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Provider Experiences Implementing Group Care: A Qualitative Study

Noureen Ahmed

A Thesis Presented to

Faculty of the Yale School of Public Health

Yale University

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Master of Public Health

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Abstract

Objective/Purpose: Group Well Child Care is an innovation in primary care delivery that may help meet the quadruple aim of health care. The objective of this study is to characterize Group Well Child Care providers' experiences, perceptions, and strategies.

Introduction: In Group Care, also known as shared medical appointments, patients with similar medical needs attend appointments together. The practice of Group Care has spread, particularly where social support is beneficial (e.g., early parenting) and among those who might experience shame or stigma for their diagnosis or background (e.g., poverty). Group Care has shown promise in improving patient outcomes, such as adherence to appointments and vaccinations, but the ways that providers experience Group Care has not yet been empirically assessed in a national sample using open-ended interviews.

Methods: Using in-depth interviews with Group Well Child Care providers we explored perceptions of providers' experience regarding families' experience and strategies in implementation. We used purposive and snowball sampling methods to capture diversity in terms of geographic location, provider-type, and experience level. Interviews were conducted in-person and via phone/video, transcribed, and coded for key themes by a team of researchers using a grounded theory approach. We conducted interviews until we reached thematic saturation.

Results: We conducted 20 interviews representing individuals from 11 programs across the United States. We identified 4 key themes representing providers' perceptions and experiences of Group Care: 1) Integrating Peer and Provider Education: the flattened hierarchy between patients and providers resulting from group practice facilitates these complementary types of education, 2) Mindfulness: having multiple families together allows providers to focus on families in the room and not worry about others waiting elsewhere, 3) Community: families who have left a supportive

community (e.g., by immigration) welcome shared appointments where they find support, and 4) Organizational Burden: due to its novelty, logistics of group are challenging and frustrating.

Discussion: Despite positive health and health care outcomes in Group Well Child Care, penetration in primary care is limited. Providers' perceptions of why Group Care might work for families and providers, which families might benefit most from Group Care and what providers need may be key levers in greater implementation of Group Well Child Care.

Acknowledgements

Thank you to Marjorie Rosenthal and Ada Fenick for all of their mentorship, work in Group Care and guidance these past two years with recruitment and analysis of provider information and interviews. Thank you to Danya Keene for being my advisor and for her guidance through this process. With the support of my mentors, family and friends this study was possible. Lastly, thank you to all of the providers who took time out of their busy schedules to speak with me.

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Introduction

Group Well Child Care is an innovation in primary care delivery that may help meet the quadruple aim of health care; enhancing patient experience, improving population health, reducing costs and improving the work life of health care providers (Bodenheimer & Sinsky, 2014). The model allows patients and caregivers with similar medical needs and conditions to attend appointments in a group setting. These practices have been implemented in places around the United States as well as other countries around the world. The model of Group Care can begin as early as prenatal care with mothers and their families all the way to pediatrics. Other forms of Group Care include those with similar diagnoses or illnesses, such as obesity, similar mental health diagnoses, cancer, and may revolve around communities who share similar lifestyles or situations that can lead to a group gathering for health care practices or problems. These groups can ultimately set a precedent for preventative care and education opportunity in health care practices for patients and their families, with the help of not only the providers but their community (Taylor et al., 1997).

At times, one-on-one visits to the doctors can be brief and rushed. Many parents try to maximize the number of questions that can be asked within their slotted time, while the practitioner is balancing their time between checking the child and tending to the parent. With the Group Care model, the time spent for questions and for physical exams are separated and longer. Group Care visits lasts between sixty to ninety minutes. The team working with the patients stays consistent. Depending on the institution conducting Group Care, the model can be solely led by one practitioner, or there can be a team of providers, from physicians to nurses to social workers, that come together for every session. Group Care is not limited to physical exams and immunizations, but can consist of educational workshops on parenting, mental health, nutrition, physical well-

being and much more. Providers work with the patients and their families along with their institutions to best understand the model that will fit their group.

A study done by Shyam Desai and colleagues assessed provider satisfaction working in Group Well Child Care through electronic surveys. These surveys had set questions and responses that providers selected measuring satisfaction with the curriculum, perceived self-efficacy and perspective on competency with trauma-informed care. This study collected strong quantifiable data representing clinicians' experiences participating in the Group Care model (2019). Despite largely positive outcomes, there has not been great up-take/implementation in Group Well Child Care across the U.S. The ways that providers experience Group Care has not yet been empirically assessed in a national sample using open-ended interviews. The purpose of this thesis is to characterize the experiences and perceptions of health care providers involved in Group Care programs in the field of pediatrics. We hypothesized that this study design may shed some light on why there are low numbers of providers involved in Group Care in the U.S.

Background

Group Care is a system and style of care that is not only limited to pediatrics, but can also be found in various fields of medicine among both children and adults. One of the first researchers to propose and write about the practice of group well childcare was Dr. Martin Stein, who penned one of the best-known publications of group well baby care in the late 1970's. His model disrupted the traditional understanding of how health care should be delivered (i.e., where care is provided from one provider to an individual patient). Indeed, Stein (1977) wrote of parent-infant groups that met at monthly intervals for one year. His proposed alternative route of care delivery was shown to have a multitude of benefits for both providers and patients, but providers hoping to implement his group model of care faced difficulty, as they did not know how to execute this model as well.

That said, Stein's study gave providers a new platform by which to create and further assess the successes and challenges of parent-infant groups.

The Group Care model in pediatric primary care improves adherence to appointments and vaccinations, as well as outcomes in mental and physical health for children, parents and guardians (Blanchard et al., 2018). In a qualitative evaluation of individual care and Group Well Child Care, researchers discovered that patients who received Group Care were more satisfied with their social/wellness visits than individuals who received traditional one-on-one care. In addition, parents of children who have group appointments experience improved senses of social support and resilience. These parents tend to become 'walking advertisements' for Group Care, touting their benefits. It is important to stress that the foundations of individual care appointments do not align with Group Care visits (De Lago et al., 2018).

Freeman and Coker (2018) describe the Group Well Child Care design, and were influential in analyzing what this method of care delivery should entail and how it may best be utilized to successfully advance this practice moving forward. These researchers address challenges that may exist in today's climates, both socially and politically, as well as how Group Care may successfully address these issues. Of course, the foundations of delivering health care remain the same for Group Care, but this practice *also* provides open discussion and discourse, whereby patients, their families, and their providers are able to engage on deeper levels with more open discussion and dialogue (Freeman and Coker, 2018). Most of what is known about Group Care appointments has been derived from quantitative-based studies, which have demonstrated improved behavioral outcomes for patients (Tanner *et al.*, 2009), as well as financial and cost-saving benefits for patients and health care institutions at large (Coker *et al.*, 2009).

This study will examine (1) how providers conceptualize Group Care; (2) successes and challenges in Group Care implementation and recruitment; (3) and perceptions of patient experience. At present, there are fewer than one hundred total articles on Group Well Child Care, although there exists a growing list of providers who have identified the benefits of this practice, with very few of these individuals covering in depth analysis of the provider perspective of Group Care. This study aims to expand findings on Group Care and more effectively share the experiences of providers practicing Group Care for patients. Historically, as mentioned, Group Care has been beneficial to lower-income communities, marginalized and vulnerable individuals, and populations that speak languages other than English; as our society continues to diversify, individuals continue to struggle with finances (including related to medical treatment), and health care institutions continue to transform, better understanding Group Care becomes increasingly important. As such, this study aims to highlight existing experiences of providers who deliver Group Care and assess the need for Group Care in more locations throughout the United States – and globally.

Problem

What are providers' experiences and perceptions implementing the Group Care model for Well Child Care visits?

Objective

The objective of this study is to characterize the experiences and perceptions of health providers participating in Group Care around the United States in designing and implementing Group Care programs, using qualitative semi-structured interviews.

Research Design

Sampling & Recruitment

Participants for this study were recruited from a list provided by the co-leaders of the Group Care Network in New Haven, Connecticut. Providers were emailed (see appendix A) asking if they would be interested in participating in an interview to better understand the practices of Group Care and their perspective on the experience. Twenty participants were recruited for the survey in an attempt to reach thematic saturation.

This study sought to include a diverse group of providers to capture variation in experiences across regions and specialties to provide in depth information and a wide scope of what providers cover during their sessions. Different communities, years of experience, styles of teaching and structure of sessions highlight the successes and hardships of partaking in the Group Care model. The model identifies a basic structure of how Group Care can take place, however depending on the needs of a community and the available resources and partnerships, the structure can vary from one site to another.

Data Collection & Analysis

The purpose of these qualitative, semi-structured interviews was to examine and record the experiences of health care providers and professionals. Guided questions highlighted participants' history, experiences, successes, challenges, and other strategies, all of which tie into their respective implementations of the Group Care model. The interview questions were created by a group of pediatricians and a social worker who participate in Group Well Child Care, to cover topics regarding provider background, Group Care model, recruitment and retention of patients, providers' perspectives on patients' experience, providers' own experiences, and funding, with several miscellaneous questions (see Appendix B for the complete interview guide).

Interviews were conducted via phone calls and were audio-recorded and transcribed by hand and by a website called Temi. Upon thematic saturation (i.e., at the conclusion of twenty interviews), the recruitment and interviewing of participants concluded. The interviews lasted an average of thirty-two minutes in length. Transcripts were then uploaded into Dedoose (Software Version 8.2), and the research team met frequently to discuss coding, which was performed using an inductive coding approach (Fereday & Muir-Cochrane, 2006). Compiled codes were analyzed using tools on Dedoose, as well as by discussion among the researchers. After the creation of the codebook, the interviews were analyzed once more to identify significant quotes that best align with the overall themes discovered.

Ethical Considerations

This study was exempted by the Yale University Institutional Review Board (IRB). Before the start of every interview, verbal consent was attained using a consent script (see Appendix C). The script provided the opportunity for subjects to deny participation or ask any questions prior to the initiation of the interview (as well as at any point during). All participants were also told that they were free refuse to answer any questions, skip questions, or end the interview at any point.

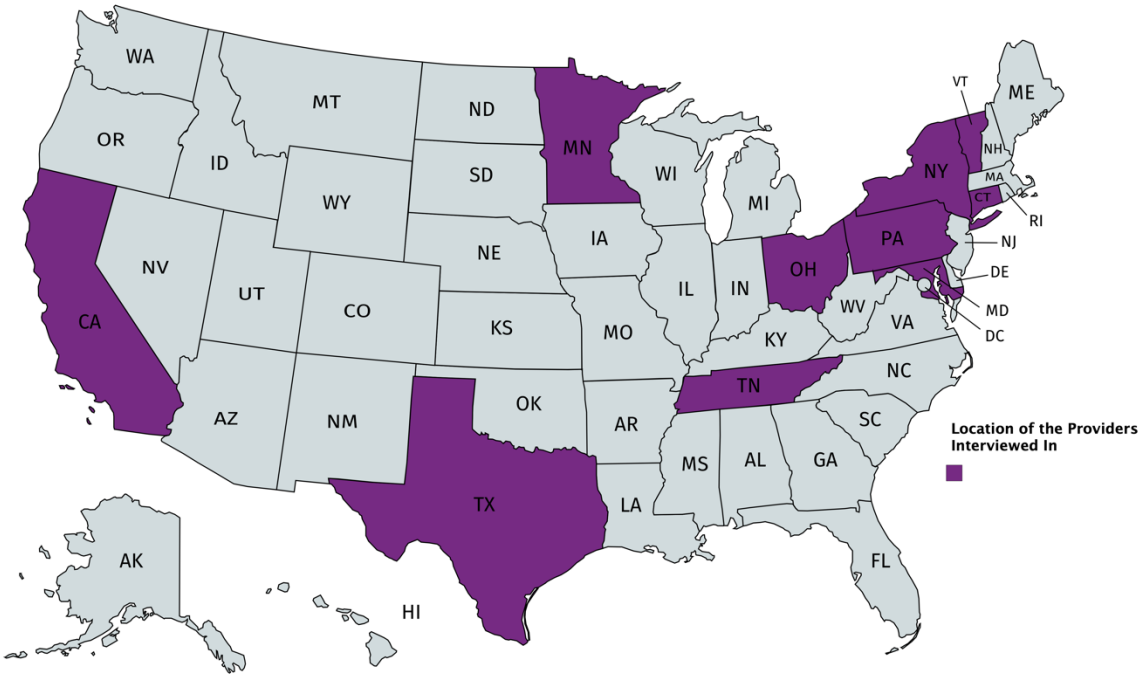
Participants were told the interviews would remain strictly confidential with no identification of their identities or places of practice. To further address the security and confidentiality of the data collected, we used Yale Box, an encrypted and secure web-based folder, to store all materials, including recordings, transcripts and any personal data.

Findings

A majority of the participants were pediatricians, with a few specialty physicians, a resident and social worker. The participants ranged in locations covering ten different states. See Figure 1 for the states covered in this interview. These providers practiced Group Care in 11

different institutions across the nation. The interviews lasted an average of thirty-two minutes in length.

Figure 1: Location of the Providers Interviewed in this Study



We identified four main themes which emerged from our analysis of the provider interviews, including: (1) Integrated Peer and Provider Education; (2) Mindfulness; (3) Community; and (4) Organizational Burden. These themes are further described below and supported with quotes illuminating the themes from the interviewed providers.

(1) Integrated Peer and Provider Education

The Group Care model serves as a foundation for teaching and learning for both providers and patients. This platform creates a collaborative environment that limits the paternalistic and hierarchical system, where the provider authoritatively tells the patients and their families what to do and not do. Instead of the provider serving as the *only* expert in the room, the Group Care

model allows fellow parents to serve as experts given the topic, as well as allowing the opportunity for providers to step in whenever needed. This relationship between the patient and provider becomes leveled in a way, whereby patients and parents are more comfortable approaching each other regarding medical and non-medical questions, as well as building connections. With the Group Care format, providers are able to build an environment which thrives off of the concept of modeling and engagement, instead of the usual format of the provider lecturing. One provider's example of this modeling style painted what it looks like to engage the patients and the families:

> *"Again it is all facilitated, so I would say, 'okay, so people tell me who started solid food yet', rather than saying 'okay, now it's six months here's what you need to do', it's, 'tell me who started solid food yet?' 'What are you doing with feeding your babies now?' And then we started to hear from all the parents, and you want to direct the conversation, but you don't want to provide all the answers, you are not the expert in the room typically."*

Many of the providers in this study, made an explicit, conscious point to take a step back in their usual role of speaking and teaching. Their role of being the expert is not lost necessarily, but the focus is instead shifted to what everyone can add in the group conversation. One provider described their experience by saying they felt like they were "in the circle":

> *The provider is in a different situation. Instead of the one doctor with one or two parents, where there's a sort of power differential, obviously, when you're in the circle where you're only one of say, five or six, it's quite different... I think it's good for us to be able to listen. Sit back and listen. Rather than always being the one talking or, in fact, instructing. We, as physicians, tend to be instructing. Saying how it should be done. So, I think it's good. We learn from being able to sit back a little.*

With a baseline rule of mutual respect for all Group Care participants, including providers and parents alike, everyone may feel increased comfort in sharing their knowledge with the group:

> *"We are like a role model for the group, in which we show how we respect everybody's opinion."*

Providers in the interview often discussed the importance of demonstrations and hands on teaching practices to encourage the ideas and knowledge that is exchanged when participating in the Group Care model. This method of engaging the patients and their families is not meant to just benefit the other patients, but it also gives the provider the opportunity to fill in the gaps with resources and correct certain practices if there is a more efficient or safer method. One provider shared this sentiment:

> *"The other thing is demonstration. The ability to comment on what a child is doing now, how that can be done differently. You can comment on parenting issues that relate to the interaction of the moment. And obviously… to get education in a group setting is always a little bit different, because there's comment, feedback, and interaction... so there's a quality in that that I think is really very nice."*

This peer education system may actually be implemented on the provider level as well, by engaging residents with experienced providers. One provider shared this:

> *"I think it's great. One of my particular interests, aside from the group well visits, is in resident education. So for me, this is a way to observe the residents doing their visits, doing teaching, providing guidance, and it's a way for them to see us modeling the way we do it, which is something that isn't really available in the traditional sense. Like I can't go into the room of every single one of my individual patients and they can't see me talking because that would be like something over the visit for them. So I think this provides a very different opportunity for them to learn and when we've surveyed the residents, it seems like something they really value."*

As well as a provider who gave residents the opportunity to learn from having one on one time with the patients and parents:

> *"If I have a resident with me. We split the load and most of the time they really enjoy it. So then we, um, once we see the patients, we have established our list of issues raised by the different parents… the residents love it. They only have positive things to say except maybe that during the first year we didn't have enough patients… I mean they're just not used to this kind of care because they are not used to hearing patients talk about themselves and talk between each other, about some very private problems, you know, that, and how much support they give to each other. And the residents really love that. And, I think it's very beneficial to them because it gives them a different window on patient care."*

The opportunity for residents to learn from one another, the patients, and experienced providers allows for a level of engagement that many clinics cannot (or do not) offer. The ability to learn from parents about child care, and having a first hand experience in witnessing healthy discourse between families and the providers, allows everyone in the room to share and process information that may have not been familiar to them before.

(2) Mindfulness

The next overarching theme expressed by interviewed providers was a sense of mindfulness found in their work. With the ability to take time and engage with a number of families for a longer time, Group Care providers are able to build relationships and help both patients and parents cultivate trust. In the usual one on one structure of well care, patients and parents are in and out of their appointments with very little time to learn specifics about care and treatment, as well as the contexts in which patients and their families are living in. The structure of traditional appointments, as mentioned previously, is focused heavily on lecturing and quickly checking the necessary boxes for the specific appointment, so that providers are able to see as many patients as possible and quickly attend to the next one in the waiting room. This traditional method was expressed as frustrating to some participants. Indeed, many of the providers we interviewed expressed how they appreciate the time they get to spend working on Group Care and not needing to worry about rushing to see the next patient. As stated by this provider:

> *"When it comes to personal satisfaction, I like group because it offers an opportunity to A, develop bonds with patients and their families over time. Um, but also it's a different distribution of your time, whereas, you know, usually you're pulled in multiple directions at once. You really get to focus on multiple families at once, kind of in the same direction. So it's, you know, a complete visit from start to finish with multiple children at once and in the same token we're able to participate in teaching residents in a much more directive way, and really watch a resident grow over time."*

Providers like the one above or this next one, truly valued their time spent with their team and the patients when providing care.

> *"You are sitting with them for 2 hours, in an informal setting face to face, having a conversation with them. That is very different from going in and seeing them for 10 to 20 minutes in a room, just talking at them. I definitely know my centering patients better and they know me better than the people that I see in the regular clinic. You also get a better sense of how the kid is doing developmentally, because you are seeing the child for a longer period of time, in a more natural setting. You know they might be running in the room or playing on the mat with the other kids."*

While providers recognized there are limitations on how they can best serve their group's needs, they repeatedly emphasize decreased stress and pressure related to having a tight schedule. Interviewees also expressed that they appreciated the opportunity to build relationships within their organized setting. All twenty interviewees used a structured Group Care model that included both or one-on-one individual wellness checkups, followed by Group Care sessions. Each provider interviewed had a unique style to his/her/their group sessions, but it was evident that each had a structure in place and that they relied on staff to ensure proper group functioning and consistency. (The importance of group structure will be discussed in a later section related to organizational burden.) The structured curriculums had pre-selected, specific topics for each Group Care session, as well as updates on vaccinations, demonstrations, and open discussions. One provider described the curriculum having more open or free space to create discussion and asking questions that may be useful to the whole group:

> *"We have a curriculum, and we follow the curriculum... but obviously, if something else comes up that the parents bring up, we would address that as well, even if that is not a part of the curriculum."*

This specific provider's Group Care team plans out what the curriculum will look like for the family, and other providers further discuss curriculums with the families ahead of time so that

they are able to come to appointments with questions prepared; this structure helps conduct each session in a smooth way.

The Group Care structure is a strong component of making the delivery of care more relaxing for providers. Having sessions scheduled for a set two or three hours allows for the provider to put all of their energy into this time and the people involved. Given that these sessions are dedicated to well child care, the level of stress associated with working with sick children is often not brought into this group time. One provider described their time in group being less stressful in this way:

> *"For my whole morning, all of my patients are with me. I'm not sitting there worrying about how many patients are waiting for me, do I have to get out of this room to get to the next patient, am I running behind or on time… I don't have the computer in front of me, which is great. I'm just sitting there talking to families."*

Many interviewees echoed that this is a nice change of pace for many providers. Traditional appointments contribute to a busier schedule and fewer breaks. On average, traditional, one-on-one pediatric well child care visits average 18 minutes per appointment (Schor, 2004). Interviewees noted that Group Care sessions vary from 60 minute sessions to 120 minutes. For providers who are new to the experience or patients who are new to the Group Care model, it may be intimidating to think about filling an hour or two with health-related conversations. However, many providers report this care-delivery model becoming simpler as relationships build and the environment becomes more comfortable and familiar for both parties. One provider said:

> *"I think that we have the opportunity to spend more time with the patient, it is little more relaxed, it is planned, we know when we are meeting. Even if it is the holidays, we would bring some food. It is just a really friendly environment that really allow people to get to know each other more and enjoy learning about the things they do, the things they value, their occupation. It is just more relax and gives everyone the opportunity to build a relationship."*

This provider's quote not only embodies how Group Care sessions are often more relaxed for providers, but how they also allow for relationship-building, which provides an even better patient-care experience for children and their families who participate in these groups. These relationships subsequently help providers better understand how their child patients are developing, as well as how parents are doing. With stronger bonds between patients, their families, and group session providers, social determinants of health (specifically things like nutrition, housing, etc.) can be addressed over time – in addition to, of course, their physical and mental health and well-being.

(3) Community

The Group Care model provides a structure that creates community among providers and their teams, as well as among the families and child patients in group. All providers interviewed in this study claimed an improved sense of community when participating in and leading group sessions. One provider described the experience by saying:

> *"The peer support, the shared experience…the opportunity to even be in a relationship…it becomes something that is much more than a doctor's visit."*

Providers reported that patients who participate in group sessions often learn to see their groups as an extension of their friends and family. Some parents take this opportunity to be vulnerable, while others choose to share what they've learned in the process of parenting to help first-time or struggling parents. A few of the providers expressed how the Group Care Model is highly successful in specific communities that share a characteristic or social location in common. One provider talks about the unique beauty of their clinic's community:

> *"Our demographic down here is very largely Hispanic. So, for the Hispanic population, this model is insanely successful. There's a term in Spanish called 'convivencia con vivir' which means literally to like co live with someone and that*

> *sort of coexistence, co-living that takes place in the group. The centering model or the group visit model is just a beautiful fit for that sort of sharing. We have moms that come from all kinds of Spanish speaking countries, Mexico, Honduras, you know, Central America, South America, and despite the fact that they come from different places because the language is the same, even though some of their vocabulary and the way they do things will be a little different. That sort of commonalities has been a beautiful thread."*

Interviewees stressed that a sense of community is built when group participants are comfortable, trusting and respectful of each another. Communities do not form just from a similarity in language, but it does help in creating relationships for individuals who may not have a support system in their larger communities:

> *"We know that families, once they are in the group, even if they don't know each other before hand, they bond and support each other. And they see each other outside of the group, and go to each other's birthday parties or they get together, or they are in contact with each other. So that's another piece of it, it's a support mechanism for most of the families."*

Building community is not limited to the time that children and their families spend inside a room during a Group Care session sitting with chairs in a circle. Some providers have also taken the opportunity to pull these relationships outside of in-person appointments through private Facebook groups or WhatsApp group chats. This bridge of connections to the electronic, web-based realm not only allows for parents to connect with each other, but it also helps them share tips and tricks or ask questions that can be answered by other parents or the providers themselves. This provider excitedly explained how their online community has grown over the years:

> *"So that's definitely been a challenge, sort of opening up outside of the Hispanic Spanish speaking population. But it's also been our success because we've had like, you know, we're up to like, I don't know, 30, 40 active groups and the groups really love to run a long time. There's a Facebook community that we have that they like belonging to. Anyone who joins parenting or pregnancy is added to this, private Facebook group that we have where we post all the pictures of the session. We put information up in there and we're up in that group. I think we have over 500*

> *individuals. So that's pretty neat. Like by that, it formed a community inside of the medical box."*

The most common forms of Group Care sessions among these twenty interviewees are those held in both Spanish and English, with the majority of patients and their families belonging to lower- and middle-socioeconomic statuses. However, we found that Group Care sessions are not solely limited to serving patients from these populations. In the Northeast, for example, there was one provider who held groups in Bengali, due to their clinic being located near a large immigrant population from Bangladesh. Another provider's Group Care sessions were centered around incoming immigrant families, both as refugees and those entering the country by personal choice. These communities have benefited heavily from the model. Group Care has allowed people from various backgrounds to the come together with the shared experience of having a young child. One provider working in an underserved community took time to explain how their Group Care sessions' support came to be:

> *"Parents in immigrant families can feel quite isolated and they may know people within their own community, but they have a really hard time connecting with people outside of their own community to language barriers. And so by doing group, anticipatory guidance, okay, this is great, I'm going to do group anticipatory guidance with more time for teaching because we'll do it in a group setting and we'll be able to create peer to peer connecting for parents and that they improved people mental health as well because they won't feel as isolated, and so that was the start of the idea and then I failed and then I finally succeeded and got enough grant money to be able to create a space in the community."*

Through our interviews, providers expressed a myriad of ways their patients embraced Group Care sessions to build bridges between each other and their respective providers. Interviewees spoke at length about the unity that comes from the Group Care model and how they have helped cultivate and create their own little communities "in the circle" discussions they provide and lead.

(4) Organizational Burden

As much as the Group Care model demonstrates great benefits to patients, their families, and providers, the participants also spoke of the difficulties that creating this form of care can entail and how there is burn-out associated with its delivery.

The Group Care model gives providers the time every few weeks or months to build a bond with the families, but this means they must come prepared. As mentioned, the Group Care model requires extensive planning and coordination. Many of the providers took time to express the deep appreciation they have for their nurses and ancillary staff. Generally, our interviewees expressed that the more support providers report having available, the less likely they are to feel burn-out from working these long Group Care sessions. One provider expressed their gratitude for his/her/their nurse multiple times throughout the interview:

> *"Our nurse is very dedicated. You need somebody who is really patient oriented and dedicated to her work, you know, so, I'm lucky to have found that person. And they really enjoy the contact, because this nurse knows them better than I do, she knows every mother because she calls them so often for reminders that she's on a first name basis with them and she fills me in sometimes or you know, this happened or that was that mother. So, it's a big help to me and she benefits because she feels valued as well, you know. So, uh, because she's not just a nurse, she's a co facilitator, which is, you know, a big thing for her. She's in charge. Yeah. So, everybody gains from that I think."*

On the other hand, some providers reported not having a particularly efficient staff, which limits what they are able to accomplish with the given time they have available for each session. One provider explained how the lack of unity and prioritization in a clinic can lead to Group Care not succeeding in a particular area:

> *"I couldn't get my nursing staff to get a really good buy in to it like, I would walk in a room and I'd say, 'can you get the two months back and ready and come in right behind me?' And then 15 minutes later they'd show up. So that was frustrating to me, and one of the hesitations I've had of doing it again in our clinic and one of*

> *the reasons I think about it losing interest and that's like, that was probably the most frustrating was the lack of understanding despite me having like five meetings with the nursing staff before I started. And talking about whether they think they can do it, how this works, you know, um, review with them before the nursing support , in our busy clinic, it was just wasn't a priority for them and it made it hard."*

The lack of administrative and nursing support really challenged several interviewees in being able to continue working in the Group Care model. Another provider expressed difficulties working with their team, reporting that prep time was a negative factor for anyone wanting to be involved in the process:

> *"What attendings, mostly faculty, didn't like is the time that it requires to prepare for the visit. The recruitment is always complicated to find, you know, seven, eight babies that are born at the same time that want to come to one particular site. And after it does require more work ahead of time. You have to be ready for a visit. It's not the showing up to see patients like you do during a regular visit, but it requires more preparation. So the faculty at the end decided that unless they have administrative support, someone that makes all the follow ups, does all the scheduling, someone that prepares room, that sets everything ahead of time, they don't want to do it. So they all stopped doing it basically."*

The greater health care team plays a substantial role in how Group Care is implemented. Other problems that add to providers' burdens and potential burn-out are certain organizational challenges: lack of resources, limited space to conduct sessions, or inadequate institutional buy-in, just to name a few. The limited space in particular is a challenge that many of the providers we interviewed shared. Interviewees expressed that being placed in a tiny room or a conference room was not conducive of the Group Care model and the needs of the families, especially of children who wanted to play while group took place (and who otherwise turned cranky or disruptive without such toys or an adequate space). When asking providers "What would you add to your groups if you had unlimited resources?" Many of them eagerly jumped at the chance of saying more space or skilled administrators. One provider said:

> *"I guess a bigger space, we are in a pretty small space, so if we have all the rooms in the world and all the resources in the world, probably like a bigger space. It would be more comfortable for the families and the providers and for everybody. I think that in a perfect world, I know sometimes if we have a week session we would provide some snacks, I know that for a lot of the moms, when they are overwhelmed taking care of the babies, it's very hard to prepare a meal, so I would have food in our sessions."*

While another simply said:

> *"A bigger room, that would be the first and foremost big thing".*

The need for help in coordinating and running the Group Care process is strongly suggested throughout many of the interviews. One provider, who reported that they did not have as much support as they needed, quickly noted that they wished they had an office manager to handle Group Care logistics:

> *"I think. Well, what would have helped for this to actually stay embedded in our practices, to have a full time person that deals with all the logistics and make sure all the patients are in there according to the curriculum, the visits and that would have helped with sustainability. So full time manager of the whole program that's not a provider, but just manages the logistics of the business."*

As the medical field continues to transition into better focusing on mental health needs and social determinants of health and well-being, it is crucial to recognize the dangers or provider burnout. The increased time, relaxed nature, and clear structure are all great benefits and strengths of the Group Care model. Overall, providers agreed that organizational burden does not inhibit the fondness and success of Group Care sessions, but that related obstacles must be addressed to help make the Group Care model even stronger, more successful, and less stressful (in order to avoid contributing to growing provider burn-out).

Discussion

Summary of Findings

Our interviewees revealed that providers generally have a positive opinion about the Group Care model. Providers give positive reviews, not only from their own experiences and perspectives, but from the reactions and experiences of their patients, residents, and health care colleagues. The Group Care model incorporates and fosters community, and it allows for the delivery of medicine and care to be inclusive and collaborative, something not always seen – or as easily performed – in traditional, one-on-one appointments between providers and patients. The implementation of peer education and anticipatory guidance in Group Care appointments help build relationships between providers, patients, and their respective families. This model of care delivery allows all participants to learn from one another, and the extended session time (compared with one-on-one well child visits), provides providers with the unique ability to expand on the education they can provide to patients, as well as helping dispel myths and relying on the creation and cultivation of community-based support and knowledge of existing resources. As stated, the Group Care model does pose challenges related to organizational burden. This model of well care delivery requires extensive planning and the assistance of multiple staff members; the structure requires a careful ability for providers to work collaboratively with other staff to plan sessions. Overall, providers identify Group Care as a useful tool to engage parents and their children patients, as well as giving patients and their parents the ability to build community – and for parents to feel empowered in their abilities to be a parent.

Limitations

Though this study provides important insight, it is not without limitations. One limitation of this study is the lack of diversity among providers, specifically in terms of regions where they

practice. The list used for recruitment was limited to the network of providers that the co-leaders of the Group Care Network in New Haven, Connecticut were familiar with, which is likely not entirely comprehensive of all Group Care providers in the United States.

While we believe that we reached thematic saturation upon completing twenty interviews, it is likely that we did not reach thematic saturation, particularly because the diversity of experiences of providers was limited, due to our sampling list mentioned above. There was greater success in the recruitment of local providers who took part in Group Care and those who were familiar with the co-leaders; as such, the practices that take place in the clinics of these providers may be homogeneous in structure compared to other sessions held in different communities by providers of diverse identities and social locations.

Self-selection bias is also a potential limitation, this study relied on providers to respond to the recruitment email, and those who felt positively about Group Care were probably more likely to respond, thus capturing only certain perceptions and experiences related to this delivery model.

Recommendations

The interviews that were conducted provided a strong foundation for understanding the was that providers implement and process Group Well Child Care. Group Care has the capacity to grow in number and practice, subsequently continuing to benefit many communities with parents who need the particular guidance and support that Group Care can effectively offer. If this model becomes a normalized form of pediatric care, it could alter the practice of medicine, particularly in the first few years of a child's life.

The benefits of Group Care are mentioned in various forms of literature, especially in terms of prenatal care. One study found prenatal Group Care to be associated with less of risk for preterm birth among at risk women who participated in Group Care instead on one on one care (Picklesimer

et al., 2012). Medical institutions and clinics who has already found success in prenatal care are beginning to implement Group Care for newborn children due to their demand for the structure.

Group Care also has the ability to address the challenges that providers face when practicing traditional forms of care. The demanding environment and need for high work satisfaction leaves those in the medical field burnt out and frustrated. Many seek work satisfaction but cannot find it due to the high levels of demand. Higher job satisfaction has been found to be connected to decreased provider burnout (Weng et al., 2011). Thus, more time with patients and stronger administrative teams, as well as institutional support for Group Care, could help lower provider stress and burnout over time. With the providers interviewed identifying high levels of work satisfaction and a positive increase in patient-provider relationships, Group Care has the potential of altering the way pediatric medicine is practiced for children, at least for well care.

Further research should continue to examine provider and patient perspectives on Group Well Child Care on an international level considering the varying cultural practices and health care access that exists across the globe. There is potential for effective methods and resources to be shared with our existing Group Care network in the U.S. Furthermore, we recommend researching Group Well Child Care and the association with improved mental and physical health and well-being for pediatric patients. Findings in this study related to the community-building capacities of Group Care suggest that this delivery model could provide important social and instrumental support, especially in minority and vulnerable communities (like refugees and non-English speakers), and future studies should continue to examine these health and well-being benefits, as well as in what ways this delivery model could be improved.

Conclusion

Through the use of semi-structured interviews with twenty Group Care providers across the United States, we identified central themes on both the successes and challenges providers face when implementing Group Care to healthy children and their families. We developed four themes that cover and characterize these providers' Group Care experience: (1), Integrated Peer and Provider Education; (2) Mindfulness; (3) Community; and (4) Organizational Burden. These themes provide a baseline of what Group Care consists of and contributes to from the provider's perspective. These twenty interviewees were candid and expressed the value of being included "in the circle" with their patients and fellow providers, all of which cultivates the meaningful experiences that the Group Care model allows for.

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Appendix

Appendix A: Recruitment Email

Subject Line: Qualitative research interview for Group Care

Dear _____,

My name is Noureen Ahmed and I am an MPH student doing my thesis with the Group Well Child Care team at Yale New Haven Hospital. I am working with the chairs of the APA Group Care Special Interest Group (SIG), Margi Rosenthal and Ada Fenick.

As a Group Well Child Care provider, I hope that you will consider participating in a short interview about your experiences. I hope to conduct 30-minute qualitative interviews with Group Care providers across the country, via phone or video conference. The results of these interviews will be de-identified, then shared with you, presented to our SIG network, and (hopefully!) published. I have an IRB exemption from Yale to conduct this study.

If you would be willing to participate in an interview, please reply to me (noureen.ahmed@yale.edu), and I will contact you to schedule an interview. We appreciate you sharing your experiences and contributing to the success of the Group Care network!

Please share this email with any Group Care providers in your network who might be interested in an interview.

Thank you for your support.

Also, my mentors want to make sure I let you know that we look forward to a collaborative, productive Group Care SIG (the first PAS SIG meeting will be May 2020 in Philadelphia!) and will keep you updated on our progress.

Yours,
Noureen Ahmed, Yale School of Public Health
Ada Fenick, MD, FAAP, Yale Pediatrics
Margi Rosenthal, MD, MPH, Yale Pediatrics
Mona Sharifi, MD, MPH, Yale Pediatrics

Appendix B: Interview Guide

Introduction

- Could you begin by telling us a little bit about your background and how you got involved with Group Care?

(1) Group Care Model

- **Can you tell me about what Group Care looks like at your institution?**
    - *Probes: patient population, structure, number of sessions, number in each group, number/type of providers*
    - *Probe: How was Group Care first started at your institution and how has it evolved since its conception? (If involved in starting the program) Would you tell me a bit about the process of implementing a Group Care model for the first time?*
    - *Probe: What are some of the things that have gone well with your Group Care model? What hasn't gone so well?*
    - *Probe: Can you tell me your thoughts on having a family advisory board for Group?*
- **Can you walk me through what your most recent Group Care session looked like?**
- **Where did the idea for Group Care first originate from?**
    - *Probe: What resources did you use to learn about and initiate group?*

(2) Recruitment & Retention

- **Can you tell me about how you recruit patients for Group Care?**
    - *Probe: Would you give me an example of how you would describe or pitch Group Care to a potential participant?*
    - *Probe: What reactions do you get from patients when they are first offered Group Care?*
- **What strategies have you used to keep patients engaged in Group Care?**
    - *Probe: How have the recruitment and retention processes adapted since you started? What challenges have you faced?*

(3) Provider's Perspective on Patient Experience

- **As a provider, how do you think Group Care has shaped your patients' experiences?**
    - *Probe: What are some examples of feedback you have received about the group model from patients?*
    - *Probe: What types of people seem to either benefit from or struggle with the group model?*
    - *Probe: How does the group model address individual needs? For patients' or parents mental health needs?*
- **How have you seen the group model impact the patient-provider relationship?**

(4) Provider Experience

- **What is different about being a provider in the Group Care setting?**

- *Probe: How has Group Care influenced your perceived effectiveness? Your work satisfaction?*

  Probe: Can you tell me about your experience working/collaborating with other providers? (ask about all of the people mentioned in the questions above - docs, nurses, NPs, child life, social workers, lactation, etc.)
- ***Are there any other members, such as residents involved in this setting?***
  - *Probe: What are benefits or challenges face with having these learners a part of the team?*
- ***What are challenges, you as a provider have faced in the Group Care setting?***

(5) Financial Support

- ***How is Group Well Child Care paid for?***

Conclusion

- Is there anything else you think I should know about Group Care (or should have asked)?
- Is there anyone else you feel we should talk to?
- What would you add to your groups if you had unlimited resources?

General probes to use frequently

- Can you tell me a little bit more about that?
- What was that like for you?
- Can you give me an example of a time where that happened?
- Oh, mhm, I see

Appendix C: Consent Script

"We are interested in understanding your experience with implementing Group Care. We will be asking you a series of open-ended questions lasting about 30 minutes. The purpose of our study is to better understand the Group Care experience from providers' perspectives, and to share our findings with you and across the national Group Care network to inform the development of future Group Care practices.

We would like your permission to record this interview for two reasons. First, this lets us listen carefully to you rather than taking notes. Second, it means we will accurately capture our conversation for analysis.

All information will be kept strictly confidential and no identifying information about you or your organization is included on the transcript. Digital files with audio-recorded material will be deleted as soon as the transcripts have been reviewed for accuracy. We don't anticipate this interview raising any risks or sensitive topics, but if at any point you would like me to turn off the recorder, please let me know. You are free to decline to participate, to end our interview at any time for any reason, or to choose to skip any question.

Is this okay with you?

Thank you. We will now begin the interview. Feel free to stop me at any time with questions or clarification."