Session # J4

An Interdisciplinary Group Medical Visit Promote Health Behavior Change with Underserved Patients

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CFHA 20th Annual Conference
October 18-20, 2018 • Rochester, New York

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

1) Understand the model of a group medical visit for promoting healthy behavior change in an underserved setting.

2) Describe importance of an interprofessional team in group visits.

3) Describe the value of incorporating a group medical visit model for prevention and behavior change

4) Understand what elements are necessary to create a financially sustainable group visit model

Bibliography / Reference

1. Brownson RC, Baker EA, Housemann RA, Brennan LK, Bacak SJ. Environmental and policy determinants of physical activity in the United States. Am J Public Health. 2001;91(12):1995-2003.
2. McAlpine, DD, Sambamoorthi, U. Racial, ethnic, socioeconomic , and access disparities in the use of preventive services among women. Preventative Medicine. 2003 (37): 475-484.
3. Epstein, RM, Fiscella K. So much to do, so little time: Care for the Socially Disadvantaged and the 15-minute visit. Arch Intern Med. 2008 (17): 1843-1852.
4. Glasgow, RE, Estabrooks, PA. Translating Effective Clinic-Based Physical Activity Interventions into Practice. Am J Prev Med. 2006; 31 (4S) S45-S56.
5. Davis, SM, Yancey, AK, Ory, MG. Dissemination of Physical Activity Promotion Interventions in Underserved Populations. Am J Prev Med 2006; 31 (4S) S82-S91.
6. Brownson RC, Glasgow, RE, et al. Physician Advice and Support for Physical Activity. Am J Prev Med. 2001; 21 (3):189-196.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Acknowledgement

This work is a product of a Prevention Research Center in collaboration with the Division of Nutrition, Physical Activity and Obesity and was supported by Cooperative Agreement Number U48 DP005026 from the Centers for Disease Control and Prevention. The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Background

- Ethnic minorities and lower-income groups bear higher burdens of chronic disease and have higher rates of sedentary behavior
- Challenges to regular physical activity among these populations are multi-level
- Many evidence based interventions are less effective in underserved populations
- New models are needed to address physical activity promotion in underserved populations

Medical Office Based Intervention

- Breadth of population served by primary care
- Physicians are considered a reliable and credible source of information
- A physician caring for a usual panel of patients would need to spend 35 hours on preventive health care during a typical week
- Group medical visits are a promising new model in primary care

Definition of Medical Group Visit

Multiple patients meet together as a group

Group facilitated by a team

Meets for 1.5 to 2.5 hours at periodic intervals

Often uses an interdisciplinary approach

Each group session includes:

- Medical management by a licensed practitioner
- Interactive patient education
- Coaching and counseling through a facilitated discussion
- Simultaneously, patients share experiences and advice with one another and with the facilitators

(Eisenstat et al 2012)

What are they used for?

- Joseph Pratt was the first to use groups for tuberculosis patients in 1907 at MGH (Pratt 1908)
- Diabetes (Naik 2011; Sanchez, 2011; Riley 2010; Taviera 2010; Kirsh 2008; Deakin 2005; Culhane-Pera 2005; Clancy 2003; Trento 2001, 2002, 2004, 2005, 2010; Sadur 1999)
- Metabolic syndrome (Greer 2011), hypertension, cardiac disease (Bartley 2010; Yehle 2009; Masley 2001)
- Asthma (Wall-Hass 2012), arthritis (Shojania 2010) ,chronic pain (Gaynor, 2007)
- Menopause (Thacker 2005), sleep disorders (Ulman 2003), stress (Ulman 2000)
- Chronic headaches (Blumenfeld 2003) and Parkinsons (Dorsey 2011)
- Geriatric patients (Levine 2010; Scott 2004; Coleman 1999, 2001; Beck and Scott 1997)
- Obstetric patients (Ickovics 2003)

Do They Work?

Health benefits of groups for medically ill:

- Increased compliance and adaptation to illness (Clancy 2007; Ulman 1993)
- Decrease in symptoms (Sadur 1999;Trento 2001,2002, 2004)
- Decrease in office and emergency room visits and inpatient admissions (Sadur 1999; Coleman 2001; Beck 1997;)

Improved blood pressure, blood glucose levels and other health targets (Edelman et al, 2012; Burke 2011; Jaber 2006; Trento 2001, 2002, 2004; Wolf 2004)

Improved access to care (Thompson 2000; Bronson 2004; Gutman 2004; Bowers 2009)

Behavioral change (Burlingham, 2013; Wagner 2007)

Do They Work?

Cochrane Collaboration Systematic Review 2005

Group based training for self-management strategies in people with type 2 diabetes mellitus

Decreased HbA1c at 6m, 1yr, 2yr

Lower fasting glucose at 1 yr

Weight loss at 1 yr

Lower systolic blood pressure at 6m

Decreased diabetes Rx

Increased diabetes knowledge at 1 yr

US systematic review (Edelman 2012) *Shared medical appointments for chronic medical conditions: a systematic review*

Significantly Decreased:

- HbA1c
- Cholesterol
- Blood pressure
- Hospitalizations

Significantly Increased:

- Health-related quality of life

Why Do They Work?

- Instill hope in patients by allowing them to see examples of success in managing a health issue.
- Add universality by disconfirming the uniqueness felt by patients regarding their conditions and/or health issues.
- Impart information and allay patient anxiety.
- Encourage an unselfish regard for the welfare of others.
- Promote imitative behavior and allow for positive role modeling among patient peers.
- Offer interpersonal and cognitive learning within the group setting.
- Provide group cohesiveness where peers can offer support among themselves.

AAFP, Family Practice Mgmt

Wait a Second…What About Privacy?

- Some patients, and some providers, are worried about protecting privacy of patients in attendance
- Group members need to have sense of confidentiality and safety in that setting
- Setting expectations early, being explicit, and always signing consent/confidentiality statements at the outset

Typical Group Visit

1:30pm- 2:00pm Patient check-in and individual assessments

2:00pm- 2:15pm Introductory activity

2:15pm- 2:30pm Interactive presentation on topic related to specific disease (DM, Smoking, Wellness)

2:30pm-2:55 pm Discussion

2:55pm Meeting closing (activity, call to action, homework)

3:00pm Finish up individual assessments

Which Components of Group Visits Affect Outcome?

- Evidence too limited to permit analysis of effects based on components or intensity of group visits

- Limited evidence suggests that groups incorporating a behavioral component are more effective than those focused solely on information

The Dream (Group Visit) Team

- Behavioral health
- Dietician
- Nursing
- Physical therapist
- CASAC
- Care Management
- Administrators
- Scribes
- other ideas

Modeling Collaboration

- Multidisciplinary team of providers who model skills in working together
- Flexible hierarchy (among MD and non-MD providers, and between Pts and providers)
- Respecting others' knowing
- Behavioral health role can include screening for mental health complications and facilitating referral

Research Aims

Aim 1: Implement a group medical visit in a federally qualified health center to promote physical activity, delivered by primary care and community partners

Aim 2: Assess the intervention's effectiveness on physical activity

Aim 3: Assess the role of policy determinants on mediating the intervention's effectiveness and outcomes

Theory of Change

- Synergy between environmental level and individual level change

- Self-Determination Theory
  - Three pillars: autonomy, competence, relatedness
  - SDT emphasizes that individuals must feel both autonomous and competent for optimal motivation

Intervention

- 12-week (6 session) Curriculum occurs every other week and takes place at Rochester housing authority building with a satellite FQHC clinic
- Patients are eligible for participation in the GMV intervention if they are 18 or older, overweight/obese and/or have a weight or inactivity-related chronic condition
- Most commonly hypertension, diabetes, pre-diabetes, depression, hyperlipidemia, chronic pain, asthma and chronic obstructive pulmonary disease

Session Components

- Each session includes
  - an interactive curriculum led by a dietician;
  - a group physical activity led by a clinician, student or community team member,
  - a brief one-on-one visit with a clinician
  - an individualized physical activity/nutrition prescription written by the clinician updated at each session
  - a group wrap-up where patients share their goals or what they learned from the session.
- Enhancement activity
  - presentation from a community partner
  - a healthy recipe cooking demonstration
  - mindfulness exercise

Procedures and Measures:

- This is a ‘pre-post’ study design
  - Body Mass Index (BMI)
  - weight (lb)
  - motivational measures
- For motivational measures, we used the Exercise Self-Regulation Questionnaire.
- This is structured with responses that represent different subscales of motivation in order from the least to the most fully internalized/autonomous.
- Comparisons between those who are more autonomously motivated versus not have generally shown enhanced and persistent behavior change.

Preliminary Results

- 49 participants
- 28 participants completed the sessions to date.
- The majority of the participants were non-Hispanic black women (75%)
- mean age of 53.4 (range, 26-70).

Results

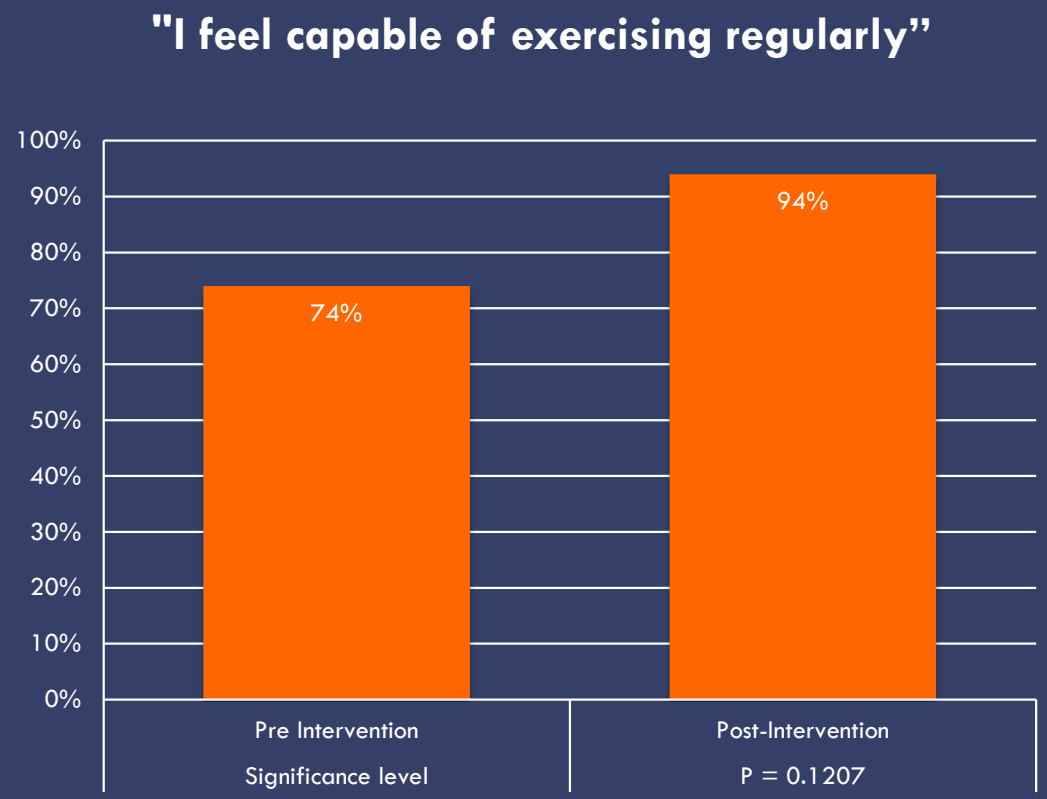
- The average weight loss was 3.64 pounds ($p = 0.04$)
- An improvement was noted in intrinsic motivation (1 point, $p = 0.000$) and identified regulation (0.8 points $p = 0.001$)

Physical Activity at Week 12

Preliminary data on a smaller subset of patients

- physical activity duration increased from 88 minutes/week to 112 minutes/week (p = 0.3660, n=16)
- physical activity frequency increased from 3.18 times/week to 3.67 times/week (p = 0.5667, n=15)

Confidence in physical activity



Community Partnerships

Successful regular presentations by Willie Murphy neighborhood weight lifting champion

100% of attendees requested a letter for R Community Bikes

New partnerships with Foodlink and Center for Community Health

foodlink
abundance shared

Center for Community Health

YMCA OF GREATER ROCHESTER

COMMUNITY BIKES INC.

Community Partnerships

https://www.youtube.com/watch?v=bT2w7-fDW9o&feature=youtu.be

Policy Applications

Organizationally

- New referral process for the Group Visit
- Created tool in EHR for Physical Activity RX

Locally

- Establish a network of community partners
- Have scaled up locally to three additional locations and in preliminary discussion for location in Ohio

Federally

- Health care is moving from a fee for service environment to population health management
- Will need creative and efficient ways to deliver chronic disease and preventative care

Policy Challenges

- Sustainability is a challenge with the difficulties in recruitment and retention
- Need to have 12-15 patients/session to cover the cost of the staffing needs
- The stability of health professional teams in community health centers that may have high rates of staff turnover

Sustainability: Billing and Coding

There is no nationally accepted standard for medical group visits

- Medicare has disseminated general policy statements in support of reimbursement of group medical visits, but there is regional variation.
- Some insurers have policies for reimbursement of group visits

An E/M visit

- Must be a “medically necessary” service to bill E/M, at a customary interval of care
- based on documentation and medical necessity
- never on the basis of time

Getting Paid

- Do not bill based on time. Rely on complexity of diagnosis and your documentation
- Document clearly:
  - Emphasize the medical management component
  - Use medical E/M code 99213 (rarely 99214)
- If more than one clinician billing (i.e, a physician and psychologist) differentiate services provided to avoid duplicate billing
- Patient education is not directly reimbursed under current system, except in specific cases such as diabetes self management education (DSME) by a certified diabetes educator (CDE)

What is the break-even point?

- 1.5 hour = 6 patients seen in the office
- Need to account for different “overhead” depending on staffing of groups
- 9-10 patients per session if billing 99213
- 12-16 patients are the “sweet spot”
- > 16 challenging for group interaction

Conditions that benefit from physical activity and improved nutrition

- COPD
- Coronary Artery Disease
- Stroke
- Type 2 Diabetes and Insulin Resistance
- Hypertension
- Hyperlipidemia
- Colon and Breast Cancer
- Overweight/Obesity
- Falls
- Depression
- Cognitive Impairment

CMS answer

the question of "the most appropriate CPT code to submit when billing for a documented face-to-face evaluation and management (E/M) service performed in the course of a shared medical appointment, the context of which is educational", was sent to the Centers for Medicare and Medicaid Services (CMS)

The request further clarified, "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?“

The response from CMS was, "...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."

Mini-visits

- The 1-1 visits are mandatory for billing E/M codes for all insurances.
- HPI/ROS on check-boxed papers that they get at check-in which match templates used to document
- Mini-visits should be 5-7 minute max

Mini-visits

- Focus on individual goal setting
- Check medication compliance
- Review vital signs
- Write exercise RX

Goal Setting

Set reasonable and achievable goals

Do not let perfect be the enemy of the possible

Exercise RX

- Can make smart-phrase to include in note
- If on AVS have to make sure they take home
- Prefer to write on index or business card that can be put on fridge or in wallet

Exercise RX

Exercising; {NUMBERS 0 - 10:25006} times a week for *** minutes

Type of exercise:

walk bike yoga/stretching trength training

other cardio (dance, exercise video, zumba, etc.)

other

Intensity:

light (a stroll) moderate (can talk but not sing while doing it)

heavy (could not carry on a conversation)

Plan for overcoming barriers:

Where Can I Go To Learn More?

Nuts and bolts, and how-to's (esp for medical providers and those of us who love them):

- American Association of Family Physicians (AAFP) Toolkit: http://www.aafp.org/online/en/home/practicemgt/quality/qitools/pracredesign/january05.html
- TransforMED website (including starter kits, forms, practice stories, curricula): http://www.transformed.com/resources/group_visits.cfm
- E. Noffsinger (2010). *Running Group Visits in your Practice.* Springer: NY.
- Society for Teachers of Family Medicine, Group visit Wiki (http://www.fmdrl.org/group/index.cfm?event=c.showWikiHome&wikiId=15)
- Institute for Healthcare Improvement (http://www.ihi.org/knowledge/Pages/Tools/GroupVisitStartKit.aspx)

Questions?

Connect

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Engage

- To join PAPRN+, email PAPRNPlus@gmail.com.
- Follow us on social media

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Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

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Additional billing information

- almost always 99213 unless they have 3 chronic conditions and we address them all during the mini-visits.
- I usually code for obesity as there is CMS guidelines about seeing patients every two weeks for this.
- Our compliance officer at URMC says we can't bill for anything that happens during the group as opposed to during the mini-visit.
- Documentation should down play the group aspect

Concern for being audited if you were billing 99214 every two weeks for HTN/DM/Depression etc. that were well controlled.

There are patients at Jordan who are really medically complicated and ill that I routinely bill 99214 for because they are complicated and their comorbidities are poorly controlled.

Using preventive codes

G0447 pays $24.0

G0473 - group visit pays $11.82

Intensive Behavioral Therapy (IBT) for Obesity

HCPCS/CPT Codes

G0447 – Face-to-face behavioral counseling for obesity, 15 minutes

G0473 – Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

ICD-10 Codes

Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45

Who Is Covered

Medicare beneficiaries when all of the following are true:

- Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared)
- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Preventive codes

Frequency

First month: one face-to-face visit every week

Months 2–6: one face-to-face visit every other week

Months 7–12: one face-to-face visit every month if certain requirements are met

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.

To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, Medicare beneficiaries must have lost at least 3 kg.

For Medicare beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.