

Putting Group Visits Into Practice

A Practical Overview to Preparation, Implementation, and Maintenance of Group Visits at Massachusetts General Hospital



Group Visit Program, Women's Health Associates

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Notes

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Note to Reader

This document is a guide for use by medical providers affiliated with the Massachusetts General Hospital, Boston, Massachusetts. The views expressed in this document represent up-to-date knowledge in the field and reflect the experiences of Mass General-affiliated clinicians who have tried a group visit model in their primary care practice.

The concept of group visits is evolving, and clinicians interested in starting group visits in their practices should do their own due diligence and research to ensure success and to meet productivity expectations, billing requirements, proper documentation, and confidentiality regulations.

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Dr. Charles Tracy, Harvard Vanguard Medical Associates, Wellesley, MA. From Group Healing: Tired of waiting for a doctor? Shared medical appointment could be the answer. Wall Street Journal, December 19, 2009. From Anne Tergesen, reporter and Jodi Hilton, photographer (Protected under copyright laws, permission granted)

Table of Contents

Introduction	4
About the Authors	4
Preface.....	4
About This Guide.....	5
Defining Group Visits	5
Group Visits: A Brief Summary of the Literature.....	6
Stage 1: Preparing and Planning for a Group Visit.....	8
1.1 Practice Resources	8
1.2 Provider Training	10
1.3 Assessing Patient Care Needs	11
Stage 2: Implementing a Group Visit at your Practice.....	13
2.1 Structure & Content of the Session	13
2.2 Timing and Scheduling	14
2.3 Billing for Group Visits.....	15
2.4 Maximizing Attendance & Recruiting Patients.....	17
Stage 3: Maintaining and Sustaining Group Visits	20
3.1 Providers	21
3.2 Patients.....	21
3.3 Practices: Fitting Group Visits into Practice & System Changes	21
Final Note	23
Bibliography.....	24
Addendum.....	26

INTRODUCTION

About the Authors

The **John D. Stoeckle Center for Primary Care Innovation** is devoted to revitalizing and redesigning the delivery of primary care in order to provide the highest level of clinical excellence, provide an extraordinary experience of care for patients and their families, and create an exciting and fulfilling professional life for current and future primary care practitioners. As a reliable and trustworthy source of knowledge and leadership, the Stoeckle Center partners with people across the country to improve primary care through collaborative work in research, innovation, education, and policy reform.

Women's Health Associates is a primary care internal medicine practice of the General Medicine Unit, Department of Medicine, at Massachusetts General Hospital that is dedicated to the enhancement of women's health services, education, and practice. Women's Health has been instrumental in expanding the use of group visits by medical care providers in the Mass General community.

Preface

CASE ILLUSTRATION

"Ms Smith has Type 2 diabetes, hypertension and hyperlipidemia. Her last HgbA1c was 9%, and she has been reluctant to start insulin. She has been trying to lose weight without success. She is overwhelmed with caring for diabetes at home: home glucose monitoring, meal planning and balancing her own needs with that of work and family. She is fatigued, not sleeping well; and just received a poor performance notice at work. In your office, she is too embarrassed to admit that she forgets to take her medication. During your interview, she acknowledges she is feeling depressed, defeated, alone and stuck. In addition to addressing her medical issues, you suggest she attend a group visit.

The **group medical care model (or group visit)** is an important inter-disciplinary care delivery innovation to complement the individual medical visit that has become increasingly popular. Harvard-Atrius Health, Cleveland Clinic, and other major medical institutions have been aggressively promoting this model of care. A group visit brings together a group of patients with similar medical needs or conditions for medical care in an extended appointment with a health care provider. Groups have been used for patients with a range of medical conditions such as asthma, diabetes, ulcerative colitis, multiple sclerosis, cancer, HIV and even menopause, insomnia, and stress.

Over time, groups have evolved to incorporate education, counseling, and group discussion around management of patients' medical conditions. In a group visit, patients have the added benefit of learning from one another and building self-management skills. As health care moves toward more integrated models for care delivery, the group visit model can provide a validated means for practices to improve efficiency, access, patient satisfaction, provider satisfaction and possibly health outcomes. The table below provides an overview of the components of a typical group visit.

Overview of a Group Visit

- Patients meet as a group, with a team consisting of a physician or nurse practitioner, and in some cases, a nurse and/or behavioral specialist
- The group usually meets for 1.5 to 2.5 hours, at a periodic interval that is appropriate for the medical need and condition
- The structure emphasizes an interdisciplinary approach to the medical care visit and has been used for a wide range of medical conditions: diabetes, hypertension, asthma, menopause, spinal disorders, and adult wellness visits
- Each group session includes an individualized medical review by a licensed practitioner, patient education, and a facilitated group discussion
- Billing is based on standard medical and behavioral billing practice

About This Guide

To develop successful group visits, each practice must balance the needs of their target patient population with the resources, strengths, and staff available at each practice. While there are generalizable best practices, there is no magic formula for how best to deliver group visits in all cases. This report reviews the current state of group visits and provides a summary of experiences from those who have experimented with group visits in a variety of Mass General-affiliated practices. Overall, group visits can be useful for any practice group, regardless of medical or surgical specialty, and is especially robust in the primary care setting. We hope this guide is helpful and we look forward to your feedback.

Defining Group Visits

Group visits, known by a variety of names, including Shared Medical Appointments (SMAs), vary depending on the goal being addressed by the medical practice. There are three general areas of focus:

1. **Access** to medical care visits
2. **Education** for patients on their medical condition or disease
3. **Enhancement of Self-Management Skills for Lifestyle and Behavioral Change**, to promote self management at home and consistency in follow through on medical recommendations.

All “groups” incorporate some combination of these (See “Types of Groups”). However, they can differ in level of staffing, behavioral techniques used and the structure. For instance, at one end of the continuum are groups that help improve *access* to the medical practice for same-day medical complaints or follow-up. In the middle are Diabetes Self Management Education Groups (DSME), conducted by Certified Diabetes Educators, CDEs, which are often nurses or nurse practitioners, exist for those with diabetes, to expand *knowledge and awareness of their condition*, review health targets with a medically trained professional, and enhance their self management skills. At the other end of the continuum is group psychotherapy, where a group of patients with a specific behavioral condition meet with a trained psychotherapist, psychiatrist or

social worker to gain a better understanding of the *behavioral* aspects of their condition and learn strategies for change, under direct professional guidance.

In general, groups can be open-ended (drop-in, when offered) or time-limited (once a week or once a month), have fixed membership or drop-in attendance, include family members or not, and vary in the degree of structure for the group discussion.

Types of Groups			
Main Focus of the Group	ACCESS To improve access to medical care and address direct medical needs	EDUCATION To provide health education and teaching skills for self management	BEHAVIORAL CHANGE To promote and enhance strategies for lifestyle and behavioral change
Examples of Groups by Focus	<ul style="list-style-type: none"> Shared medical appointmentsⁱ Group medical clinics, veterans administration hospital 	<ul style="list-style-type: none"> Diabetes self-management education groups by CDE diabetes nurse educators Health coaching 	<ul style="list-style-type: none"> Medical group visits² Group psychotherapy Patient peer-to-peer support groups

Some payers have offered a definition of group visits. For example, Blue Cross Blue Shield of North Carolina (BCBS-NC) recently published a corporate guideline defining the group visit service: as multiple patients seen as a group by a medical practitioner for follow-up or routine care; (a group visit) includes access to physicians, the benefit of counseling with additional members of a health care team (i.e., a behaviorist, nutritionist, nurse or health educator), and patients sharing experience and advice with one another. For coverage by BCBS-NC to apply, the following criteria must be met:

1. The patient is an established patient enrolled in the medical practice groups
2. The group visit is disease or condition specific and includes those designed to address aspects of multiple chronic conditions for patients with co-morbid conditions
3. Patient attendance is voluntary, and patients can have individual medical appointments as needed
4. Adequate facilities and time are provided for group visits
5. Appropriate staff members are maintained to facilitate the group discussion and coordinate the meeting
6. The interaction is documented in the patient’s medical record

For more information regarding the history underlying the development of the definition of group visits please refer to addendum.

Group Visits: A Brief Summary of the Literature

Research on the use of group visits has established several benefits particularly relevant to treating patients in the primary care settings. Group visits have been successfully used to improve access to medical care (Bronson, 2004); better monitor the complex, chronic care needs for a high-risk population, such as the elderly (Beck and Scott, 1997; Scott, 2004); and conduct routine annual physical examinations (Noffsinger, 2002).

Patients with diabetes seen in group visits have shown improved adherence to standards of care, higher trust in their providers, significant improvements on clinical measures such as lowered glycosylated hemoglobin (HbA1c) levels, increased self-efficacy, increased satisfaction with care, and lower hospitalization rates. Medical group visits have also been linked to increased quality of life, increased diabetes knowledge, and decreased use of hypoglycemic agents. (Sadur, 1999; Trento 2001, 2002, 2004; Wolf, 2004).

Patients treated through group visits have shown decreased emergency department and outpatient utilization, increased quality of life, improved self-efficacy, and higher satisfaction with care (Beck, 1997; Blumenfeld, 2003; De Vries, et al, 2008; Jaber, Braskmajer and Trilling, 2006).

There are several reasons why group visits have been so successful. Groups provide the medical provider a more streamlined way to review medical health targets and progress (DeVries, et al 2008). It is also hypothesized that group visits offer hope to patients by integrating education with medical treatment and by facilitating the development of effective coping skills to improve adherence to treatment plans carried out at home. Often groups provide a unique opportunity for patients to come together in a supportive setting to deal with the social and psychological effects of their illness (Goodman, 1989).

The rationale for all group treatment programs is that a unique process occurs when people come together in a group. They are more suggestible and feel psychologically more powerful than when outside the group. A trained group leader can harness the suggestibility to help members address their feelings of powerlessness and implement constructive changes. Groups also provide a unique opportunity to reduce the intense shame and isolation associated with many chronic medical conditions by bringing individuals together in a protected space and creating a healing community in which members feel validated (Ulman, 1993). The group bonding and camaraderie that develops over time (from patient-to-patient interaction and from the interactive discussion between medical providers and the group) give individual members a chance to learn that they are not alone with their struggles and an opportunity to identify with someone who is a bit ahead of them in self-care behaviors. These group experiences foster increased feelings of self efficacy, a greater understanding of patients' medical conditions, and improved coping skills for patients to manage their health problems at home.

STAGE 1: PREPARING AND PLANNING FOR A GROUP VISIT

Group visits require advance planning. Before introducing group visits as a care delivery option, each medical practice must dedicate the time to assess three key issues:

- 1) Practice resources: Staff and space**
- 2) Staff training**
- 3) Patient care needs**

1.1 PRACTICE RESOURCES

A. Staffing the Group Visit Team

1. Key Team Roles in a Group Visit:

There are three key team roles in a successful group visit: **1) medical clinician, 2) behaviorist health care provider and 3) support staff.** The clinician who serves as team leader is typically a physician, but can also be a nurse practitioner. The behaviorist health care provider is typically a provider comfortable with running a group and trained in appropriate group facilitation skills, or a provider with mental health training (psychologist or social worker). This role may be taken by a physician or nurse practitioner if they feel comfortable with the role, by a psychologist, other mental health worker, nurse, pharmacist, or dietician with the right training. The support staff fills the need for any pre-visit screening, patient intake, preparation of the space for the individual examination, and/or transcription support for documentation of the visit. When choosing your team, remember that in a fee-for-service reimbursement model, level of financial reimbursement you are eligible to receive for your group visits is directly affected who is running the group. For example, a physician-led group is more highly reimbursed than a nurse practitioner-led group (*See Section 2.3, Billing, for more details*). Group visit team member responsibilities, which will vary depending on the overall group visit structure, are summarized in the chart below.

Staffing the Group Visit Team*		
Medical Clinician	Behaviorist Healthcare Provider	Support Staff
Physician (MD) Nurse (NP, RN)	Physician (MD) Psychologist (PhD) Nurse (NP, RN) Social worker (MSW, LICSW) Registered dietician (RD)	Nurse (NP, RN) Medical student Medical assistant Medical transcriber Administrative assistants

*This table lists the most common staff choices at Mass General and is not exclusive.

While the group visit team does not require three team members to run to group, some tasks are better suited to certain staff or providers, given their training, skills, and compensation level. For each practice, choice of group visit team members is largely influenced by available practice resources and patient needs.

2. Important Qualities of a Physician/Team Leader:

The success of the group visit program is greatly enhanced by having a physician champion to lead the practice's team, even if the actual group visit is conducted by a nurse practitioner or other staff member. Based on observations of successful group visits and feedback from Mass General clinicians, the characteristics of a physician "champion" and other team providers include:

1. Excellent clinical decision-making skills
2. An ease with making quick decisions in a short period of time in front of other people
3. A history of teaching ability with patients, students, or other clinicians
4. Comfort with the unexpected challenges that arise when patients with different personality types and medical conditions come together in a group setting
5. Strong interpersonal and facilitation skills and good relationships with support staff

3. Strategies for Recruiting Physicians and Other Medical Care Providers to Support and Participate in Group Visits

Physicians have two important roles in practices offering group visit programs. Some physicians may participate directly by leading groups, while others support the program by referring their patients for group visits conducted by others in their practice. Engaging active physician support is critical. Physicians are strong patient recruiters because patients trust their own physician's recommendations. Their participation also can affect reimbursement strategies under the current reimbursement model (*See Section 2.3, Billing*).

Winning support from physicians for groups can be enhanced by the following strategies:

- Encouraging all key physicians to sit in on existing group visits to observe the process
- Emphasizing the improved quality of life, productivity, and work satisfaction that is consistently emphasized by physicians who lead groups.
- Hearing directly from other physician colleagues about the merits and benefits of group visits
- Providing research-based evidence in support of group visits
- Making it easy for physicians to refer patients to group visits. This can be accomplished by having a simple process for referring patients to groups. Suggestions include:
 - Have a point person at the front desk responsible for booking group visits
 - Create electronic medical record tools or templates to be used by practice clinicians for referral
 - Have flyers with the dates for group visits readily available in the examination room for distribution to interested patients
 - Alert providers as to who might benefit from a group visit by using a patient registry or more sophisticated population manager or patient web portal

B. Space: Finding an Appropriate Location for the Group Visit:

1. Where to Hold Group Visits

There are a few important attributes for a space to work well for a group visit:

1. The space is ideally large enough to accommodate at least 10 people, and is easily accessible to patients from the waiting room.
2. The space is private, to assure confidentiality (avoid open lunch rooms or auditorium spaces where people outside the group can enter during the session).
3. For teams planning to conduct the medical review component outside the meeting space (integrating a traditional individual medical visit into the experience), there is easy access to a private exam area, located close to the group.
4. There is a computer with high-speed internet access in the room (ideal, but not crucial) in order to access electronic medical records and online resources during the session.

For practices without access to a room specifically designed for group visits, there are a few options:

1. Hold the group in the practice's waiting area before or after normal business hours (assuming privacy can be maintained)
2. Hold the group in communal conference rooms, if booked ahead of time.
3. Hold the group at another location outside your practice. Some practices have found that their patients have difficulties reaching their office for early or evening groups, due to traffic or parking issues at Mass General at rush hour. Patients have been willing to travel to locations outside their usual doctor's office for group visits, particularly if personally invited to do so by their physician. You may consider utilizing space outside your practice for the group visits, or work with the local community to identify an appropriate location in the practice's catchment area, (assuming this is covered by your medical malpractice insurance carrier).

▶ **TIP:** Studies indicate that parking vouchers, a relatively small expense, can be a strong incentive for hesitant patients to attend group visits (Kawaski et al, 2007). If the group visit is conducted during meal times, having a light lunch or snacks available is also a draw.

1.2 PROVIDER TRAINING

▶ **KEY POINT:** In addition to clinical background, having group facilitation skills is an important provider skill for running group visits, and may require additional training in order to meet the needs of the group.

A. Learning Group Facilitation Skills

Because traditional clinical training focuses primarily on one-on-one provider-patient interactions, physicians, nurse practitioners, and nurses often need additional training in behavioral management skills and on how to facilitate group interactions effectively. The first skill is to know how to create well-defined parameters for the group, such as setting goals, methods to achieve those goals, and defining the roles of patients and providers. This allows patients and providers to feel confident about what they can expect from the group, and creates a sense of safety. Other group facilitation skills include how to manage certain personality types (such as dominant, troublesome or quiet group members), how to manage questions, how to keep group discussion robust, how to listen for themes to help group members integrate the information during the session, and how to create group cohesion.

Learning how to organize the group with a coherent beginning, middle, and closing to the session, while maintaining an open discussion, is crucial to the success of the group. There are processes which can be helpful when facilitating groups, for instance, providing validation following a member's comments ("I hear that ___ is a concern for you and perhaps this is true for others...."), asking the group to respond to a member's comments ("What do the rest of you think?"), and knowing when to be silent, and when to comment as the medical provider. While these may appear simple and obvious, using them effectively can greatly enhance the group experience.

Content for a Training Program in Group Facilitation Skills

- Understanding the goals of a group
- Building group cohesiveness
- Incorporating behavioral techniques such as Motivational Interviewing
- Strategies for individual and group problem solving
- Enhancing communication between group members and manage different personality types (difficult patients, the quiet ones or the “chirpy” patients)
- Stress management skills and simple relaxation exercises for reducing one’s response to stress (i.e., breathing, muscle relaxation, meditation, visualization or mindfulness)
- How to help patients start exercise with demonstration
- Opportunities to rehearse and receive feedback using role play and analysis of video of a simulated group

B. Using Mind/Body Stress Management Techniques

Mind/body stress management techniques can be particularly effective self-management tools for patients in group visits (Astin et al, 2003). It is helpful to dedicate 10 - 15 minutes of a group visit to practicing some form of mindfulness training or mind/body relaxation technique such as simple meditation or breathing exercises. Please refer to the Links Resources section for more information.

1.3 ASSESSING PATIENT CARE NEEDS

A. How to Choose the Appropriate Structure of the Group Visit for Patients

► **KEY POINT:** The group structure should be tailored to the patients’ and practice’s need for appointment access, education or behavioral support.

Many medical providers are inclined to focus group visits on a single disease or condition, but unless a practice has a large cohort of patients with a single condition (and many who express interest in trying a group visit), filling sessions can be a challenge. Setting a broader scope is often beneficial for patient outcomes, group dynamics, as well as group energy levels. For instance, a group visit initially targeting those patients with diabetes could include patients with metabolic syndrome or hypertension. Patients tend to be struggling with the same challenges in managing their condition, despite having different diagnoses, and even if patients do not currently share a specific condition, they are able to relate through past experience or the experience of others they know. Having a diversity of patients in the group often encourages reluctant patients to open up about their experiences as other patients share their range of experiences.

For most medical group visits, 9 to 16 patients is a good target attendance. The dynamics of the group visit are strongly influenced by group size. While the intimacy of small groups (~ fewer than 7 patients) may allow for more focused discussion, a larger group (10-16 patients) provides broader patient interaction and is a more efficient use of medical staff resources. Group more than 16 patients can start to feel like a class, rather than a group visit. In addition, most

physicians must meet productivity standards, which require a minimum attendance level (usually 9 to 10 patients).

B. How to Choose the Appropriate Patient

Generally, most patients will benefit from the group experience, whether used as an alternative to the individual medical visit, or complementary to it. However, there are some considerations to make before inviting a patient to attend a group visit.

Patients with Special Needs. Patients with hearing impairments who cannot participate in the discussions and patients who do not speak the language of the group may not be good candidates for group visits. Having a mental health diagnosis such as depression or anxiety does not preclude participation; in fact, these patients often do very well in a group setting. However, patients with serious psychological issues that interfere with their ability to communicate effectively in a group setting, or individuals who are simply uncomfortable in a group setting, are not ideal candidates.

If a patient is very uncomfortable, divisive or especially demanding in the group visit, it may be best to offer an individual appointment with the physician, nurse practitioner or psychologist before or following the group. Both patients and physicians should see the group as a positive experience.

There are several ways to ensure that patients are appropriate for group visits. One is to rely on referring physicians who are familiar with the group visit program to identify and refer suitable patients. Another is for a medical or mental health professional to conduct a brief screening interview by telephone prior to the first group visit.

STAGE 2: IMPLEMENTING A GROUP VISIT AT YOUR PRACTICE

After the initial planning and assessment, there are several operational challenges to launching group visits. This section provides suggestions for best practices for these key implementation challenges:

- 1) **Structure and content**
- 2) **Timing and scheduling**
- 3) **Billing**
- 4) **Recruiting patients and maximizing attendance**

2.1 STRUCTURE & CONTENT OF THE SESSION

All group sessions include a medical review, education and group discussion. The variation in structure reflects the variation in patient populations and staffing expertise at each practice.

Basic Format of a Group Visit in 10 steps	
1.	A group of patients are invited to meet as a group with medical professionals
2.	The session is scheduled for 1.5 to 2.5 hours
3.	Prior to the group visit the leading provider or team (physician, nurse practitioner and/or nurse) conducts chart reviews
4.	As patients arrive for the group, support staff obtain vital signs for each patient and patients complete pre-visit survey
5.	At the start of the group visit, the leader explains the format of the group and obtains HIPAA consent
6.	Medical review is integrated into the session, either in the room or, if there is enough staffing and not too large a group, the physician or nurse practitioner can call patients out for a separate individual medical visit during the session
7.	Disease-related education is provided (by physician, nurse practitioner, nurse or specialist, such as a nutrition or exercise specialist)
8.	Facilitated discussion is conducted (by physician, nurse practitioner, psychologist or social worker)
9.	If enough time is allotted, the leader does a relaxation or meditation exercise with the group
10.	The medical and behavioral leader complete post-visit documentation, triage, referral for specialty, and follow-up services

A. The Educational Component:

► **KEY POINT:** While it is tempting to develop detailed lesson plans for the group visit content, it is not recommended.

Researchers have found that patient groups will naturally choose to discuss topics that health providers want to discuss. By leaving the choice of discussion topic up to the patients, the group participants form closer bonds and develop a greater sense of self-confidence that facilitate change behavior. Patients want generally want basic information from providers, and it is rarely necessary for the medical providers to research a topic to provide quality education for patients.³

This type of teaching is a different from what most clinicians are used to, and is not the same as teaching medical students or house staff, which tends to be more focused or scripted.

It is also important to remember that the natural dynamic of the group is a powerful tool for drawing out issues, concerns, and support that would not otherwise be addressed in a traditional individual office visit (Yalom, 1995). For instance, patients will often spontaneously discuss issues of non-compliance with medical recommendations, and then problem-solve as a group to find strategies to improve self-management at home and improve adherence. This issue might not surface if there were simply a didactic review of medication types with the group.

► **KEY POINT:** It is essential for the group facilitator to welcome and encourage the expression of negative feelings about the disease and the burdens of self-care activities.

6 Sample Topics For Education Component of a Group Visit
1. Review of medical condition, including health targets, preventive care strategies, and associated medical complications
2. Medications used for the treatment of medical condition, the benefits, and the side effects
3. Special circumstances in treating medical condition (e.g., for those with diabetes, a review of sick-day management)
4. Nutrition counseling, meal planning, healthy grocery shopping
5. Exercise
6. Stress reduction and identification of depression

► **TIPS:**

1. Demonstrations are often helpful, such as showing a group of patients with diabetes how to do home glucose monitoring, or demonstrating how to pick healthy foods for a balanced plate.
2. Keep a visible checklist of topics you would like to cover, and periodically review the checklist with the group to help organize discussions. Some group leaders pick half of the topics to cover over the course of the program, leaving the group to choose the remaining half.⁴

2.2 TIMING AND SCHEDULING

A. How to choose the time of day

Choose a time of day that best suits your target patient group. Often the best times for patients who work full-time are either in the morning (before 8:30 AM) or evening (between 5:00 PM-7:00PM), before/after the practice's normal operating hours. For retired or senior patient groups, during the day is often best (usually 12:00- 2:30 PM).

B. How often to have the group:

Group visits can be held on a weekly, bi-weekly or monthly basis. This choice is best based on how many patients are within the prospective population and how many resources can be devoted to promoting the group visit program. For a population of high- utilizing patients, a monthly meeting over a 4-8 month period is often appropriate. Patients report that they enjoy having the extended visit with medical providers and sharing with other patients, and they feel more connected to the medical practice, especially if referred by their primary care provider.

2.3 BILLING FOR GROUP VISITS

A. Making a Business Case

Assuming the practice does not need to rent a room, and can utilize their own staff, costs incurred in developing and implementing group visits are generally low. The staff present for a normal physician's clinical session are just deployed in a different way. Please note that in the Noffingser model (Shared Medical Appointment, SMA), there is a dedicated nurse who facilitates the group and assists the physician, and a staff member who serves as documenter (he/she creates the medical care note which is later reviewed and signed by the physician). Generally, revenue comes from standard billing practices, which are reviewed in this section.

► **KEY POINT:** Group visits must provide clear documentation that individual medical evaluation and management components of care are provided in the context of a group visit. If this requirement is met, physicians and nurse practitioners may bill for group visits using a medical E&M code 99213 or 99214, if there is appropriate medical complexity.⁵ While patient education may be clinically important, is not directly reimbursed under the current system, except in specific cases such as diabetes-self-management education, DSME, visits.

B. Background

Currently, there are no nationally accepted standards for coding and billing for group visits. Several years ago the American Academy of Family Practitioners (AAFP) sought to clarify Medicare billing requirements and received the following response from the Western regional Medicare contractor:

“...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.”

In 2011, Blue Cross Blue Shield of North Carolina issued a new policy statement regarding group visits. The policy states:

Group visits (shared medical appointments) may be covered if the following criteria are met:

- 1) The patient is an established patient already enrolled in the practice
- 2) The group visit is disease or condition specific; however, this does not preclude coverage of group visits that are designed to address aspects of multiple chronic conditions for patients with co-morbid conditions
- 3) Patient attendance is completely voluntary; patients are entitled to have individual appointments, as needed
- 4) Adequate facilities and time are provided for group visits

5) Appropriate staff members are maintained

Although these policies seem to justify the use of standard E&M service codes to bill for medical care provided in group visits, we are aware of no explicit guidelines for billing medical group visits provided by the regional Medicare authorities in the Northeast region or local private commercial payers. Mass General compliance staff members have reviewed current models for coding and billing of group visits in use at Mass General.

C. Determining Appropriate Group Visit Reimbursements

Billing codes for care delivered in a group visit are determined by:

1. The professional qualifications of the provider leading the group
2. The content of the care provided

Poor understanding of billing standards and requirements is a common barrier to implementing financially sustainable group visits. Although CPT⁶ coding requirements are set by national standards, there is wide variation among clinicians regarding the coding requirements and documentation levels. Below is a scale summary of reimbursement levels according to who leads the group visit.

Reimbursements Tied to Group Visits			
Reimbursement	CPT Code	Group Visit Leader	Notes
\$\$\$	Level 3 E&M 99213 + 96153 (for PhD)	(MD or NP for medical component) + (PhD for behavioral component)	This type of medical group visit includes individualized medical management provided by an MD or NP, integrated with a group behavioral session led by a clinical psychologist
\$\$	Level 3 E&M 99213	MD or NP	The MD/NP led medical group visit is facilitated by support staff during the visit (e.g. RN, MA or other support staff.)
\$	DSME*: G0109	CDE Nurse	The nurse (NP or RN) is supported by affiliated MDs who refer patients to the group visit; these often include DSME or other education-focused group visits.
0	Out of pocket payment	Non-clinician	This model is often used for follow-up group visits, and can be led by a health services student or by a peer facilitator.

*DSME is the abbreviation for Diabetes Self Management Education and is conducted by nurses, nurse practitioners or nutritionists with special certification. Certified diabetes educators (CDEs), whether nurses or dieticians, are reimbursed at a slightly higher rate using this code in a group setting than under normal billing protocol, but it is only applicable for ADA-certified DSME programs.

D. Billing for Specific Group Visit Types

1. About Diabetes Self-Management Education (DSME) Group Visits

DSME visits are conducted as both group and individual visits by nurses who have received special certification as diabetes educators (CDEs). Group DSME visits by CDEs have been part

of diabetes care in many of practices for years. For many primary care practices, having their nurses attain certified status is a challenge, especially for those practices with only a small population of patients with diabetes. Within the DSME program at Mass General, the combination of certified and non-certified staff providing the DSME group visits across practices has been a barrier to the standardization of billing practices for DSME group visits.

2. Group visits that include a psychologist or other mental health professional

In some group visit models, such as those conducted at WHA, group visits include a medical component and a psychological/behavioral component led by a physician (or nurse practitioner) and psychologist respectively. There is both individualized medical management provided by the physician (or nurse practitioner), and counseling and facilitated group discussion related to behavior change provided by the psychologist. In this model, billing is based on the standard medical E&M visit (usually 99213, sometimes 99214) plus a separate charge for the psychologist's services. The latter is coded as 96153: "health and behavior intervention provided in a group setting."

► **KEY POINT:** In this type of group visit, it is important to differentiate medical services provided from psychological/behavioral care; there must be no duplication of billing for similar services.

3. Out-of-Pocket Payment Alternatives

Some practices successfully utilize out-of-pocket payment alternatives for group visits. However, this model is generally effective only with motivated, well-educated patients who are able to self-pay, a system that creates access barriers to patients of limited financial means. Based on practice experience, the ideal out-of-pockets cost for an 8-week group visit is \$400, including a materials fee (\$40), with a 10% reduction for patients who pay upfront. Other practices have offered much lower fees (\$90 for 10 visits), but these prices are subsidized by outside funding, research grants or private donations.

2.4 RECRUITING PATIENTS & MAXIMIZING ATTENDANCE

A. Best Practices for Recruiting Patients for Groups: What influences Patients to Attend Medical Group Visits?

► **KEY POINT:** The most effective strategy for recruiting patients for any type of group visit is persuasive physician endorsement. For this reason, practices interested in conducting groups must have an engaged physician champion.

Strategies that have been successful for other practices include:

1. **Frame the group visit as a part of the practice's standard of care** (as opposed to an optional supplement to care). The most effective way to maintain attendance in groups is direct physician endorsement.
2. **Use personal language** (for example, the physician might say: "I want to personally invite you to...") or have flyers readily available in the examination room for the physician to hand directly to the patient when the concept of a group is discussed.
3. **Give promotional materials or scripts that use patient-friendly language at an appropriate reading level**, to front-desk staff, and display them in practice bathrooms and examination rooms. Some practices utilize social media and web based patient portals to announce upcoming groups.

4. **Promote the group visit based on patient feedback and testimonials.** Common patient feedback is that medical group visits improve the doctor-patient relationship, are superior to usual patient-education handouts, address issues that otherwise would not emerge in a typical office visit (such as noncompliance with medications and social stressors), provide a strong support system and opportunity for socialization with others with similar concerns, and allow more time with the physician and medical team.

Before crafting a group visit recruitment strategy for the practice, be aware that not all patients with the same disease perceive their disease in the same manner. Often a patient's health condition requires preventive counseling and active self-management, which can be overwhelming for many patients to consider addressing. Many may be in denial of their illness, trying to avoid medical intervention because of fear and shame, or they may feel embarrassed if not adhering to expected medical recommendations. Patients are often at different stages of change⁷ when it comes to addressing their medical needs and medical recommendations, especially with lifestyle changes, and this can influence attendance, as well as the communication strategy the practice should use.

Data shows that even with the best of intentions, patients may perceive medical provider advice and intervention as intrusive. Anderson and Funnell (2004) note that "In their efforts to control patients' diabetes, many healthcare professionals are perceived by patients as trying to control their lives," a feeling that often results in noncompliance as an attempt to maintain and reaffirm control over their own lives." Marketing the group visit as a way to support patient autonomy and self-management may be a way to draw in patients. The interactive and extended care system of group visits provides education, support, and advice from peers, as well as health care providers. Patients see the stages of health of their peers, and are able to build and maintain a sense of control, self-efficacy and autonomy surrounding their health care.

The Group Visit team should be cognizant of the referral patterns of medical providers in their practice, and how much autonomy individual practitioners are willing to give to the group leaders to make medical decisions (such as medication titration) during the group session.

▶ **KEY POINT:** It is critical to understand the needs of your patient population, and equally important that your practice's marketing strategies accurately address patient concerns and ensure medical continuity.

▶ **TIP:** Conducting patient surveys, focus groups with patients, and even focus groups with medical providers can help to access this information.

B. How to Frame the Invitation or Referral for a Group Visit

Help frame the patient's group visit invitation by:

1. Making your invitation personal
2. Framing the group as the prescribed standard of care in your medical practice for the patient's condition
3. Emphasizing how this group is complementary to your care and that the increased amount of time patients spend with medical staff better connects them to their medical practice and can streamline care
4. Do not describe the group as being "therapy" or a "class," but instead describe it as a medical visit that provides a chance for patients to learn from their peers and medical providers in an integrated way, become more knowledgeable about their medical conditions, and gain more confidence and long-term support to manage their medical conditions at home

- ▶▶ **TIP:** Practices that call patients to confirm their attendance at groups have seen improvements in attendance. These reminder calls must be repeated for each group and can be done by an administrative assistant, medical assistant or nurse.

STAGE 3: MAINTAINING AND SUSTAINING GROUP VISITS

Without a means for maintaining the quality, outcome and satisfaction improvements achieved through group visits, practices only manage to make a temporary, surface-level change in these measures. In order for a medical group visit program to address the root of these improvements and make sustainable changes in medical care delivery, structural and management investments must be made among:

- 1) **Providers**
- 2) **Patients**
- 3) **Practices**

3.1 PROVIDERS

Establishing Strong Group Visit Administrative Support

Including a practice-based administrative leader who is familiar with the practice work flow can help facilitate the operational and administrative aspects of the group visits and ensure integration and efficiency. Having a goal or vision for where the group visit program fits into the overall process of care in a practice is critical for continuity of care and continuous improvement.

Integrating group visits into medical practice requires some degree of practice culture change. To support expansion of the group programs throughout an institution, it is helpful to have central leadership to ensure integration into existing services, efficient use of available resources to support the practices willing to try this, staff training, and tools for outcome evaluation.

In summary, factors that improve success with group visits include:

1. A medical professional (“Champion”) in a medical practice dedicated to the model
2. An interdisciplinary medical care team willing to work with the medical provider
3. Supportive practice leaders (medical and practice directors) and providers willing to refer patients to the program
4. A clear marketing strategy for patient recruitment
5. Space to hold the group visit sessions
6. Active patient participation during the group
7. Opportunities for training and skill building in group processes
8. A strategy for tracking billing
9. A qualitative evaluation strategy for assessing the effectiveness and impact on health targets, quality of life, and provider and patient satisfaction.

3.2 PATIENTS

A. Assessing Success: Conducting Patient Satisfaction Evaluations and Tracking Health Targets

► **KEY POINT:** The patient experience should be regularly assessed in the process of developing group visits and that a strategy be in place to track improvement in health targets, quality of life, and patient and provider satisfaction with the program.

Although many group programs are small, making a rigorous evaluation impossible, some practices have been able to conduct observational studies by tracking changes in key health

targets, laboratory measures, blood pressure, and weight over time using the electronic medical record; studying the impact of medical groups on quality of life using standardized measures and soliciting patient and provider feedback through interviews and surveys. This is an area ripe for future development and coordination across practice sites and will be expanded on in the future.

B. Follow-up Strategies for Addressing Long-Term Group Support and Self Management

Ongoing support is critical to maintaining outcome improvements for patients beyond the short-term period that they are participating in the initial group visits. Some practices have addressed this by piloting extended support group visits led by uncompensated nurses or medical and nursing students (with a clinician present). These are very effective at helping patients maintain long-term improvements in measures such as HbA1c levels, and have other benefits including improving patient satisfaction and helping students meet clinical hour requirements and.

3.3 PRACTICES: FITTING GROUP VISITS INTO PRACTICE & SYSTEM CHANGES

A. How does the Group Visit Model fit in with the Patient Centered Medical Home (PCMH) Model and other care coordination efforts?

Group visits are one of many innovative care delivery models that to fit into the evolving concept of the Patient-Centered Medical Home (PCMH), a high-quality, well-coordinated system for providing primary care. Group visits facilitate the patient-centered focus that the PCMH strives to achieve, by helping practices focus on integrating behavioral healthcare and self care management more effectively in routine office visits and medical treatment planning. The collaborative nature of a group visit provider team and the extended, multi-patient setting require that group visits have efficient information management and care coordination. In addition to facilitating more coordinated care, group visits are an excellent opportunity to encourage shared decision making. Group visits are also a natural setting for facilitating self-care processes, as patients learn from and support one another during the visit. Although there are many strategies for practices to redesign care delivery to meet the National Committee for Quality Assurance (NCQA)'s requirements for PCMH certification, encouraging group visits can be a very effective way to do so.

B. A Note on Future Program and Outcome Evaluation

Whether or not it is cost effective in the short term, there is strong value added by a group visit program in terms of physician and provider satisfaction, patient satisfaction, and health care outcomes and productivity measures in some practices.

Qualitative data analysis using patient surveys and review of electronic medical records is useful in understanding the impact of group visits on patients and staff. There continues to be a need for more rigorous evaluation of the health and service impact of group visits. The table below identifies suggested areas for evaluation.

Five Target Areas for Evaluation of Group Visit Programs

Target Area	Evaluation measure
1. Health targets	Specific to the medical condition
2. Knowledge awareness and impact on self-management skills	Improvement in knowledge over time
3. Impact on patient activation, self-efficacy, quality of life, and behavioral change	Confidence with self management, attitude toward disease and future, improvement in disease-specific self-care activities, functional level at home, medical adherence, etc.
4. Analysis of medical group visits on the process of care and utilization of services	Emergency Department admissions, inpatient hospitalization, cost of care, referral to specialists, pharmacy costs, etc.
5. Continuous quality practice improvement	Patient and medical provider satisfaction, coordination of care, etc.

FINAL NOTE

After reading this document, you may find the following questions helpful in determining your practice's readiness for starting group visits.

Are You Ready to Start Group Visits in Your Practice?

1. Will your clinicians refer patients to a group?
2. Can you reallocate staff (MD, NP, RN, MA) to conduct a group?
3. Do you have a physical space to hold a group?
4. Is there interest among your patients to participate in a group?
5. Do you have a curriculum?
6. Have you identified the goal of the group?:
 - a. Increase medical access
 - b. Provide patient education and support
 - c. Promote behavioral change
7. Have you identified the revenue stream?
8. Do you have a mechanism for tracking the group's progress and health-related targets?
9. Have you identified your target group?:
 - a. Diabetes
 - b. Hypertension
 - c. Cardiac disease
 - d. Metabolic syndrome
 - e. Smoking cessation
 - f. Obesity / weight loss
 - g. Chronic pain
 - h. Inflammatory arthritis
 - i. Insomnia
 - j. Depression / anxiety
 - k. Geriatric
 - l. Well-child visits
 - m. Prenatal care
 - n. Others
10. Have you considered a strategy to address the potential barriers:
 - a. Patient attendance
 - b. Lack of group-facilitation skills
 - c. Variable reimbursement for time
 - d. Lack of time in the schedule
 - e. Preparation for the groups

In conclusion, the authors hope this manual has been helpful in learning more about group visits. As changes in the medical care delivery and reimbursement system evolve, this kind of model will be very useful and we hope more practices at Mass General will take the opportunity to conduct group visits.

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¹ SMA, group visit model to improve access and address acute medical needs, developed by Noffsinger, previously known as Drop-in Group Medical Appointments (DIGMAs)

² Cooperative health care clinic (CHCC) model, for patients requiring frequent broad spectrum care or disease specific care for chronic disease management, developed by Scott

³ Group Health's "Group Visit Starter Kit," See Bibliography for more information

⁴ Those conducting group visit for patients with diabetes often follow standard American Diabetes Association guidelines for patient education.

⁵ According to the Office of Billing Compliance for the Mass General Physicians Organization

⁶ CPT (Current Procedural Terminology) codes are numbers assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. They are used by insurers to determine the amount of reimbursement that a practitioner will receive, and are developed, maintained and copyrighted by the American Medical Association. (<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>)

⁷ See Prochaska, 1994

ADDENDUM

More about the history of Group Visits

The original group visits were both physician led, but have evolved over time to include other medical professionals as leaders, such as nurse practitioners and psychologists. One model was developed by John Scott, MD, and the other by Edward Noffsinger, PhD. They vary in their structure, staffing, content, and how the discussion component of the group is conducted. Institutions such as Harvard Atrius, Cleveland Clinic and others have robust medical group visit programs, frequently following the Noffsinger model. The American Academy of Family Practitioners (AAFP) has easily accessible on line resources for clinicians, and has actively promoted both of these models of medical group visits.

The Scott model, the Cooperative Health Care Clinic (CHCC), was developed with a strong focus on disease management, for a specific disease or condition, such as diabetes or for a particular age group, and was originally designed to address the needs of the geriatric population (who often have multiple medical conditions). In the CHCC model each medical group visit session had five key components: socialization time, education, a break, a question and answer period and one-to-one physician- patient time (Noffsinger and Scott, 2000). The Noffsinger model, the SMA (originally called physical shared medical appointments or PSMA in the literature) and DIGMA (drop in group medical appointment), was designed for a changing group of patients that, in practice, is more like an individual office visits, seen within a block of time, with “observers” (other patients and support staff present). While many had similar conditions (for example, a group of patients with a variety of cardiac conditions), the group was not always medically homogenous. Also, most of the patients participating were from the physician’s own patient panel. The group did not draw from patients of other clinicians. Unlike the Scott model, the SMA and DIGMA require a nurse or medical assistant and an administrative assistant.

Although originally developed to address two different challenges (chronic disease management and access to medical care, respectively), both the Scott and Noffsinger model provide a highly valuable medical visit for a medical provider-led care team to meet the complex, time-intensive needs of their patients in a group setting that include patient engagement and education as part of the treatment plan. In practice, the use of group visits is much more variable than a description of the Scott and Noffsinger models would suggest. How group visits are implemented varies depending on practice resources, staffing, provider understanding of the concept, patient interest in attending groups, and the specific needs of the target patient population. In the Noffsinger Model the leader directs the education and discussion, while in the Scott model the discussion is often generated by the group. Also, the models differ in how the physician (or nurse practitioner) manage the medical component; for the Noffsinger model, the medical review occurs in the room while the group is underway, and in the Scott model, patients are often asked to step out of the group for an individual medical visit. As a result, the implementation of group visits in each practice is often an amalgamation of these two models.