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Implementation Outcomes of Group Medical Visits in Primary Care: A Scoping Review

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ADMINISTRATIVE INFORMATION

Support - Collaborative grant.

Review stage at the time of initial registration - Piloting of the study selection process.

Conflicts of interest - None declared.

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Amendments - This protocol was registered with the International Platform of Registered Systematic Review and Meta-Analysis Protocols (INPLASY) on 23 November 2026 and was last updated on 23 November 2026.

INTRODUCTION

Review question / Objective This review aims to examine and map the implementation outcomes of Group Medical Visits (GMVs) in primary care settings. Specifically, it seeks to identify which implementation outcomes have been assessed during the implementation of GMVs, how these outcomes have been measured, and the approaches used to plan, adopt, and evaluate them. The review will also synthesize results from implementation outcome evaluations and explore factors that influence GMV implementation success or challenges in primary care.Examine and map implementation outcomes of Group medical visits in primary care.

Review questions:
1. What implementation outcomes have been examined with the implementation of GMVs?
2. How are these outcomes being measured? Specifically, how were they planned, adopted and/or evaluated?
3. What are the results of the implementation outcome evaluation of GMVs?
4. What factors influence the implementation outcomes of GMVs?

Background Primary care is essential to the sustainability of healthcare systems, yet many countries face growing challenges related to timely access, workforce shortages, and increasing demand for chronic disease management. At the same time, population growth and aging have contributed to a rising prevalence of cardiometabolic diseases and their associated risk factors. Collectively, conditions such as metabolic syndrome, hypertension, dyslipidemia, diabetes, and obesity affect a substantial proportion of adults worldwide and contribute significantly to multimorbidity. This growing burden strains already overstretched primary care systems and underscores the need for innovative, scalable approaches to chronic disease prevention and management.
Group medical visits (GMVs) are an innovative model of care in which one or more healthcare

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professionals provide services to multiple patients simultaneously. Within primary care, GMVs typically integrate clinical care, health education, peer interaction, and self-management support, offering a promising approach to chronic disease prevention and management. By delivering care to several patients at once, GMVs may improve access to care, enhance patient engagement, and support more efficient use of healthcare resources.
GMVs have been implemented for a range of chronic conditions, most notably diabetes, as well as hypertension, obesity, and cardiovascular risk reduction. Existing evidence suggests that GMVs are an acceptable, safe, and effective alternative to traditional care delivery. Clinical outcomes are generally comparable to usual care, with some studies reporting improvements in glycated hemoglobin (HbA1c) and systolic blood pressure, particularly among individuals living with diabetes. Additional benefits include enhanced disease knowledge, peer support, self-efficacy, and self-management behaviours.

Rationale Despite this growing evidence base on GMVs, research has focused predominantly on clinical effectiveness, leaving important gaps in our understanding of implementation. For complex interventions such as GMVs, successful integration into routine practice depends not only on patient outcomes but also on factors influencing uptake, delivery, and long-term maintenance. Implementation outcomes such as acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability provide valuable insight into these processes.
Synthesizing implementation evidence remains challenging because studies use diverse frameworks, methods, and outcome measures. Furthermore, some investigations report implementation-related findings without explicitly using implementation science terminology, limiting cross-study comparison and hindering the translation of evidence into practice. A common implementation-outcomes lens may facilitate a more consistent understanding of how GMVs are planned, delivered, evaluated, and sustained.
Therefore, this scoping review aims to map reported implementation outcomes of GMVs in primary care, as well as the planning, implementation, and evaluation processes associated with these outcomes. This synthesis will help identify factors that support successful adoption, scale-up, and sustainability of GMVs in routine primary care settings.

METHODS

Searching for the evidence A comprehensive search strategy was developed in collaboration with an academic librarian to identify accepted peer-reviewed manuscripts. The search is planned for November 2026 and will use the following databases: Academic Search Complete, CINAHL, EMBASE, MEDLINE, PubMed, ScienceDirect, and Scopus. No limitations or filters will be applied in the searches, including no date or language limitations. Backward and forward citation tracking will also be conducted to screen for additional eligible articles. Predefined eligibility criteria will guide screening and data extraction, which two independent reviewers will conduct. Results will be synthesized descriptively. The full search strategies for all databases will be included in the final review publication.

Eligibility criteria Primary evidence examining the evaluation process of the implementation of GMV's in the health care context, based on implementation outcomes, not limited to effectiveness, will be eligible for inclusion in the review sample. Relevant contexts include virtual or non-virtual, at the primary care level, for all health conditions or diagnoses, and mixed diagnosis groups. Any type of primary evidence source that is pertinent to answering the research questions, including qualitative studies, will be included in the review sample.

Implementation outcomes will be conceptualized according to Proctor et al. (2011)'s definitions, which identify outcomes distinct from clinical or service outcomes and that specifically reflect the success of implementation efforts. These outcomes include acceptability, defined as stakeholders' perceptions that an intervention, service, or innovation is satisfactory or agreeable; adoption, referring to the intention, initial decision, or action to use an innovation or evidence-based practice; and appropriateness, which reflects the perceived fit, relevance, or compatibility of an intervention within a particular setting, for a given provider or population, or to address a specific problem. Costs refer to the financial impact associated with implementation, including incremental implementation expenses. Feasibility captures the extent to which an intervention can be successfully implemented and used within a given setting. Fidelity refers to the degree to which an intervention is delivered as intended and may include adherence to the intervention protocol, the amount of intervention delivered, differentiation of program components, quality of delivery, and participant responsiveness. Penetration describes the integration of an intervention within a service setting and its subsystems and may be assessed

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by the proportion of providers delivering the intervention or the proportion of the target population receiving it. Finally, sustainability refers to the extent to which an intervention is maintained or institutionalized within routine practice and ongoing organizational operations over time.

If retained studies report results on factors that have influenced or potentially influenced the implementation process, as well as the program's sustainability, this information will be retained as additional outcomes.

Studies in group care contexts where no health care professional had prescribing rights (I.e., health education sessions, health education programs), and studies at secondary or tertiary care levels, will be excluded.

Source of evidence screening and selection Study screening and selection will be carried out systematically using Covidence SR software (Veritas Health Innovation, Melbourne, Australia; available at http://www.covidence.org). Search results will be imported into the review software, which will automatically remove duplicates. Title and abstracts will then be screened independently by two reviewers. Disagreements will be resolved through discussion until consensus is reached. A third reviewer will be consulted if necessary. Retained studies will then proceed to full-text article screening, again by two independent reviewers, with the same disagreement resolution process. Study quality will not be assessed, as this is not required for a scoping review.

Data management Two reviewers will independently extract data from retained articles, with the same process to resolve differences as in the screening stage. Data will be extracted into a standardized data extraction form, integrated into Covidence, and guided by the review questions and outcomes of interest. Data extraction will be pilot-tested by the review team. Data retrieved will include study characteristics (i.e., author, year, study type), population (i.e., medical diagnosis of interest), characteristics of the primary care setting in which the GMVs were implemented, GMV characteristics (i.e., duration, number of sessions, spread of sessions, education topics, health professionals involved, etc.), implementation outcomes assessed (as per Proctor et al., 2011), methods used to plan, adopt and/or evaluate the implementation process and/or outcomes, and, when available, results related to factors having influenced the implementation process. Results pertaining to implementation outcomes and influencing factors will be retrieved as verbatim text to enable basic qualitative content analysis, as described in the following section.

Reporting results / Analysis of the evidence Results will be synthesized using descriptive statistics and narrative summary. Characteristics of included studies will be summarized in tables, including publication year, study type, population, primary care setting, GMV characteristics, implementation outcomes assessed, and methods used to evaluate implementation outcomes. Implementation outcome findings will be descriptively synthesized by implementation outcome category using a basic qualitative content analysis. Findings on factors influencing GMV implementation will also be summarized qualitatively, with relevant results organized into emerging categories.

Presentation of the results Results will be presented in tables, figures, and narrative summaries. A PRISMA flow diagram will show how the evidence is distributed and outline the study selection process. Included reviews will be described in terms of their characteristics, populations, measured implementation outcomes, and the methods used to plan, adopt, and/or evaluate implementation.

Language restriction Yes : English, translated in English or French.

Country(ies) involved Canada.

Other relevant information Medical Subject Headings:
o Shared Medical Appointments
o Process Assessment, Health Care
o Program Development
o Program Evaluation
o Implementation Science
o Health Plan Implementation
o Delivery of Health Care

Keywords Shared medical appointment, group medical visit, implementation science, implementation outcomes, program evaluation, healthcare.

Dissemination plans Findings from this scoping review will be shared through journal publication, a thesis literature review, conference and academic presentations, and with relevant stakeholders in primary care and the PARTAGE-D study.

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