

Group Visits HIT THE ROAD

By taking group visits to his elderly patients, this physician found a way to meet their needs and those of his practice – and have fun at the same time.

Douglas Dreffer, MD

As Clara stood in front of my practice patiently waiting for the taxi again, she voiced her opinions about the dearth of services for elders in our small town of 5,000. Clara is one of 11 patients in my family medicine practice who live two miles away in the Maple Leaf apartments, our town's senior-citizen complex. Watching Clara wait, I began to ponder a different way of reaching this group of patients.

After finding and reviewing all our Maple Leaf patients' records, I discovered that the members of this group shared many common chronic medical problems and needed to see their physicians regularly. Most of them also had transportation issues similar to Clara's. I felt I had an opportunity to try something new, so I decided to take the medical care to these patients all at once – by conducting a group visit at Maple Leaf.

Planning the visit

Planning my first group visit turned out to be invigorating. Since I had never conducted a group visit before, I started out by doing some research. I discovered that the most common types of group visits are coordinated health care clinics (CHCCs) and drop-in group medical appointments (DIGMAs). CHCCs are generally two-hour, invitation-only, physician-led (with nurse support) appointments that focus on a specific disease or health topic; while DIGMAs are generally 90-minute, weekly appointments co-led by a physician and a behavioral health professional and attended by any patient with

any condition who wants to “drop in.” I also learned that CHCCs have most notably shown a decrease in visits for high users of the medical system, and DIGMAs seem to work best for the “worried well.”

Although the CHCC format seemed like the closest fit for my group of Maple Leaf patients, neither of the formats were exactly what I was looking for. So I decided to borrow something from each of the formats to create a visit that would be tailored to

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Douglas Dreffer, MD, conducts group visits at the local senior-citizen complex where 11 of his practice's patients reside.



To minimize transportation problems and increase satisfaction for his elderly patients, the author decided to conduct a group visit at his town's senior-citizen complex.



The most common types of group visits are coordinated health care clinics (CHCCs) and drop-in group medical appointments (DIGMAs).



The agenda for the author's group visit was designed to be flexible and quick-hitting.



The agenda allotted time for an introduction, paperwork, discussions, mini-assessments and one-on-one time with the physician.

the needs of my group-visit patients. For example, I decided to focus on a health topic common to all, which I took from the CHCC format, and I decided to provide one-on-one time at some point during the visit, which I thought would allow patients to discuss their specific needs with me in a "drop-in" format similar to that of a DIGMA.

Once I had decided on the overall visit format, I started building a specific agenda that would be both flexible and quick-moving. I knew I wanted to take some time to explain the group-visit concept, hold focused discussions on common health topics, perform mini-assessments on each patient, answer questions and allow interested patients the opportunity to spend some one-on-one time with me. So, I divided the visit into 15- or 20-minute blocks, allotting time for all of these elements. (See my agenda for this visit below.) I listed several guidelines or reminders for myself to keep the visit on track and maximize the effectiveness of any future ones:

- Remember that the goal of the visit is to create a group discussion, not to lecture.
- Do not let someone dominate the discussion.

I knew we were going to be fine when one of my patients signed in as Phyllis Diller.

A GROUP-VISIT AGENDA

My first group visit was two hours long. It was essentially broken up into 15- or 20-minute segments as follows, allowing time for discussions, breaks and individual assessments. While we didn't end up following it exactly, this is the agenda I went in with.

1:30 - 1:45	Socialization. Snacks provided.
1:45 - 2:00	Introduction of the group-visit concept. Distribution of confidentiality forms.
2:00 - 2:15	Clinical topic discussion: hypertension or osteoarthritis
2:15 - 2:25	Break
2:25 - 2:40	Clinical topic discussion: osteoarthritis or hypertension
2:40 - 3:00	Individual patient evaluations
3:00 - 3:10	Questions
3:10 - 3:30	One-on-one assessments (as needed)

KEY POINTS

- Taking group visits to your patients allows you to better meet their needs and see them at ease in their own environment.
- In addition to providing high-quality, convenient care for your patients, group visits can also be fun for you and your staff.
- If you bill for the individual services you perform at a group visit, many payers will provide reimbursement.

- Try to stay open to topics.
- Focus on self-management skills.
- Hold to the time schedule, if possible.
- Assess the effectiveness of the visit by distributing a survey at the end.

Getting paid for the visit

With the agenda for the visit in place, the next thing I had to do was figure out how to get reimbursed for this

type of visit. Although I knew that Medicare would not reimburse specifically for a group visit and would not reimburse for counseling in a group setting, my research and instincts told me that I could fall back on the standby – documenting and billing for the services I performed for individual patients. If eight to 10 patients attended the visit, I could justify three hours out of the office for the visit and associated documentation time.

To streamline the documentation process during the visit and when we were updating our electronic medical records (EMRs), I prepared a special form for documenting the history of present illness (HPI) and the mini-assessments (or physical exams). The symptoms list on the form, which focused on hypertension and osteoarthritis, corresponded to drop-down lists in our EMR. (See the form on the next page.)

To find enough interested patients, I decided to ask Mary, one of the resident leaders at Maple Leaf, to be my "mole" for this operation. She started generating some interest in my upcoming group visit by discussing it with the other residents. Then I secured the Maple Leaf recreation room and sent invitations to 15 Maple Leaf

residents – our 11 patients and four others. I feared that only Mary would show up.

Conducting the visit

Despite my fears, my staff (a third-year resident and a medical assistant) and I arrived to a packed house. Thirteen people – eight of our Maple Leaf patients, two of our patients who drove to Maple Leaf for the visit and three Maple Leaf residents who see

other doctors – were eagerly awaiting our arrival. I was nervous when I first began circulating the sign-in sheet and confidentiality agreements, but I knew we were going to be fine when one of my patients signed in as Phyllis Diller.

I started the visit by explaining the group-visit concept to the patients and giving each of them a copy of the special documentation form I'd created. I asked them to

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During a group visit, it is important to maintain a discussion rather than a lecture, stay open to topics and focus on self-management skills.



Since Medicare does not reimburse for group visits or for counseling in a group setting, the author documented and billed for the services he performed on individual patients.



To make documentation easier, the author created a special form for documenting the history of present illness and the physical assessments.



The group visit began with confidentiality paperwork, an explanation of the group-visit concept and distribution of the author's documentation form.

GROUP-VISIT DOCUMENTATION FORM

Name: _____

Date: _____



For the patient

Do you struggle with any of the following problems associated with high blood pressure or arthritis? If so, please circle and/or fill out the appropriate answers:

High blood pressure

- Headaches
- Bloody nose
- Fatigue
- Dizziness
- Chest pain
- Shortness of breath or breathing problems
- Swelling in your legs

Arthritis

- Falls
- Problems getting up/out of a chair
- Problems walking
- Problems walking without use of a walker or cane
- Pain in your shoulders
- Pain in your hips
- Pain in your knees
- Pain in your hands
- Pain in other joints: _____

Is there anything else you need the doctor to know?

For the doctor

BP: _____ HR: _____

Heart exam: _____ Lungs: _____ Edema: _____

Ambulation: normal hesitant wobbling needs device needs assist

Sitting to standing: normal (no arms) slow without use of arms/with use of arms/with devices

Get up and go: < 20 seconds 20-29 seconds > 30 seconds

Overall fall risk: none small moderate significant

ROM of knees: normal limited markedly limited

hips: normal limited markedly limited

Hands: Heberden's nodes ulnar deviation bony enlargement



After the group discussed hypertension, the author conducted mini-assessments on each patient while others took a break.



A discussion about osteoarthritis and OTC medications followed, with time left at the end for 1:1 visits with the physician as necessary.



Satisfaction surveys showed a high level of satisfaction from all of the patients involved in the group visit.



The author received reimbursement for 99213-level visits on all of his patients who attended the group visit.

complete the HPI section of the form by circling the appropriate symptoms or concerns.

Next, we began the group discussion portion of the visit. After a quick vote, the group decided to talk about hypertension first. The patients did most of the talking while I provided some clarifying points. Though I'd planned to have a short break in the middle of this discussion, we skipped over it since no one in the group said they needed one.

After the hypertension discussion, I conducted mini-assessments on each patient. In the assessments, I focused on vitals, heart, lungs and some geriatric assessment scores (e.g., balance, get-up-and-go and range-of-motion of knees and hips). I documented the assessments in the physical examination section of each patient's HPI form.

Once the assessments were complete, we used the portion of the agenda set aside for questions to resume our group discussion, this time focusing on osteoarthritis and over-the-counter medications.

Finally, I left the last 20 minutes at the end of the visit for interested patients to spend some one-on-one time with me. Three of the seniors, two of whom had other doctors, stayed for this portion of the visit. For those with other doctors, I politely provided advice and steered them back to their own physicians. Then, all of a sudden, my first group visit was over.

The results

Satisfaction surveys I received from the participants in this group visit were extremely positive. All of them said they would like another visit and would welcome a dietitian, pharmacist or counselor at the next visit. Subsequent discussions with my mole also confirmed that we were a hit. What was even more notable was my own level of satisfaction with the group visit. In short, this was great fun. I enjoyed learning more about my patients and seeing them at ease in their own environment.

Since my HPI forms corresponded so closely with my EMR templates, I was able to document these visits quickly in our system. I transferred the HPI and physical exam notes from the visit documentation form, and then I added my assessment

FPM ARTICLES ON GROUP VISITS

"Group Visits 101." Houck S, Kilo C, Scott JC. May 2003:66-68.

"Group-Visit Consent Forms (Ask FPM)." Masley S. February 2003:56.

"Coding Group Medical Visits (Coding & Documentation)." Moore KJ. September 2002:25.

"Planning Group Visits for High-Risk Patients." Masley S, Sokoloff J, Hawes C. June 2000:33-37.

"Making Good Time With Group Visits." Henry LA. July/August 1997:70-75.

and plan. This allowed me to review each patient's previous blood pressures, risk factors, medications, etc. In the end, I was able to successfully document and bill for

10 99213-level visits (I didn't bill for the three seniors who had other physicians). It is important to note, though,

that although I was reimbursed for the codes I submitted, this may not be the case with all payers. In fact, the CPT Editorial Panel gives different advice, suggesting that physicians submit CPT code 99499, "Unlisted evaluation and management service," instead. If you don't want to go into a group visit without knowing how your payers want it coded and whether they will pay, discuss the options with your payers first. Just make sure they understand what services you plan to provide to the group and to individual patients. [For more information, see "Coding Group Medical Visits (Coding & Documentation)," September 2002, page 25.]

Having fun

As I left Maple Leaf after that first group visit, I had a spring in my step. I had just reached out to a group of needy patients, provided good care, made money for my practice and had a great time doing it. I am currently planning my next group visit at Maple Leaf and expect many more such visits to follow. As a faculty member in a family practice residency program, I plan on using group visits as a way of showing residents not only how to do geriatric assessments but also how to have fun in their practices. **FPM**

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