Group Visits: Moving Beyond the One on One Office Visit

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Background
A Brief Review of Group Visits

- Group visits have been implemented in managed care settings since the mid-1990’s.

- The main focus has been on chronic illness: diabetes, asthma, osteoporosis, coronary artery disease.

- No single model or definition exists.
Three Group Visit Models

1. Cooperative Health Care Clinic
   - High-utilizing elderly patients are seen regularly over a given time period

2. Combination of Medical Visits + Group Education
   - Booked in advance with continuity over specified time frame

3. “Drop-in Clinic”
   - Patients with a particular illness can drop-in during a certain time period on monthly basis
Group Visit Variability

- Conducted by medical doctors, nurses, and health educators
- Different models exist depending on the disease and the patient population
- Structure depends on whether they are conducted in a managed care setting, a nationalized health care setting, or a fee for service setting
Group Visits share common ground...

- Partnership - patient, clinician, healthcare team
  - Clinician is the facilitator
  - All inclusive, coordinated care
    - Medication review
    - Disease control parameters
    - Guideline adherence
    - Acute medical issues
    - Nursing support
  - Intensive counseling/education targeting many at one time
  - Limited physical exam
  - Social support
Implementation Issues

- **Patient Selection**
  - *Desire* for Participation
  - Who should not be included in group visits?
    - Uncontrolled psychiatric disease
    - Frequent “no shows”
    - What about people w many comorbid illnesses?
      - Multiple comorbid illnesses
      - Too sick for a group visit?
        - Time constraints imposed by tx of comorbidies
    - Dementia
    - Active substance abuse
    - Non-English speakers
Implementation Issues

- **Administrative issues**
  - Adequate space conducive to “group environment”
    - Exam room nearby if needed
  - Dedicated scheduling and nursing staff support
  - Consistent scheduling of dates of group visit (ex 2nd Friday qo month)
  - Same provider
  - Reminder system

- **Optimum Core Group Size**
  - 15-20 patients
  - 70-80% show rate
  - Need 13/group for cost effectiveness
What it takes to be a good leader

- Educational topics to cover for discussion points
- Flexibility
  - Conversation can and will follow issues that are immediately relevant to patients’ interests / issues
  - You are the discussion FACILITATOR – NOT the LECTURER
  - Must cover medically relevant topics
- Ability to redirect if needed
- Good listening skills
- Sensitivity
Benefit of Group Visits

1. Decreased utilization, hospitalizations, ER visits, and subspecialty referrals (Scott et al., 2004)

2. Metabolic outcomes
   - Indicates improvement (Trento et al., 2001)
   - Failed to demonstrate consistent statistically significant improvement in A1C, BP, or lipids (Riley & Marshall, 2010)

3. Patient and provider satisfaction with this mode of health care delivery (Clancy et al., 2003; Riley & Marshall, 2010)

4. Improve some physiological outcomes (Riley & Marshall, 2010)

5. Improved outcomes seem to be associated with curriculum (Riley & Marshall, 2010)

4. Potential cost benefits
   - Increased provider productivity (Noffsinger & Atkins, 2001)
   - Decreased cost of care (Riley & Marshall, 2010)
Nivi Mahidhara, MD
Billing for Group Visits

- No individual/ separate billing codes exist for the group visit model
- Can be billed on level IV only if patient is seen one-on-one
- Unable to bill on face-to-face counseling
- Not an issue in managed care or nationalized health care settings
- Continue to use the traditional office visit Evaluation and Management (E&M) codes employed in standard one-on-one office visits
Incorporating residents and medical students into the group visit model
Resident training

- ACGME does not yet recognize the group visits education portion to replace the resident continuity clinic …

- BUT… the ACGME does recognize the one-on-one individual visits performed within the group visit setting.
Resident trainee benefits

Davis, 2006

- Residents felt they had more impact in helping patients with self management of their illness.
- Residents were more confident in communicating diabetes management in a manner which the patients can understand.
- Their ability to diagnose and treat diabetes improved.

Trainees felt more empowered to promote lifestyle changes in the portion of the population that were in denial.
Resident trainee benefits

Nuovo, 2004:

- Greater appreciation of the psychological impact of diabetes
- Understanding the extent of influence of diabetes in the patients’ daily routines
- Importance of social support when dealing with this population to improve their well being
- Promote understanding of the seriousness of the illness
Medical student trainee benefits

- Medical students also find Group Visits educational

  “The group dynamic was great to see how patients can share both strengths and weaknesses of their lifestyle and support each other while also pushing each other to do better.”
Funding

- Start-up funding is helpful
  - Educational materials
  - Recruitment
  - Implementation into current care structure
  - Training

- Potential funding sources:
  - Quality improvement grants
  - Local community funding
  - Discuss benefits with clinic sponsor
University of Colorado’s Experience

Ingrid Lobo, MD
University of Colorado
Who is participating?

- Adult (age > 18), English-speaking patients with type II diabetes
- Patients with a HbA1C ≥ 6.5
- Exclude patients with cancer, terminal illness, cognitive deficits
- Patients were sent a letter inviting them to participate
- Maximum of 14 patients accepted at each site anticipating 6-12 patients at each group visit
Group Visits are:

- Physician run
- An individual medical visit + a group education session
- Within specific allotted times that allow the physician to see any patient individually if needed
- Booked in advance with patient and provider continuity for the duration of the visits
- Monthly for 6 months (6 sessions)
- 2-hour sessions
University of Colorado
Group Visit Topics

- The meaning of diabetes and its complications
  (e.g. retinopathy, nephropathy, etc.)
- Nutrition
- Exercise
- How to grocery shop
- Skills that patients can adapt in social settings
  (e.g. how to eat out at a restaurant or a party)
- Mood
- Coping skills
- Troubleshooting
- Medications
University of Colorado Results

- Originally recruited 30 participants
  - 6 never attended any group visits
  - 2 officially requested to be removed—Both were independently well controlled diabetics who stated that they did not find the sessions helpful

- Average attendance of 8 patients per session
  - Range = 6 - 11
## University of Colorado Participant Demographics

- Among 30 originally recruited participants

<table>
<thead>
<tr>
<th></th>
<th>N (%)</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9 (30)</td>
</tr>
<tr>
<td>Female</td>
<td>21 (70)</td>
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<tr>
<td><strong>Race</strong></td>
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<tr>
<td>Cauc.</td>
<td>12 (48)</td>
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<tr>
<td>Afr. Am.</td>
<td>10 (40)</td>
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<tr>
<td>Latino</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Filipino</td>
<td>1 (4)</td>
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<tr>
<td><strong>Age</strong></td>
<td></td>
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<tr>
<td>Mean</td>
<td>58</td>
</tr>
<tr>
<td>SD</td>
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* Only recorded for 25 participants.
University of Colorado Clinical Outcomes

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<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Final</th>
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<tbody>
<tr>
<td>Hemoglobin A1C</td>
<td>7.8</td>
<td>7.9</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>134.1</td>
<td>133.8</td>
</tr>
<tr>
<td>Diastolic BP</td>
<td>70.8</td>
<td>66.1</td>
</tr>
<tr>
<td>Low-Density Lipoprotein (LDL)</td>
<td>67.9</td>
<td>75.4</td>
</tr>
<tr>
<td>Weight</td>
<td>206.9</td>
<td>205.1</td>
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</table>
University of Colorado Clinical Outcomes

- Percent Compliance

<table>
<thead>
<tr>
<th>Service</th>
<th>Baseline</th>
<th>Final</th>
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<tbody>
<tr>
<td>Foot Exam</td>
<td>80</td>
<td>100</td>
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<tr>
<td>Microalbumin</td>
<td>65</td>
<td>100</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>81</td>
<td>100</td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td>75</td>
<td>100</td>
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</tbody>
</table>

Graph showing baseline and final percent compliance for different services.
## University of Colorado Financial Metrics

<table>
<thead>
<tr>
<th>Provider</th>
<th>Average $\frac{1}{2}$ Day wRVU*</th>
<th>Average Group Visit wRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1</td>
<td>7.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Provider 2</td>
<td>7.3</td>
<td>9.4</td>
</tr>
</tbody>
</table>

* wRVU = Work-Related Value Unit
Medical University of South Carolina
Experience

Kimberly Davis, MD, FACP
Medical University of South Carolina
Group Visit Structure
2.5 hr Schedule

- 45 minutes of warm-up and socialization
  - During this time MD provides medical care
  - Patient receives individual feedback regarding their disease measures

- 45 minutes Group educational presentation with questions and answers
  - Frequently includes discussion of disease measures

- 60 minutes-- One on one care
  - Time for pt to be seen in private if necessary
  - Pt requests, pap/pelvic, arthrocentesis etc
Medical University of South Carolina
Group Visit History

- This group has been together for 9 years - since 2/2002
- Offered to disband when study ended 2006 and see in my private continuity panel - all said ‘no’
- Group size-attrition over the years - 18 down to 14
- Personal experiences-patients sharing personal medical experiences and coach/encourage each other
Physician Satisfaction

- Enjoyable for physicians
  - Less frustration with care delivery with group
  - Less time constraints with group
- Provide patient education in addition to medical care
- Develop mutually accountable relationships among patients and with the physicians
Patient Comments

“I love it! I get a lot out of it – I’m learning and I enjoy sharing it with others.”

“That book we got is phenomenal!”

“Everyone with Diabetes needs something like this – a group to go to, to get information and support – and not have it cost an arm and a leg.”
Limitations

- The most poorly controlled diabetics who might benefit most may be least likely to participate.
- Some patients without transportation and other patients who work may find it difficult to attend two hour group visit sessions.
- Self-selected participants may be more motivated to change.
- It may be difficult to fill diabetes group visits every year.
Moving Forward

- Potentially a financially sustainable model for fee-for-service environments
- Expansion to other chronic disease management programs
- May help an institution obtain certification to be a “medical home”
- Dissemination into community based clinics that serve lower income and vulnerable populations
- May serve as a model to increase accessibility as the health care system is rapidly changing