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Group Visits for Chronic Illness Care: Models, Benefits and Challenges

With proper planning, group visits can expand your options for managing the care of chronically ill patients.

Chronic illness is proving to be one of the most pressing public health issues of the 21st century. Managing chronic diseases, which includes gaining a comprehensive knowledge of patients and addressing their risky behaviors, can be complicated by current demands on physicians' time. The Future of Family Medicine Project identified the need for patient-centered care that eliminates access barriers and improves quality, outcomes and practice finances.¹ Group visits, which were identified as an important facet of a "new model" of care described in the Future of Family Medicine report, allow physicians to deliver extensive patient education and self-management instruction while possibly increasing financial productivity. The Future of Family Medicine Project estimated that group visits have the potential of generating an additional \$15,411 per

physician per year.² In addition, group visits offer patients with similar illnesses an opportunity to interact with and learn from one another.

The purpose of this article is to describe current group visit models and to discuss the unique advantages and challenges group visits present for physicians based on our four-year experience.

What are group visits?

Group visits include not only group education and interaction but also most elements of an individual patient visit, such as the collection of vital signs, history taking and physical exam. In this, group visits differ from other forms of group interventions, such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians. ►

Group visits have enabled our practice to make high-quality care more accessible to chronically ill patients in our community.

Group visits typically follow two basic formats:

Cooperative health care clinics (CHCCs) are generally used to provide care to elderly patients with chronic conditions or who frequently utilize medical resources.³ A later variation of this model, the high-risk cohort model, targets patients of all ages with similar chronic problems, such as diabetes or coronary artery disease.⁴ Another variant, the chronic care clinic eschews a formal educational component, focusing instead on interactive discussions related to patient self-management.⁵

In each of these models, individualized medical care usually takes place in a private room near the meeting site. A physician encounters patients individually, allowing up to five minutes per patient, while a nurse takes vital signs and other measurements for the rest of the participants. CHCCs generally last from two to 2.5 hours and include no more than 20 patients at a time. Approximately 30 minutes should be allocated for collecting patient data and conducting individual sessions; the rest of the time should be spent addressing group concerns, providing educational material and answering participants' questions.⁴ These groups may meet monthly or quarterly, depending on need.

While CHCCs always include at least one physician, a variety of practitioners can also be involved. For example, a midlevel provider may assist with individual encounters, and dietitians or pharmacists may lead educational sessions. Topics, such as

medication management, stress management, exercise and nutrition, and community resources, may be suggested by the group facilitator or by patients, who raise concerns, share information and ask questions. In programs emphasizing self-management, physicians and patients work together to create behavior-change action plans, which detail achievable and behavior-specific goals that participants aim to accomplish by the next session. Once plans are set, the group discusses ways to overcome potential obstacles, which raises patients' self-efficacy and commitment to behavioral change. Patients' family members can also be included in these group sessions.

Drop-in group medical appointments (DIGMAs) are composed of different patients from meeting to meeting who "drop in" when they have a specific medical need.⁶ These groups may focus on a specific diagnosis, or they may target all chronically ill patients within a given practice. DIGMAs typically last for 90 minutes and involve 10 to 15 patients.

DIGMAs often include a behaviorist who facilitates group processes and addresses each patient's psychosocial concerns. The physician conducts individual medical sessions within the group setting instead of in a separate space and often engages the group in providing solutions to patient problems; by doing so, the physician provides education throughout the visit, rather than a formal lecture. After the educational session, patients who need to see their doctor privately can do so.

■ Group visits include not only group education and interaction but also most elements of a traditional patient visit, such as the history and exam.

■ In a two-hour group visit, roughly 30 minutes should be reserved for collecting patient data and providing individualized care.

■ The majority of time should be spent addressing group members' concerns and educational needs.

About the Authors

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Our program

We have been offering group visits since 2001, using a hybrid format based on the high-risk cohort and the chronic care clinic models. Individual visits are held privately, not within the group. Since the program began, more than 240 patients (most of them female and in their mid-50s) have participated in group visits.

To date, we have offered programs for asthma, osteoporosis and lipids management, with the osteoporosis program being the most popular. Patient satisfaction has been measured on a five-point Likert scale and has averaged above 4.5 across all programs.⁷

Our programs differ from those reported in the literature in a number of ways. First, whereas group visit participants are usually recruited from within a physician's existing practice through billing, pharmacy or insurance records, 70 percent of our participants are recruited from the local community and just 30 percent originate from within our Wellness and Chronic Illness Program. This is deliberate, as we began providing group visits to serve patients we could not accommodate in our already full practice. Second, our group visits take place over three or four consecutive weeks, with refresher sessions for program "graduates" taking place once or twice a year. Finally, we provide in-depth nutritional and mind/body education, including such experiential components as potluck meals that reflect nutrition information provided, meditation sessions and, in the case of our osteoporosis group, an exercise session focusing on strength and weight training.

Group visits have enabled our practice to make high-quality care more accessible to chronically ill patients in our community and have increased patients' ownership of their illnesses and satisfaction with our practice. These results are consistent with those found

in the literature.³ The program has produced sufficient income for our practice.

Challenges

Group visits do offer several challenges.

Billing. Group visits are not specifically covered by Medicare or most private health insurance plans because billing codes for group visits are not established. While the CPT Editorial Panel has suggested that physicians use the evaluation and management (E/M) code 99499, "Unlisted evaluation and management service," to report individual claims for Medicare patients participating in group visits, we believe this is risky. Code 99499 is a miscellaneous code for which no set value is assigned and, therefore, may not be reimbursed by insurers.

Instead, it has been recommended that group visits be billed as individual office visits, using existing CPT codes (e.g., 99212 to 99214, depending on the level of care provided).^{4,8,9} CPT codes should be chosen based on the level of complexity of the individual visit and not on length of time spent with the patient in the group education session; time can be used as a controlling factor when counseling dominates individual visits but not when it is shared in a group context. We have adopted this approach in our practice and have been successful for four years. Physicians should inquire whether their health plans have group visit billing policies. Completing forms and reviewing charts prior to the group visits facilitates the documentation of complexity levels after the encounters.

Physicians might also be able to obtain reimbursement for time spent outside of the individual visits in group education and behavioral change coaching. As mentioned, group sessions are time-intensive and often require preparation and updates. They could be billed with modifier -25 in addition to the E/M code for the individual visit. The additional code would be either for preventive medicine group counseling, such as 99411 or 99412, or for physician educational services in a group visit setting, such as 99078. However, managed care companies that provide reimbursement for this

The educational portion of a group visit may focus on a particular disease or a broader topic, such as self-management or behavior modification.

In the authors' clinic, patients report that they like group visits, with osteoporosis being the most popular program.

The authors bill for group visits using the most appropriate office-visit code, depending on the level of care provided in the individualized portion of the visit.

FPM RESOURCES

The *FPM* archives, accessible at <http://www.aafp.org/fpm>, offer the following group visit articles and tools:

"Group Visits Hit the Road." Dreffer D. September 2004:39-41. (Includes a sample agenda and nursing home encounter form.)

"Group Visits 101." Houck S, Kilo C, Scott JC. May 2003:66-68. (Includes a sample invitation letter.)

"Group-Visit Consent Forms (Ask *FPM*)." Masley S. February 2003:56. (Includes a consent form.)

"Planning Group Visits for High-Risk Patients." Masley S, Sokoloff J, Hawes C. June 2000:33-37. (Includes a diabetes encounter form.)

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code do so mostly for diabetes-related education. In addition, Medicare and Medicaid do not cover these codes. Using these codes would require patients to pay out-of-pocket for these services, in addition to paying the copay required at each visit. Therefore, we have refrained from using them, but we remain hopeful that insurance companies will cover these codes in the future.

Waiting time and patient flow. Frustration may result within a group visit if patients are required to wait for their individual medical sessions before or after the group educational session. One solution might be to assign several physicians to conduct the individual sessions, reducing the amount of time necessary to wait for each appointment. Additionally, physicians could stagger individual visits, as we have done, so that half the group is seen before the group educational session and half afterwards, scheduling patient arrival time accordingly. Since our groups are run in the evenings, our medical assistants are allowed to leave after obtaining vital signs from all patients, thus minimizing our overhead expenses.

Confidentiality. A third challenge presented by the group visit model is that of confidentiality. Patients who attend these sessions discuss their conditions openly with one another, and laboratory and examination results are often shared within the group. In addition, when individual visits are conducted within the group setting, patients routinely witness medical encounters. To date, we have not received a single patient complaint regarding breaches of confidentiality. Although the Health Information Portability and Accountability Act does not specifically address the issue of group visits, precautions may be prudent. For example, physicians' offices could obtain releases in which patients agree not to reveal personal information about other patients outside the group setting.⁹

Drop-out rates. Patient drop-out rates may increase as the length of the program or the interval between group meetings

increases. In our review of the literature, groups that met every three to six months over two years had the highest attrition rates.^{5,10,11} In contrast, the drop-out rate for our weekly program is extremely low.

Conclusion

Group visits are a feasible, albeit time-intensive, way to improve chronic disease management. The group visit model cannot be applied to all patients, as it requires commitment to behavior change and active participation within the group, but it is a valuable treatment option for the motivated patient and deserves consideration by primary care physicians. **FPM**

Send comments to fpmedit@aafp.org.

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■ Staggering individual visit times or having several physicians available can help reduce the amount of waiting time at group visits.

■ To protect confidentiality, practices can require patients to sign a release stating they will not discuss one another's personal information outside of the group.

■ Patients are more likely to drop out of group programs if the intervals between meetings are too long.