The Group Visit Solution: Creating a Health+Care Experience

The Institute of Medicine states that there is a "quality chasm" stifling healthcare in the U.S. In a recent publication, the IOM wrote, "Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge – yet there is strong evidence that this is not the case."

The weight of the growing number of patients with chronic disease is bearing down hard upon the U.S. population, the number of physicians in the country are dwindling – leaving physicians with more patients and less time. Delivering quality care to every single patient is rapidly becoming an impossible task. The solution to the problem is easily verbalized: physicians need more time with each patient. But, with some physicians already seeing as many as 35 patients a day – is finding "extra" time even possible? Pioneers of the industry say yes. These forward thinkers are launching the next generation of effective treatments for chronic disease: patient group visits.

What are Group Visits?

Group visits (GV), also known as shared medical appointments, have become the viable solution for primary care physicians struggling to find the time to deliver the highest quality care to an ever-growing number of patients plagued by chronic illness. GVs offer the opportunity for a physician to see multiple patients as a group for follow-up or routine care. These visits are voluntary for patients and provide a secure but interactive setting. In this setting, patients not only have access to their physicians, but they can learn from the first-hand experiences of their fellow group members and receive well-rounded advice.

Research in the last decade has uncovered strong evidence that the solution to chronic disease does not exist solely from a pill bottle – no, successful treatments incorporate lifestyle changes and hold patients accountable for their efforts. GVs provide an atmosphere for education and support, improving the quality of care for all patients and addressing the needs of one of the fastest growing segments of the population – patients with chronic disease.

In 2009, The Lancet published the findings of a 10-year study, based on the Diabetes Prevention Program (DPP) sponsored by the National Institutes of Health. This study was designed to test the efficacy of two diabetes treatments: metformin versus healthy lifestyle changes. After just three years, the findings were clear: patients in the lifestyle group reduced their development of diabetes by 58 percent, compared to a placebo, while the metformin group reduced development by 31 percent.

Many other community-based programs have been proven to work better than current conventional treatment approaches that focus on one-on-one counseling. These studies and community observation confirm that the most effective weapon against chronic disease is lifestyle changes. GVs encourage this key component of success and overcome the two biggest barriers to successful execution: time and accountability. Through an available simple, turn-key model, GVs allow physicians - with minimal resources - to see at least twice as many patients in the same amount of time and benefit from the group dynamic in regards to accountability.

Group visits are the practical, efficient, cost-effective solution to serious challenges that physicians and patients face under the current health care system. GVs include not only group education and interaction, but also many of the elements of an individual patient visit, such as the collection of vital signs, medical history and a physical exam. Group visits differ from other forms of group interventions, in that they are physician led and include a one-on-one consult with the physician.

The American Academy of Family Physicians (AAFP) endorse group visits, stating, "Research indicates group visits can also provide an improved quality of care and a higher level of patient and physician satisfaction - Group visits have proven to be an effective way to improve patients' dietary compliance and intermediate markers for diabetes and coronary artery disease." And, according to the AAFP website, "Group visits are one component of the system changes needed for the new model of care."

How can Group Visits benefit My Practice?

CLINICAL

- Better health outcomes
- Increased patient accountability
- Greater catalyst for lifestyle change

FINANCIAL

- More patients, less time
- Reduced administrative tasks

EFFICIENCY

- Provider has more time with patients
- Group patients with similar conditions together
- Avoid repititious advice
- More available slots for new/high acuity patients

How can Group Visits benefit My Patients?

CLINICAL

- Improved quality outcomes
- Greater information and lifestyle education
- Unique patient 'experience'

FINANCIAL

- Increased time with physician
- Insurance billable
- Potential cost savings for cash pay patients

RELATIONAL

- Extra time with their own physician
- A more relaxed pace of care
- Help and support from other patients
- High levels of patient satisfaction

Who is using Group Visits?

Group visits have been utilized in clinical practice since the early to mid-1990s, but have gained significant traction over the last several years. Major medical institutions, including Yale Health, The Cleveland Clinic and Kaiser Permanente have made group visits part of their practice. But, the model isn't just for large health corporations – even small, individual practices can implement group visits – reaping the rewards without adding resources.

According to a recent article in Time magazine, group visits may soon become a major model for medical practice, "Since 2005, the percentage of practices offering group visits has doubled, from 6% to 13% in 2010. With major provisions of the Affordable Care Act due to be implemented by next year, such group visits are also becoming attractive cost savers — patients who learn more about ways to prevent more serious disease can avoid expensive treatments."

Physicians using group visits are finding success and satisfaction, not only for themselves, but for all things related to their bottom line: healthy patients, time and profitability.

The Evolution of the Group Visit Model

The group visit model began in 1991, when John C. Scott, MD, began the Cooperative Health Care Clinic (CHCC) as a solution to his frustration with his ever-present hurried state – rushing from room to room and patient to patient, always late and never fully able to immerse himself in each patient's needs. His initial model is the oldest and therefore the most-studied, as current comparisons are difficult to achieve due the standard practice of billing and coding group visits.

Dr. Scott's model was carefully studied before implementation, following the same cohort of homogenous patients for 2.5 hours sessions over an extended period of time. His quality outcomes were favorable, but improvements in access and productivity were minimal. This paved the way for a new model, the Drop-In Group Medical Appointment (DIGMA), created in 1996 by Dr. Scott's colleague, Edward Noffsinger, a general psychologist at Kaiser Permanente in California. DIGMAs allowed patients to sign-up for scheduled group sessions or drop-in as their schedule allowed. This model gave patients more flexibility in scheduling and changed the dynamic of the group each time.

Both models were greeted with successful outcomes – one popular example of the power of the group dynamic was cited from one of Noffsinger's DIGMAs, "One poorly –controlled diabetic patient refused to take insulin in spite of numerous entreaties by his physician; at a DIGMA, another diabetic remarked, 'you remind me of myself before I had my first amputation.' The patient started insulin."

The success of the DIGMAs led Noffsinger to launch a number of primary and specialty care DIGMAs, as well as refine the approach with another group visit model known as the Physical Shared Medical Appointment (PSMA). The approach differed from DIGMAs slightly, with the addition of private physical screenings to go along with the group discussion.

As the years have ticked by new pioneers have emerged offering a fresh take on the successful group visit model of medicine. First in 2000, Steven Masley, MD seemingly merged the DIGMA and CHCC models, to better suit the needs of the private practice physician. And, most recently, in 2008, Shilpa P. Saxena, MD began her work, perfecting group visits using the DIGMA model and infusing functional medicine concepts to semi-mixed patient groups.

Dr. Saxena discovered that outcomes could be improved if groups were offered not only exclusively by classification of disease, but also by the similar lifestyle changes necessary to achieve success. As an insurance-based primary care physician, she evolved the DIGMA model and created four distinct curriculums that the majority of her chronic disease patients could benefit from: inflammation, blood sugar balancing, stress hormones and gut health. By focusing on the success rate of lifestyle changes and group settings, Dr. Saxena was able to create unique patient education curriculums along with a turn-key model and toolkits that physicians, can adopt to fit their current practice model and patient needs.

Below is a snapshot comparing the evolution of the group visit model - from its conception to today:

Group Visit Pioneers	Model	Description	Primary Patient Focus	Target # of Pts	Formal Education	Typical Session Length	Pro/Cons
Scott, 1991	**CHCC**- *Cooperative Heath Care Clinic*	Follow same cohort of pts - seen regularly over time. Typically homogeneous patient types	High utilizing, often multi-morbid geriatric patients	15-25Pts	Yes	2.5 Hours	Pro: Improves patient outcomes Con: Minimal productivity improvements, Patient access limitations, Not insurance-friendly
Noffsinger, 1996	**DIGMA Heterogenous** *Drop-In Group Medical Appointment*	In its original form resemble individual office visits done in a group setting. Pts can 'drop-in'	Follow-up visits, as medically necessary. Completely mixed patient types.	10-16 Pts with chronic illness	No	1.5Hours	Pro: Improves access, Increases productivity, Greater positive patient outcomes Con: Lacks formal education
Noffsinger, 2001	**PSMA** Physical Shared Medical Appointment	Private physical examinations with group discussion	Annually New & Est. Primary and specialty care	7-9 Males 6-8 Females	No	1.5-2 Hours	Pro/Con: Same as DIGMA heterogeneous
Masley, 2000	**CHCC/DIGMA-Mixed Private Practice Model**	Combines education component of CHCC with individual pt assessment DIGMA model	Follow-up visits. Homogeneous grouping of pts (diagnosis-specific patient registry)	20-30Pts	Yes	2 Hours	Pro: Improves access, Increases productivity, Greater positive outcomes Con: Limited growth of practice due to homogenous grouping, Reduced efficacy of varied group dynamic
Saxena, 2008	**DIGMA-Hybrid Functional Model**	Hybrid between homo and heterogenous DIGMA model - Retaining education component of CHCC	Follow-up visits, as medically necessary. Structured education for lifestyle intervention.	8-16Pts	Yes	1.5Hours	Pro: Same as DIGMA + • Multi-faceted group dynamic • Easy to incorporate lifestyle education • Insurance friendly • Functional medicine friendly

Group Visits Yield Positive Outcomes

An extensive number of published studies do not currently exist to fully represent the efficacy of group visits, however the studies that have been conducted, in conjunction with the data from studies like the 2002 DPP study, strongly suggest that group visits yield positive outcomes. Of the handful of prospective studies that have been completed, primarily from the Cooperative Healthcare Clinic (CHCC) model, multiple improvements in patient outcomes have been observed, as well as patient and provider satisfaction.

Creating an environment where many of the coping and compliance issues, education and support can be addressed by the patients themselves is far more efficient and, as accumulating data suggests, more effective than one-on-one time with physicians or other caregivers. DeeAnn Schmucker, MSW, LCSW, author of Group Medical Appointments: An Introduction for Healthcare Professionals, relays her observations of the benefits of the model, "Physicians loved the groups. They could finally practice the medicine that was in their heart, giving each patient more attention and a wider range of treatment and support without compromising financial or insurance requirements, or extending their hours. They could actually spend less time, accomplish more healing and increase reimbursements per hour." Ms. Schmucker accurately describes how this new model of healthcare brings the quality and heart back to practicing medicine – reaping benefits for both physicians and patients.

Building Connection and Community for Better Health

A key facet of this system is that it taps into a huge well of resources for management of chronic diseases – stemming directly from the patients of the group. Bringing the patients together builds a collective resource of individuals who have vast experience and great wisdom in living with multiple chronic medical conditions. GVs strive to create a community of caring within each patient visit, and change the story of the patient of one from isolation, frustration and fear to one of hope, dignity, community and empowerment.

Dr. Mark Hyman, a well-known advocate of promoting healthy lifestyle changes to battle chronic disease, discusses why this "movement" toward community-based wellness is the wave of future of medicine, "This movement is starting to spread. Doctors frustrated with the failure of medication to treat their patients with chronic illness, obesity and diabetes are starting small groups...and meeting weekly to teach them about nutrition, cooking, shopping, exercise, stress management and more..... This community-based group approach solves many enormous obstacles to reversing this epidemic faced by the health care system."

Group visits create a bond among the patients and even restore hope and faith in the effectiveness of care. Bonding and trust among individuals experiencing similar struggles is a powerful motivator and key components for effective accountability and, ultimately, successful achievement of goals.

The Simple Process of Billing and Coding Group Visits

Many physicians embrace the concept of group visits, however apprehension rises when billing and coding are considered. However, the process isn't any different than a one-on-one visit - most clinicians code a GV assessment with a typical E/M code, like 99213.

The AAFP carefully investigated the billing and coding aspect of group visits, inquiring directly to CMS, "Is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?"

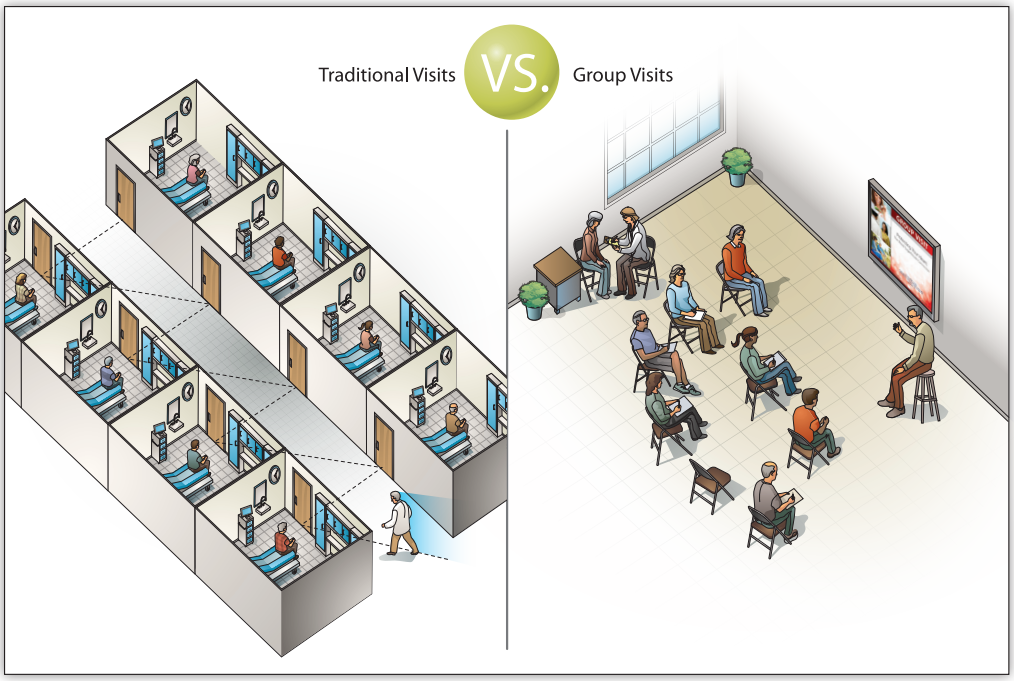
The CMS responded, "…under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary."

Billing group visits are best envisioned as a series of individual doctor visits with other patients as observers that are conducted in a supportive group setting, based on the complexity of the visit (not the time spent in an individual visit). When not billing based on time alone, a 99213 for DM, for example, requires: a chief complaint; 1 to 3 questions about diabetes (frequency and values of self-monitored blood sugars, vision, feet, exercise, diet etc); 1 ROS (review of systems) question; and low complexity care of diabetes; an assessment of controlled diabetes; and a plan that deals with the diabetes. Documentation of GV assessment and care plan can be streamlined with the use of a well-formatted template, of which Noffsinger and Saxena have both developed, and have available commercially for other clinicians to adopt. Group Visit Toolkits are based on Dr. Saxena's DIGMA-hybrid model and have four unique curriculums, as well as SOAP note documentation templates, which allow physicians to easily structure their group visits and maintain records of each patient and visit.

More Information on Group Visits

As you can see, group visits are not a new concept. Since 1991, pioneers in medicine have charted the course evolving shared medical appointments and group visits into the dynamically effective, yet simple to use model that exists today.

However, if you begin from conception, the number of resources - and more importantly, the sheer length and volume of these resources - can seem overwhelming. As a physician, you want to give your due diligence to this new way of practicing medicine, but you also need your information in a manner that doesn't consume your already very busy schedule. For those looking to understand and implement GVs without hassle, you may wish to consider adopting an already proven and well-designed system: the clinical support tools offered through the Lifestyle Matrix Resource Center (LMRC). Several unique Group Visit Toolkits have been designed and are available through the LMRC to support nutrition, lifestyle and functional medicine based group visits with all of the necessary components for insurance-friendly patient encounters and meaningful patient education.



Other great resources include the American Academy of Family Practice Physicians' website and, for more extensive resources dating back to the beginning of this concept, see Dr. Edward Noffsinger's textbooks, *Running Group Visits in your Practice* and *The ABCs of Group Visits*. Dr. Noffsinger is known as the godfather of group visits and offers these expansive references that give insight into the vast nuances of group visits.

How can Group Visits Fit into Your Practice?

You don't have to turn your practice upside down to incorporate group visits that will improve your revenue, influence and efficiency. The solution is a simple, turn-key business model that includes everything you need to plan for your insurance-friendly group event, educate your patients and document your assessments. The Group Visit Toolkit (GVT) created by one of the pioneers of group visits, Dr. Shilpa Saxena, is that solution. The Group Visit Toolkit allows you, the practitioner, to educate your patients with chronic disease or dysfunction on different lifestyle and functional medicine topics. Patients needing similar lifestyle education are grouped together to maximize your time and facilitate a supportive environment for patients to acquire the information and motivation needed to change their health trajectory.

References

1. ABCs of Group Visits: An Implementation Manual for Your Practice (Noffsinger 2013)
2. Running Group Visits in Your Practice (Noffsinger 2009)
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4. Beck A, Scott J, Williams P, et al. A randomized trial of group outpatient visits for chronically ill older HMO members: the cooperative health care clinic. J Am Geriatr Soc 1997; 45: 543-9.
5. http://www.aafp.org/dam/AAFP/documents/patient_care/fitness/GroupVisitAIM.pdf.
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To learn more visit the resources listed below:

http://www.thelifestylematrix.com/group-visit-toolkits/

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