

Group Medical Visits

A Quality Improvement Initiative

Access III of the Lower Cape Fear

Serving Bladen, Brunswick, Columbus, New Hanover,
Onslow and Pender Counties

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National Perspective

- GMV model developed at Kaiser (Dr. John Scott) and Cleveland Clinic (Dr. Richard Maxwell)
- Endorsed by:
 - Institute for Healthcare Improvement
 - American Academy of Family Physicians
 - Included as one of the new models of care in the Future of Family Medicine Project
 - American Diabetes Association
 - Included as a “Strategy for Improving Diabetes Care” in the 2006 ADA Clinical Practice Guidelines

Local Effort

- Practice in our network asked for our help with implementing GMVs
- We researched literature, identified this as a best practice QI approach, got Dr. Maxwell from Cleveland Clinic to come do evening meeting with providers, received grant funding to have MPH/RD on staff help practices to implement

What Are GMVs or Shared Medical Appointments?

- A doctor's visit for continuing care in the provider's office
 - **Medical care**
 - *plus* education
 - *plus* group support
- 8-10 patients share a 2 hour appointment
- Seen by Doctor, Nurse, and sometimes "guest expert"
- Each patient receives individual medical care
- All patients benefit from education

What type of patients are seen?

- Any group of patients who share a condition:
 - Diabetes
 - Hypertension
 - Other heart disease
 - Asthma
 - Cancer
 - Frail Elderly
 - Depression
 - prenatal visits or well child visits
- Best when each group is somewhat homogeneous in condition and needs

What Makes them Special?

1. Patients come!
2. Providers have more time with patients with complex illnesses –more ability to follow best practices
3. Patients benefit from hearing other patient's questions and the care recommendations providers make to others
4. Time for education
5. Social Support and Motivation
6. Self- sustaining- once trained, providers are able to offer GMVs as a billable service

Benefits to Providers

- Increased Satisfaction
 - More time, less repetition
- Improved care quality—more time/better able to adhere to evidence based treatment guidelines
- Increased productivity by providing 8-10 level 2, 3 or 4 visits in about two hours—Dr. Maxwell reports 8% increase in provider productivity by adding one GMV per week

Benefits to Patients

- Diabetes group visits have shown:
 - improved HbA1C levels
 - improved blood lipid levels
 - fewer emergency room visits
 - improved compliance with preventative procedures
 - improved patient knowledge
 - improved patient satisfaction
 - decreased health care costs
- Wagner, et.al. “Chronic care clinics for diabetes in primary care: a system-wide randomized trial.” *Diabetes Care*. 2001 Apr;24(4):695-700.
- Trento et.al. “Group visits improve metabolic control in type 2 diabetes: a 2-year follow-up.” *Diabetes Care*. 2001 Jun;24(6):995-1000.
- Masley S, Sokoloff J, Hawes C. Planning group visits for high-risk patients. *Fam Pract Manage*. June 2000:33-37.

How do you Bill?

- You bill each individual patient for the ***medical care*** provided to ***that individual patient***.
- You bill each individual patient based on the level of care provided to that individual patient.
- You cannot bill on the basis of time.
- You cannot bill on the basis of shared education.
- There is no CPT billing code for group medical visits.
- Documentation is always critical, individualized to *each* patient.

How do you Bill?

March 28th 2007, Centers for Medicaid and

Medicare Services (CMS) official response:

- An Evaluation and Management Service (E/M) code (99201-99215) can be reported for a medically necessary face-to-face encounter with an individual patient participating in a group medical visit.
- The E/M level of service reported should be consistent with the services provided to the individual patient. The documentation must support the criteria for the E/M code reported.
- Services provided as part of the group encounter cannot be considered in the determination of the code for the individual encounter.
- Separate billing for services provided to the group is not allowed.

Emily Hill, PA, President of Hill & Associates, Coding and Compliance Professionals, prepared these summary points from this letter. Ms. Hill is available for consultations if you have further questions or need assistance. Please contact her at Emily@CodingAndCompliance.com or 910-762-1978.

Key Concepts for Successful Group Visits

- This is a “REAL” Doctor’s Visit!
- This is NOT a class
- Bill for the medical services you provide to each individual
- Make the Group Medical Visit a regular part of your practice

Successes

- We were able to help about 27 practices to implement these at some level—FQHCs, large practices, Rural Health Center, etc--anyone
- Required us to have one staff person who could train practices on how to implement the model
- We have now trained IPIP staff to be able to help practices across the state
- Able to get many more Medicaid patients to attend these than classes—people want to hear from their provider

Barriers

- Self-sustaining in terms of funding, but staff turn over in the practice, hectic pace of practices can lead to drop off in participation
- Need someone to teach the model/help practice learn how to implement
- Smaller practices sometimes lack the physical space
- Some providers not yet comfortable with being in group exam/education role

Win-Win-Win

- We find them to be a Win-Win-Win for patient, provider, and payer
 - Better patient outcomes
 - Improved care quality
 - Leads to reduced costs

For More Information

- Institute for Healthcare Improvement
www.IHI.org
- American Academy of Family Physicians
www.aafp.org
- Cleveland Clinic, workshops with Dr. Richard Maxwell (MaxweIR@ccf.org)
 - www.clevelandclinicmeded.com/courses/shar-edappts