An Improved Approach to Followup Care for the Urological Patient: Drop-in Group Medical Appointments

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Purpose: To increase prompt access to routine office visits the concept of the group appointment was developed in the primary care setting. Drop-in group medical appointments have been piloted at our department. We hypothesized that 1) efficiency could be improved by seeing 6 to 14 patients at 1 appointment, 2) access to appointment times would increase and 3) patient satisfaction would be enhanced with 60 minutes of didactic contact and discussion with the urologist.

Materials and Methods: Patients were invited to participate in a drop-in group medical appointment. Appointments were made based on sex and not on diagnosis. A 60-minute group teaching session was followed by a private 2 to 5-minute physical examination or further testing, as indicated. Confidential satisfaction surveys were administered to drop-in group medical appointment participants and patients seen at traditional individual (solo) appointments. Results were compared.

Results: From September 22, 2003 to August 30, 2004, 279 patients attended a drop-in group medical appointment. Mean patient age was 63 years and 142 patients were 65 years or older. Most diagnoses were prostate cancer, erectile dysfunction, benign prostatic hyperplasia, incontinence, neurogenic bladder and chronic discomfort syndromes. Of the patients 287 were surveyed, including 177 at drop-in group medical appointments and 110 at solo appointments. Patient satisfaction with the drop-in group medical appointment format was as high as that of solo patients with 87% of drop-in group medical appointment patients rating their experience as excellent or very good vs 88% by solo patients.

Conclusions: Drop-in group medical appointments can be implemented successfully in a urological practice with high patient satisfaction despite the sensitive nature of topics discussed. Ideal patients are those with chronic or complex conditions and those requiring repetitive discussions, such as elderly individuals.

Key Words: prostate, appointments and schedules, geriatrics, patient satisfaction, urogenital system

The delivery of quality care in a busy urology practice is a challenge. Decreasing Medicare reimbursements and increasing expenses only intensify this challenge, especially when seeing complex cases. With the growing numbers of patients in the urology clinic more efficient strategies to serve individuals will become a necessity. Multiple chronic conditions and numerous medications along with the psychosocial issues of aging make it difficult to meet the needs of many urological patients in the standard 15-minute office visit. Furthermore, geriatric patients are also frustrated by these suboptimal interactions. A recent study of Medicare beneficiaries showed that the most commonly reported reason to forego followup was the patient feeling that the physician lacked responsiveness to their concerns.[1] This was reported by patients as a greater deterrent to seeking health care than other, more tangible barriers, such as cost or transportation.

The question then arises of how to spend more time with elderly patients for education, discussion and support without the expense of additional office staff or physician burnout. Successful adjuncts to the office appointment, such as self-help resources[2,3] and support groups,[2–5] have helped other urological patients with chronic illnesses such as prostate cancer, erectile dysfunction or interstitial cystitis. However, these supplements do not offer increased time with the physician.

An approach to improving delivery of care and information to patients has been the conception of the group medical appointment. In early models of the group outpatient visit, such as the Cooperative Health Care Clinic in Denver, Colorado[6] and Stanford Health Partners in Palo Alto, California,[7] the 90-minute to 2-hour multidisciplinary session was developed for 8 to 12 patients at once. The setting provides more time for education and discussion facilitated by the physician. In addition, patients receive the benefits of information and emotional support through interaction with each other. Group visits are currently used at academic centers throughout the United States, including Stanford University,[7] the Cleveland Clinic Foundation,[8] University of Colorado,[9] Dartmouth and the United States Department of Defense. Such programs have been directly related to decreases in repeat hospital admissions and emergency care use in the elderly population.[6,9] Studies randomizing patients with diabetes to group or nongroup visits showed that patients in groups had lower HbA1c, higher high density lipoprotein cholesterol, a lower body mass index and fasting triglyceride, improved knowledge of diabetes and higher quality of life.[10–12] Staff at

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managed care organizations where shared appointments are implemented have been able to see more patients in less time and decrease the cost of care per patient.[7–9] Furthermore, these studies reiterate a higher level of physician as well as patient satisfaction.[6–8]

While a number of studies in the literature describe the advantages of the group medical visit, to our knowledge there are no reports of DIGMA in the urological setting. Urological disorders may be uniquely challenging in the group setting, given the potentially embarrassing nature of patient complaints. We evaluated DIGMA implementation at an academic urology department. We hypothesized that this group appointment model would improve efficiency in the clinic, increase patient access to the surgical subspecialist and enhance patient satisfaction.

METHODS

The drop-in group appointment program was piloted at the department of urology at our institution. Three adult urologists and 1 pediatric urologist participated in the pilot program. DIGMA was modeled after the approach of similar group medical appointment formats in the primary care setting.[6,8] Figure 1 shows a flow diagram of the DIGMA format. Support staff members in the clinic were trained in different aspects of DIGMA management, including scheduling, directing patients and billing. Multiple practice sessions and role playing exercises were completed with the consultant to present an efficient and professional group medical appointment format that has been successful at other institutions.

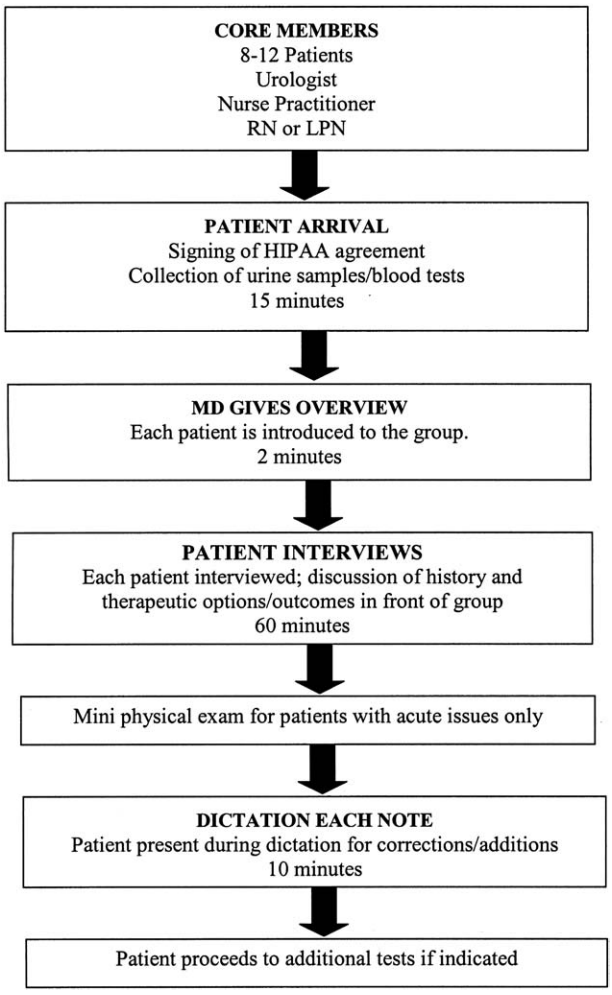

FIG. 1. DIGMA. *RN*, registered nurse. *LPN*, licensed practical nurse. *HIPAA*, Health Insurance Portability and Accountability Act of 1996. *MD*, doctor of medicine.

DIGMA was used exclusively for followup visits. The term DIGMA does not mean that patients drop in with acute issues. Rather, due to the group format DIGMA is more readily available. Patients who described acute issues such as urinary retention or fever when making an appointment were scheduled for traditional 1-on-1 visits. Patients of all ages were randomly asked by the urologist or office staff to participate. Groups were formed by combining patients of the same sex and not diagnosis. Patients of all ages, including those 18 years and older, were represented in an adult urology DIGMA. Spouses and caretakers were invited to accompany patients to the shared appointment.

The average DIGMA consisted of 8 patients with 12 as the goal number of attendees. Group visits were held during regular clinic hours in the clinic conference room. Each DIGMA was scheduled for 90 minutes. A urologist, nurse practitioner, registered nurse and social worker staffed the appointment, in keeping with the original primary care models of group appointments. Eventually the social worker position was eliminated from the staff since those services were not being used and the position was an added financial expense. Upon arrival patients were greeted by a registered nurse or licensed practical nurse and asked to sign a Health Insurance Portability and Accountability Act of 1996 privacy agreement. Urine samples and blood samples were collected, as appropriate. After the didactic and discussion portions of the visit approximately 15% of patients per group underwent physical examination.

It is important to reiterate that the DIGMA is neither a group lecture nor a group therapy session. Each patient and history are presented to the group. Different topics are introduced and discussed according to participant complaints and diagnoses. A private 5-minute physical examination is done in any patient with an acute complaint. After the physical examination patients proceed to additional laboratory or radiographic tests, as indicated. Finally, the note for each patient is dictated in front of the patient, including them in the process. This technique allows even more patient interaction with corrections or updates of which the physician may not be aware. Each patient is billed as an individual level II visit, as reflected by any 2 of a problem focused interval history, a problem focused examination or a straightforward medical decision. Patients present the usual co-payment. DIGMA is best envisioned as a series of individual patient encounters but with an audience.

An 18-question survey was created by participating physicians to evaluate patient satisfaction. Surveys were randomly distributed and collected from patients attending DIGMAs. In addition, the same survey was randomly distributed to patients attending traditional 1-on-1 patient-physician appointments in the department. These surveys were confidential and anonymous.