Group Medical Visits in Primary Health Care

Implementation Guide

June 2021

"It's time for my next appointment. I have my questions written down but there never seems to be enough time to ask them with the 15 minutes I have booked. It's hard dealing with this health issue.

I've made a few changes, but I know my primary care provider still isn't seeing the results she wants, and well, neither am I. It would be nice to talk to others who are experiencing the same thing. Maybe even learn something from them. If only there was another option…"

"There are so many patients with complex needs. I feel as if I am on auto pilot answering the same questions and giving out the same advice. Our wait lists aren't getting any shorter either. I honestly thought supporting patients would be different.

I think James could really benefit from hearing about the successes Ahmed has had making changes with his diet and exercise. It would help to bring them together. If only there was another option…"

Contents

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Michele Leblanc, Nova Scotia Health

Members of the *Group Medical Visits in Primary Health Care Task Team*: Lindsay Cormier, Isabelle d'Entremont, Kim Rose, Kim Bartholomew-Pushie, Kolten MacDonell, Maryanne Jackson, Jennifer Riis, Carla Green, Shari Landry

About the Implementation Guide

This guide was designed by Primary Health Care and Chronic Disease Management Network, Nova Scotia Health, to support the implementation of Group Medical Visits (GMVs) to enhance patient care. Implementing GMVs creates opportunities to provide care in a different way, supports the development of self-management skills and offers an innovative option for caring for patients with ongoing health conditions.

In addition to the guide you will find tools and resources to help get you started. These tools are available at PHCQuality.ca, in addition to additional support resources. It is important to maintain the integrity of the GMV model, but don't be afraid to think 'outside of the box' and consider how this could work in your practice.

All website and video links are active for those reading this guide digitally. Questions? Email PHCPracticeSupport@nshealth.ca.

Primary Health Care and Chronic Disease Management Network

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Defining Group Medical Visits

Group Medical Visits [GMVs] deliver efficient, high-quality health care through expanded appointment times to groups of patients with similar health needs. While there are different models to deliver GMVs, similarities include:

- involvement of the patient's health care team,
- group discussion led by a skilled facilitator,
- self-management focus,
- emphasis on peer learning,
- holistic approach to wellness/chronic disease management.

Group Medical Visits:

- Extended medical appointments delivered in a group setting
- Often clustered by patient needs (chronic disease, risk factors)
- Three key components: brief personal exam (medical component), education and group interaction
- Can be held in-person or virtually

Overall, GMVs are about organizing care differently to optimize the time spent by providers and patients. The time required by primary care providers in GMVs is similar to traditional appointments, however the quality of care patients receive is greatly enhanced through longer contact with the health care team and peers with similar health conditions.

Unique to GMVs is the patient guided discussion facilitated by the provider and care team. This is a departure from what man health care providers are familiar with in traditional group education formats. Additionally, brief one-on-one time with primary care providers is available to patients throughout the GMV.

Creating Opportunities for GMVs
URL: www.youtube.com/watch?v=mCmj2ygPeyo
Run Time: 9 mins 12 sec

For more information on GMV models see Classic Group Medical Models.

Group Medical Visits are identified in research, grey literature and on websites by a number of different names. These names are often used interchangeably although they may not mean the same thing. Common examples include: Expanded Group Medical Appointments, Shared Medical Appointments, Shared Visits, Shared Medical Visits, Group Medical Appointments, Group Visits, or Group Care. To simplify, we are referring to all of these different names under the umbrella term 'Group Medical Visits' or GMVs.

Why Offer Group Medical Visits?

Benefits to offering GMVs exist for the patient, the provider and the health care system. Evidence supports the use of GMVs with persons living with diabetes and research is growing in other areas related to chronic health conditions, such as depression and obesity. Strong evidence exists to suggest GMVs improve quality of care and decrease costs to the health care system and moderate support that GMVs can improve a patient's mental health (e.g., depression, anxiety); health behaviours, self-efficacy, and disease specific outcomes (e.g., lower HgA1C).

The nature of GMVs avoids didactic (lecturing) teaching methods and instead focuses on *involving* the patients in their care. This is enhanced by working collaboratively with an interdisciplinary health care team, which results in patients becoming exposed to a wider group of clinicians with a wider scope of practice to improve patient care. Also, seeing trusted health care providers engage with and welcome the ideas of other team members helps build the patient's trust of new providers and contributes to developing team-based care.

Benefits of GMVs

For Patients:

- ✓ Increased satisfaction with care
- ✓ Increased self-management
- ✓ Better quality of life
- ✓ Improved access
- ✓ Improved health outcomes (e.g. BP, A1C)

For Providers:

- ✓ Increased productivity
- ✓ Opportunity to provide more holistic care

For Health Care Systems:

- ✓ Fewer ER visits
- ✓ Fewer repeat hospitalizations
- ✓ Fewer visits to specialists

"Tell me and I forget. Teach me and I remember. Involve me and I learn."
- Benjamin Franklin

Are you thinking of trying GMVs? Gather your team and check out the GMV Planning Worksheet.

GMVs can also give providers the opportunity to discover more about their patients and the context of their lives. Evidence suggests people learn well from others who are experiencing the same conditions and issues. They have the unique ability to challenge and support each other in ways that differ from usual health care provider/patient communication.

Why offer Group Medical Visits?
URL: https://youtu.be/uAqcovE-CQU
Run Time: 1 min 29 sec

Benefits of Group Medical Visits
URL: https://youtu.be/AXGaW_lKS-E
Run Time: 5 min 26 sec

For more information on the costs of GMVs and their value for patients, providers, communities and health systems, refer to the Further Reading supplement.

Who is Involved in GMVs?

This depends on the focus of the GMV, the needs of the patients and available resources. There is no recommended mix. Team members working to their full scope of practice supports the distribution of resources and expertise. While admin/clerical support is always involved, the actual delivery of care, at minimum, would involve the person most responsible for care (e.g., family physician or nurse practitioner). The model can expand to include a diverse multidisciplinary team, which is the vision that Nova Scotia Health Primary Health Care supports for GMVs.

Virtual GMV Considerations:

- Designate a "tech moderator" to manage the technology aspects of the GMV, e.g. admitting patients from the virtual waiting room, monitoring the chat box, setting up and managing breakout rooms and polls, etc.
- Tech moderator could be:
  - member of the health care team (provider or administrative staff)
  - experienced provider from another team
  - PHC leadership team member (Coordinator or Health Services Lead)

Health Care Team: GMVs can be offered in many combinations, with some classic models suggesting specific care providers who need to be involved. Generally, a GMV involves a physician, nurse practitioner or other clinician to provide the medical component PLUS someone to manage and support the group experience. The person supporting the group experience would ideally be someone who has experience facilitating and working with groups, with some knowledge in either self-management or the subject matter being discussed. Healthcare professionals who may be involved in fulfilling this facilitator role include registered nurses, licensed practical nurses, dietitians, pharmacists, physiotherapists, occupational therapists, recreation therapists, etc. While the classic model involves the physician/NP in delivery, GMVs have been successfully offered by two or more interdisciplinary team members who report back to the physician or NP when appropriate.

Administrative Staff: Like health care providers, administrative support staff are crucial to the success of GMVs. Responsibilities of administrative support staff could include: inviting participants (by phone, mail, or e-mail); answering questions (including selling the idea of GMVs to patients); booking meetings and appointments; helping to organize patients when they arrive for their appointment; and assisting patients and providers with accessing and using virtual platforms.

Patients: You will want to consider inviting patients to participate in a GMV who are appropriate for a group setting. GMVs are not going to work for everyone - and that's okay. E.g. Patients who have cognitive challenges, unstable chronic conditions, or difficulty engaging in groups may not be appropriate. Identify and invite more patients than you expect; e.g. if you want a group of 10, plan to invite at least 20.

Who Participates in Group Medical Visits?
URL: https://youtu.be/U4bZw7KDjW8
Run Time: 1 min 51 sec

For additional patient considerations, refer to the Early Logistics Planning Guide.

Virtual GMV Considerations: Patients attending a virtual GMV will require access to a computer, tablet or smartphone; reliable high-speed internet; and be open to utilizing videoconference platforms. For patients without access to required technology, connect with a Primary Health Care leader in your area to consider if the free *iPad Borrowing Program* could help.

What happens in a Group Medical Visit?

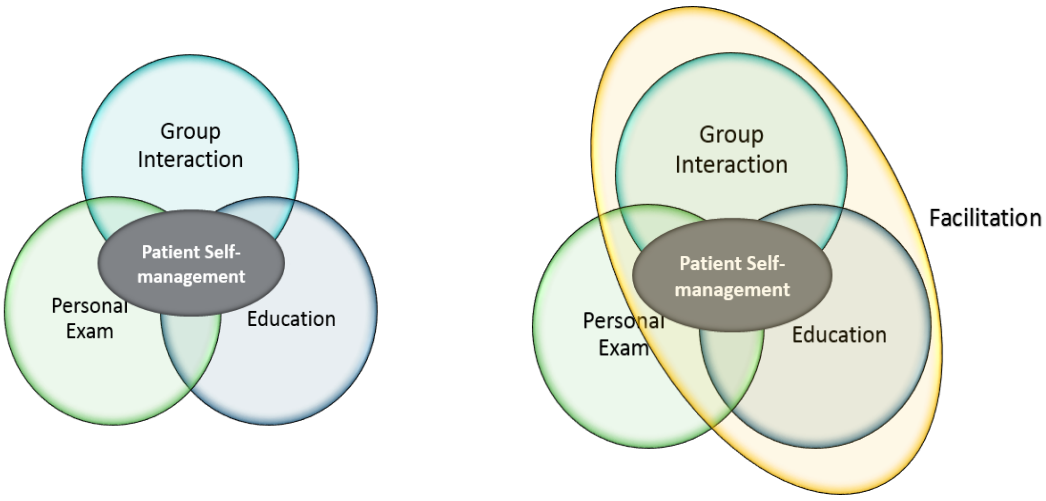
GMVs are comprised of the following Three Main Components:

Brief Personal Exam (Medical Component)	Education	Group Interaction
Brief 1:1 time with provider to address individual medical needs. Typically provided by a physician or nurse practitioner, but could also be family practice nurse or allied health clinicians who perform medical interventions as a part of their role/scope. Examples: Blood pressure monitoring, medication review / adjustments, insulin adjustments, blood work review, mental health assessment, anthropometrics	Group-based learning specific to the participant's clinical and lifestyle needs. Education topics stem from the participants themselves; at times the health care team may need to discuss a topic based on a clinical or self-management need that is not raised by the group. Education may focus on increasing participants' understanding of their health condition, and supporting behaviour change and self-management skills.	Participant-led interaction facilitated by the health care team that contributes to learning and behaviour change through peer support and connection, and sharing of ideas, experiences, and solutions. The health care team supports the group to address questions and clarify misinformation.

The goal of a GMV is to contribute to *patient self-management* through a deeper knowledge and understanding of their condition, and what they can do about it.

In theory, all components equally impact a patient's development of self-management skills. *In reality, it is the group interaction where most patients will gain the knowledge and confidence to manage their chronic conditions.* What is evident from practice is the importance of facilitation and group interaction. This component enhances the GMV experience and movement to patient self-management.

Group Medical Visit Theory: Importance of Facilitation



Preparation for GMVs takes time. Ideally the prep work is done in collaboration with the health care team delivering the GMV. The following provides a brief outline of what occurs during a GMV appointment.

For a detailed example of time and preparation, refer to the Sample GMV Preparation Timeline.

Participant Arrival:

For **in-person GMVs,** participants are registered based on normal team processes and welcomed into the physical space. Any forms that need to be completed may be provided or can be distributed once all participants arrive. At the first visit Confidentiality and Informed Consent Agreement must be reviewed as a group and signed by each patient; agreements signed by patients are kept in the patient's chart. It is important to have a conversation about what confidentiality means and to both state and agree upon expectations and potential risks. These should be reviewed at the beginning of each subsequent GMV.

For **virtual GMVs**, participants will wait in the virtual 'waiting room' for the GMV to start. Confidentiality slide is presented and verbally read to the group, and patients are asked to use the "thumbs up" symbol to confirm agreement; virtual agreement is documented and recorded in the patient's chart.

Introductions: It is important that each person has the opportunity to introduce themselves for both in-person and virtual GMV. This should be done following the confidentiality discussion. Icebreakers can help the group get to know each other and get people talking.

For icebreaker examples, refer to Facilitation Tips & Tricks.

Depending on what type of GMV is being implemented, the below is a guide to the various components that are required for success. The order in which they flow is dependent on how the GMV is structured.

Brief Individual Assessment: For **in-person GMVs**, the individual assessment / personal exam can happen privately in a separate room or area, or in the same space where the GMV is taking place. In **virtual GMVs**, this can happen in a virtual breakout room. Either of the following approaches to individual assessment are appropriate, and the one you pick depends on the GMV model and the context in which it is being conducted.

1) Assessment conducted in group setting. Disruption from participants exiting/entering group room is minimized, improving appointment flow and ensuring participants do not miss key points in group discussion. Participants may have increased privacy or confidentiality concerns.

2) Assessment conducted in private, separate room. May be better suited for physical examinations requiring clothing removal, other privacy concerns. Process of bringing participants in and out of group room may be disruptive to group interaction quality. For **virtual GMVs**, providers may separate an individual into a private breakout room to complete the individual assessment.

Education: Questions asked to the primary care provider that may benefit other participants are encouraged to be held and, when appropriate, answered in front of the larger group (e.g., "Great question! I think the group could really learn from that. Do you mind if I answer that when I return to the

group?"). While the provider is engaging in brief individual exams, the facilitator supports discussion related to the reason the group has come together (e.g., pre-natal care, type 1 diabetes, obesity management, osteoarthritis). If they are not subject matter experts, they could be simply collecting the questions from the group until the provider (e.g. physician/NP) arrives. Questions that can be addressed by fellow group members or the facilitator will be answered accordingly, while questions specific to the physician/nurse practitioner will be recorded and held until the full group reconvenes.

Group Interaction: This can be one of the most powerful components of GMVs. Participants learn from and with each other through peer support and connection, and the sharing of lived experience such as challenges and solutions. It is important that the health care providers allow this to occur naturally and only intervene when information being shared is misleading or may cause harm.

Conclusion / Wrap-Up: Prior to concluding the session, participants work to identify an individual action plan or goal for themselves. A summary of the GMV occurs and highlights any outstanding questions that need to be addressed during the next visit (if applicable). Participants are informed when the next visit will take place and are encouraged to follow-up on any tests, advice or learning they have been provided. Remind participants to continue working on their action plan or goal. Provide a paper or electronic evaluation form for feedback.

How to Run a Group Medical Visit
URL: https://youtu.be/KlHvGFK9abA
Run Time: 3 min 26 sec

Challenges of Group Medical Visits
URL: https://youtu.be/XoWP4Dw5ubE
Run Time: 2 min 37 sec

Consider this…

GMVs may also meet a social need not otherwise being met in a patient's life

- Start with the end in mind. (i.e., reinforce that GMVs are a 'time-limited opportunity' with the groups have end dates)
- Support the establishment of healthy relationships within the group
- Offer opportunities to share information for connection outside of the group

Important Tools to Get Started:

- Find info on what's involved and expected timelines in the Early Logistics Planning Guide and the Sample GMV Preparation Timeline.
- Unsure how to address confidentiality? See our sample Example Confidentiality Agreement and Informed Consent.
- For more information on the flow of the appointment see a Sample Agenda.
- Struggling with how to introduce the first visit? Read a sample of the Facilitator Introduction.
- Looking for a check list of equipment? Check out a sample Equipment/Resource List.

Group Education vs. Group Medical Visits

By name alone, it is easy to confuse GMVs with group education. Both approaches have value for the participants, but there are key differences. In GMVs, the content of the discussion is, either in whole or in part, set by the participants. In group education, the topic content and order in which it is presented is decided upon by the facilitator. In a GMV, "education" is not the dominant component; the transfer of knowledge is less important than building the motivation, skills and confidence to take action. Patients often have a lot of information on what they *should* be doing, but rarely take the steps to follow the information they already know. Instead, the focus is on promoting the change from knowing to doing.

Another key difference is with shared learning between participants. While this may happen as part of a group education session, it is not normally considered a primary outcome. In group medical visits it is a key feature.

Fear of letting go of the agenda is often found in the argument "how can a group that isn't aware of all the things they need to do to manage their health, set the content for the discussion – after all *we don't know what we don't know*"? The emphasis here is to **trust the process.** More often than not, when facilitators support the group to set the content, the same information is covered over the duration of the session(s). The difference is that it may not occur in the order or on the timeline the facilitator would have normally set/is used to sharing it. This is where the role of the health care team once again comes into play. Similar to their role to correct misinformation that may be offered by fellow participants, the health care team would also ensure that if a crucial topic is missed, it is at least introduced to the group to see if they want to learn more. Feeding information to a group that isn't ready to hear it isn't helpful; similarly, groups often already know what they "should" be doing; the crucial piece is supporting them to take action and implement it.

	Group Medical Visit	Group Education
Content	Set by participant	Set by facilitator
Professional-led education	*May be* a component	**Primary** learning mode
Learning from interactions, experiences and questions of participants	**Key** feature	*May be* a feature

Roles and Responsibilities

Facilitator: The role of the facilitator in GMVs should not be underestimated. Although not the subject matter "expert", the facilitator manages the actual experience of the GMV. Ideally, the facilitator would have previous experience working with groups and training in facilitation skills. What is also important is an interest and desire to learn and be involved with the group (including believing in the GMV process); comfort being in an interactive role (and not relying on a pre-made presentation like PowerPoint); being intuitive and observant, and having good listening skills. Practice is key! No one is completely proficient when they first start. Good facilitators develop with practice.

Facilitators...

- Sense what the group needs
- Fosters participation
- Build confidence

- Inspire excitement
- Cheer the group on
- Bring the 'fun'

- Guide the process
- Keep group focused
- Regulates dynamics

Teacher or Facilitator?
URL: https://youtu.be/2Sj4xwcafXo
Run Time: 1 min 58 sec

For more information on the facilitator role, see Facilitator Responsibilities.

Primary Care Provider: Physicians and nurse practitioners play an integral role in the GMV. Examples include performing medical assessments, ordering tests, starting or changing medications, sending referrals to specialist, and other clinical functions that cannot be performed by other health care providers. Questions outside of the scope of practice of the facilitator are held for the primary care provider and answered when the entire group comes back together. Other roles include identifying patients to attend and in some cases inviting them. Many patients appreciate the personal touch of being called and invited to attend a GMV, rather than being sent a standard letter.

Administrative Team: The role of the administrative team is critical to the success of GMVs. Administrative team members should be involved in the GMV planning process from start to finish as they are often first and last point of contact for patients. The administrative team supports planning of the GMV, preparing patient information prior to the GMV, and most importantly, act as champions for the GMVs. In many situations, the administrative team will actively drive recruitment (i.e., sending out invitation letters/e-mails, calling patients to confirm attendance, answering general patient questions about what to expect, etc.).

For more information on inviting patients to participate in a GMV, see a sample Invitation Letter on and a sample Telephone Invitation Script.

Virtual GMV Considerations: Consider who will play "tech moderator" to manage the technological aspects of the GMV, e.g. admitting patients from the virtual waiting room, monitoring the chat box, setting up and managing breakout rooms and polls, etc. The tech moderator could be a member of the health care team (provider or administrative staff), an experienced provider from another team, or a PHC leadership team member.

Billing and Documentation

Billing codes and documentation requirements for care delivered in a GMV are determined by:

1. professional qualifications of the provider leading the group as guided by respective licensing body
2. content of the care provided
3. in-person or virtual delivery modality (see ***Box 1*** for MSI virtual service claims, and ***Box 2*** for Nova Scotia Health documentation requirements)

Billing and documentation will vary based on the health care team that is involved. If two groups are partnering, each will likely want to document using normal practices for their respective roles. For example, if a chronic disease management/wellness team from Nova Scotia Health partners with a community fee-for-service family physician to deliver a Group Medical Visit [GMV] for patients from the physician's practice, they would each document according to their own practices and standards.

Costs incurred in both the development and implementation of GMVs are generally low. Assuming sufficient physical space or virtual platforms are available, and a clinic can utilize their own staff and/or collaborate with willing partners, the time commitment of the staff involved is often reallocated rather than expanded.

Clear documentation is required to demonstrate that individual medical evaluation and management components of care have both been provided during the GMV. Currently, there are no nationally accepted standards for coding and physician billing for GMVs. Poor understanding of billing standards and requirements is a common barrier to implementing financially sustainable GMVs. To support GMV claims submitted to MSI, physicians are encouraged to use the same ethical billing practices used for other visits. Documentation should include the ***W5 approach*** (what, when, where, why and who). For virtual GMV delivery, documentation requirements for MSI service claims remain the same but text is required on the claim to specify how the care was delivered (see Box 1 below). For more information see the MSI Physicians Manual. Nova Scotia Health provides additional guidance for documentation of the medical component of virtual GMVs (see Box 2 below).

To remain cost neutral, it is encouraged that a primary care provider would see *at least* the same number of patients they would normally see within the time frame of the scheduled GMV. For example, if a physician normally sees 4-6 patients within 60 minutes, they would want at least 4-6 patients attending a 60 minute GMV, or 6-8 patients attending a 90 minute GMV. Each patient is billed for uniquely for their visit (e.g., 0303). Other codes may also be used depending on the content of the GMV. An appropriate medical record must be maintained for all insured services claimed.

MSI requires the minimum record contain:

a) Patient's name
b) Patient's Nova Scotia health card number
c) Date of the service for which the claim is being made
d) The reason for the visit/presenting complaints
e) Any clinical findings appropriate to presenting complaints and reflective of service codes claimed
f) Working diagnosis
g) Treatment prescribed
h) Time and duration of the visit (in case of time based fees)

i) Name of referring physician (where appropriate)
j) Name of consultant / rationale of referral (where appropriate), and if referral was for diagnosis or treatment
k) A consultant will send a report to the referring physician when appropriate and retain same on file

Box 1: MSI Virtual Care Service Claims

The following excerpt from the March 24, 2020 MSI Physicians Bulletin provides guidance to physicians for the delivery of non face to face services:

In view of the extenuating circumstances and recommendations for social distancing, and in order to promote continued delivery of patient care as seamlessly as possible, **effective March 13th, 2020 all office based non-procedural services that are normally rendered in a face to face setting will be permitted to be reported whether they are provided in person, by telephone, via telehealth network, or via a PHIA compliant virtual care platform**. Such services would include limited visits, consultations, psychotherapy, and counselling where appropriate to be delivered in a synchronous non face to face encounter. Long Term Care, Residential Care, and Hospice services normally rendered face to face due to medical necessity could be reported using this format. During this interim measure these services will be paid at the same rate as they would be if delivered face to face.

Please submit your claims for encounters as you usually would, using your normal practice location. For all services not rendered face to face at that location, include the following text on the claim to denote the mode of synchronous care delivery:

- If service was provided via phone call: **Pandemic telephone**
- If service was provided over the telehealth network: **Pandemic telehealth**
- If service was provided over a virtual care platform: **Pandemic virtual care**

Box 2: Nova Scotia Health Documentation Guidelines for Health Care Providers (Synchronous Virtual Care)

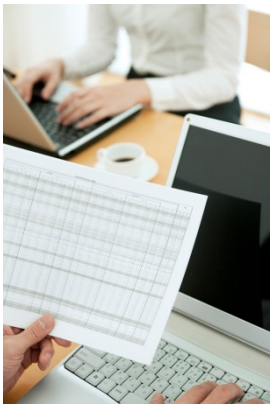
The following excerpt from the Guidelines for Health Care Providers – Zoom for Healthcare, developed by NSHA IM/IT Virtual Care in collaboration with NSHA and IWK Privacy Offices and NSHA IM/IT Primary Care, highlights documentation requirements related to the provision of virtual care using Zoom for Healthcare or other communication platform. Non-NSHA/IWK Providers who are not delivering services on behalf of NSHA or IWK are considered to be custodians of patients' personal health information and it is recommended they follow these guidelines.

Documentation

HCPs are responsible to **ensure the following items are documented** in the patient's health record **in addition** to standardized documentation policy and procedures.

- **Communication Platform Used (i.e. Zoom for Healthcare, Phone, Medeo, etc.)**
- Informed consent obtained
- Summarize any relevant communication via video or chat
- The patient's location (home, work place, etc.)
- Identify all participants in attendance
- Any incidents that impacted the delivery of care
- Any significant technical issues

Outcome Metrics



Measures of success for GMVs will vary depending on the purpose of the group. Some teams may choose to evaluate specific clinical indicators (e.g., reduction in HbA1c, blood pressure, waist circumference, etc.), while others may look at wait times, patient and provider satisfaction, reduction in wait lists, rates of return visits, etc.

Important things to consider:

- What's a realistic outcome given the GMV's purpose and set up?
- What supports are in place to support intended outcomes?
- What baseline data already exists?
- What mix of qualitative and quantitative data is the team looking to collect?
- How will data be collected?
- Is the data being collected for quality assurance or is there a research study component (e.g. will this require ethics review?)
- What does the team plan to do with the data collected?
- What's a reasonable time expectation to see a change?

See an example Patient Satisfaction Survey and an example Provider Satisfaction Survey.

Practice Change

Making changes to existing practices and routines is never easy. Beyond being willing to try something new, it means being open to new ways of working that may contrast with past practices. This process is gradual and goes at different speeds for every individual and team. For some, it may take many conversations to bring a team to a place where they can implement GMVs. For others, the process may be much quicker. Early adopters are given the opportunity and encouraged to champion practice changes they consider to be positive. Providers typically prefer hearing from their colleagues about new practices and innovations, and rely on frontline evidence to inform their view in making the effort to change. If you are an early adopter, you will likely be evaluating outcomes and communicating your experience to support other colleagues.

To successfully engage a team to begin implementing GMVs, start small. Work with those who are interested in building practice capacity and excitement. Having current evidence on-hand and not becoming discouraged if the answer isn't an immediate yes is key – as humans, we often need to hear the same message three or more times to understand, appreciate, and get onboard with a process or change.

It can be helpful to take a quality improvement [QI] approach when putting new ways into practice. QI helps to ensure the changes you are making are leading to improvements, and improvements are sustained over time. Visit PHCQuality.ca for QI resources and tools to support you.

How to Engage Physicians
URL: https://youtu.be/UsWohwVZ5Kk
Run Time: 1 min 05 sec

Advice on Group Medical Visits
URL: https://youtu.be/sayZ7gvNbBk
Run Time: 2 min 44 sec

Supporting Documents

The following supporting documents are available at PHCQuality.ca to help you to begin the process of implementing GMVs within your team. The templates are meant to begin team conversations and may be adapted to suit individual team needs.

Patient materials should be reviewed for plain language, and when possible, offered at a grade 5 literacy level. Nova Scotia Health Library Services staff are an excellent resource to support you in developing appropriate patient materials. Library staff may not be content experts, but they do offer expertise in creating documents for community members and patients that account for varying levels of literacy and health literacy.

- GMV Model Overview
- Adapting to Virtual GMVs
- Planning Worksheet
- Early Logistics Planning Guide
- Preparation Timeline
- Sample Agenda
- Patient Invitation Letter
- Telephone Invitation Script
- Facilitator Introduction
- Facilitator Responsibilities
- Facilitation Tips and Tricks
- Confidentiality Agreement
- Group Guidelines
- Patient Satisfaction Survey
- Provider Satisfaction Survey
- Sample Measurement Tools
- Equipment Lists
- Common Myths & Concerns
- Further Reading & References