more information than you can get from one visit-- talking about hot flashes or libido... this sharing provides extra information in their context” [MD]
- “I know that issues were raised during those GMVs that prompted important follow-ups for a couple of people like issues that were I don’t know if they would have been addressed” [MD]



Providers are satisfied with their work

- What happens is its kind of a win all around because when you increase your productivity you increase access for patients. Your waiting times go down, patients like it, doctors like it, staff likes it and we're better able to meet the evidence based guidelines for different things because there's a team taking care of patients rather than a single provider...Its just worked out really, really well.... its really provided the clinic patients with lots of choice for different things. [MD]



Other findings

- Confidentiality not a major concern among most patients, when addressed appropriately by providers.
- GMVs are not for everyone—patients who have anxiety in like groups, hard of hearing, not fluent in English, dominating personality, extremely unique medical conditions, mental health issues, or have an acute medical condition (and should be taken to the ER).
- Effect of GMVs on patient health outcomes still unclear
- GMVs are an important part of practice redesign and primary care reform



Discussion

- Preliminary results
- New model of delivering PHC that is showing promise
- More work needs to be done with First Nation patients and those who do not speak English as a potential model for care delivery
- No Canadian published research on effectiveness of GMVs



Thank you!

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