Lifestyle Medicine: Shared Medical Appointments

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doi: 10.12788/jfp.0278

INTRODUCTION

A clinical encounter in which healthcare is offered and delivered in a group setting is known as a shared medical appointment (SMA). All participants receive healthcare services, including education, counseling, physical examinations, and clinical support, within a group environment. The earliest described versions of SMAs include drop-in group medical appointments (DIGMAs) and Cooperative Health Care Clinics (CHCCs).[1] DIGMAs include patients from a single provider's panel who may have differing diagnoses, and these patients can drop in and out of the group visit as needed. For example, 21 patients could come and go during a 2-hour window as they meet with the provider and have their medical needs addressed. This would be instead of scheduled individual visits in which 1 patient might be seen every 15 minutes. CHCCs focus more on specific diagnoses or behaviors, and patients are scheduled to be present for the entire time. For instance, 10 patients could all be scheduled for a CHCC visit at the same time to have their hypertension addressed. More recently, programmed SMAs (pSMAs) have been described as a defined sequence of SMAs that offer specific educational content on a particular topic.[2] One particular type of pSMA is lifestyle medicine shared medical appointments (LMSMAs), in which the focus is on lifestyle changes that have the potential to improve health outcomes. This article will summarize the benefits of LMSMAs for patients, providers, and health systems; describe author experiences with one type of LMSMA; and offer guidance related to the implementation of such services.

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DISCLOSURES

The authors have no conflicts of interest to disclose.

SHARED MEDICAL APPOINTMENTS BENEFITS

SMAs have been researched targeting a variety of topics and conditions. Egger et al[2] offered a pSMA intervention for weight loss consisting of 16 to 18 weekly visits, with reported benefits in cost savings, participant and provider satisfaction, and time efficiency. A qualitative study of veterans participating in SMAs concluded that these group visits are innovative and offer high levels of patient satisfaction and identified "empowerment, teamwork, convenience, and positive provider characteristics" as some of the many positive themes.[3] A retrospective review of a breast cancer survivorship SMA that offered education and experience in culinary medicine, nutrition, physical activity, and stress relief practices demonstrated a significant weight reduction post-intervention.[4] Reports of quality of life, depression, and perceived stress trended positively, and patients reported a statistically significant decrease in average weekly fat consumption of 31%. A narrative review of a multidisciplinary, nonpharmacologic SMA by Menon et al[5] showed that it was associated with decreased costs and improved diabetes-related behavior and lifestyle. Znidarsic et al[6] conducted a pre- and post-analysis of a chronic pain SMA that included 178 participants and concluded that the participants reported reduced pain and improved social, physical, and mental health measures. Overall, these research findings have demonstrated significant improvements utilizing SMAs for a variety of lifestyle-related factors such as weight, dietary intake, and stress reduction.[2-5]

SMAs have many benefits for the participant. The SMA interactions with other patients, healthcare providers, and clinicians may be a means to combat isolation,[7] which is a significant health concern. These patients can learn from and share with each other while realizing that they are not alone in their experiences. They also have the opportunity to meet individually with the clinician. Those participating individuals who are doing very well may inspire those who

are struggling. The total amount of time they are with their provider, although shared with others, is substantially longer than the time they would have for individual appointments. Convenience may also be a benefit, with participants having options about when to participate.[7]

Healthcare teams; healthcare purchasers, including insurers; and healthcare systems may also benefit.[9] Physicians have an opportunity to work closely with other team members and to utilize their time efficiently. They can make impactful statements to the group instead of repeating these same statements during individual appointments. The pressure of time constraints is relieved in that there are not multiple appointments in a row with SMAs, as there are during traditional medical appointments. Also, patient notes can be recorded by a facilitator, allowing the provider to fully engage with the participants.[2] Potentially, SMAs may enhance clinician well-being, prevent burnout, and improve retention.[8]

When compared to traditional one-on-one visits, SMAs are cost-effective and in some cases profitable.[10-12] While more research in primary care cost-effectiveness is needed, many researchers have found benefit among certain populations. Clancy et al[10] noted a significant decrease in outpatient visit charges among patients with diabetes who participated in SMAs, which was thought to be related to a decrease in specialty medical visits. Sidorsky et al[11] demonstrated that SMAs provided a better return on investment than traditional clinic visits across multiple specialties including dermatology, plastic surgery, gastroenterology, oral health, and orthopedic surgery. This article indicated that the mean reimbursement rate would have to fall below 10% for the SMA profitability to be less than that of a traditional one-on-one model. This finding is also supported by the work of Seesing et al[12] when applied to the specialty of neurology. Per the article, an SMA was fiscally viable when the group size was maintained at a minimum of 6 patients and at least 75% of the patients were evaluated by the treating neurologist.

IMPLEMENTATION OF LIFESTYLE MEDICINE SHARED MEDICAL APPOINTMENTS

Lifestyle medicine clinic visits focus on the "use of evidence-based lifestyle therapeutic intervention, including a whole-food, plant-predominant eating pattern, regular physical activity, restorative sleep, stress management, avoidance of risky substances, and positive social connection, as a primary modality, delivered by clinicians trained and certified in this specialty, to prevent, treat, and often reverse chronic disease."[13] The fundamental nature of lifestyle medicine lends itself very well to a group-based, multidisciplinary delivery approach. While these LMSMAs have been described only more recently in the literature, the historical experiences of SMAs can be of guidance in the planning and delivery of this model.

A well-planned and -supported LMSMA is essential for optimal outcomes. The atmosphere of these groups should be relaxed and fun, offering the participants a chance to explore, learn, and share. The entire healthcare team needs to know how to conduct LMSMAs, which may require training and experience. LMSMAs should be seen not as a replacement for individual visits but as a means to provide optimal services and enhance outcomes.[14] These LMSMAs tend to support behavioral change over time through presenting information and reinforcing healthy lifestyle changes. It may even be beneficial for participants to witness the triumphs and struggles of other group members as they navigate their condition.[7]

There are some special considerations when implementing LMSMAs, including confidentiality and privacy, appointment location, and patient and staff census levels. Additionally, the need for accurate and complete documentation and billing is paramount to ensuring the cost-effectiveness of this delivery model.

Providers must address confidentiality and privacy concerns. One recommendation to do this is to inform the group that if there is anything that needs to be addressed privately, an opportunity can occur during a break or after the LMSMA concludes.[14] Distributing a standard confidentiality form for the participants' signatures is an important legal consideration. Participants must be allowed to join and leave willingly. LMSMAs are usually delivered over a 2-hour period and should include time for individual consultation with the healthcare clinician.[15]

Traditionally, group visits have been conducted in person. In this instance, facilities need to be well lit, roomy enough to accommodate the group, and comfortable, with an exam room nearby. With the onset of the COVID-19 pandemic, many SMAs were converted to a virtual platform. The delivery method is beneficial as it eliminates transportation and physical space barriers. However, this method does initially present challenges with respect to internet access and familiarity with group conferencing technology. The Medicare Diabetes Prevention Program (MDPP) example provided here represents a real-time adjustment from in-person to virtual presentation.

The following is one experience related to LMSMAs. In August 2019, an MDPP was implemented by the primary author within a suburban continuing care community in Indiana for 11 individuals ranging in age from 75 to 87 years. While the MDPP doesn't require provider oversight, these group visits do offer lifestyle interventions within a group setting and have demonstrated considerable positive out-

comes related to activity levels, weight loss, and prevention of diabetes.[16] In February 2020, the pandemic made it necessary to move the group to an online format. While the first few sessions required extra time and effort, all members of this cohort were able to successfully attend virtually via Zoom for the remainder of the program. While initially the goal was to just maintain the MDPP, many benefits were experienced. The group was able to maintain a social connection virtually and continued to learn and share. This LMSMA was convenient for the provider and facilitator, as there was no longer time needed to commute and set up the room.

For future virtual LMSMAs, the MDPP facilitators plan to offer individual sessions, in the beginning, to assist with technology orientation to make certain the participants are able to connect and participate virtually. It was encouraging that all members of this cohort, despite advanced age and the healthcare team's inability to assist them in person to get them started, were able to connect and participate fully. This group's higher educational attainment and socioeconomic status may have contributed to their success. The ability and resources needed to attend virtually must be considered. Overall, the experience was positive and all members successfully completed the program.

GROUP SIZE AND STAFFING

Participant census is critical to participant and provider satisfaction as well as to financial viability. Limiting the number of participants ensures that there is enough time for everyone. However, adequate numbers (10-12 participants) are needed to foster group dynamics and promote an appropriate return on investment.[15] It is prudent to start small and grow as needed, such as with a pilot project.

Adequate staffing is required, with a minimum of 1 physician or non-physician clinician and 1 support person. Traditionally, the group leader is a physician, physician assistant, or advanced practice registered nurse such as a nurse practitioner. An exception to this is the MDPP, which can be run by a trained facilitator. Additional team members allow for the incorporation of a multidisciplinary approach and may include but not be limited to nurses, dietitians, exercise and mobility specialists, and behavioral health specialists. Dedicating a staff member to arranging visits and follow-ups, recording vital signs, and taking notes is helpful for improving session flow.[15]

BILLING

Three potential revenue sources for SMAs are private pay, contract billing, and traditional fee-for-service. While it is beyond the scope of this paper, prior to beginning an LMSMA, much groundwork will need to be laid to address other aspects prior to billing, including gaining familiarity around the ever-changing policies, laws, reimbursement fundamentals, privacy issues, and liability concerns. The Centers for Medicare & Medicaid Services is currently considering implementing a separate model under the CMS Innovation Center to test and evaluate virtual MDPP services.[17] If this does occur, this may be an avenue for billing for virtual MDPP visits, which is not currently in place. For the traditional fee-for-service, evaluation and management codes are generally utilized for established patients. The 99212 to 99214 codes may be appropriate based on the complexity of the individual portion of the visit. Time-based billing should not be utilized for LMSMAs because this type of billing only captures the time associated with an individual visit. For example, in a 60-minute SMA, the clinician does not spend the full 60 minutes focused on one individual patient. Therefore, billing codes should be based on the evaluation and management code that aligns with the level of medical complexity required by each individual patient. Additionally, new patients should have an initial one-on-one visit with a clinician prior to enrolling in an LMSMA.[18] The **TABLE** provides more potential billing options. Along with providers, other healthcare professionals such as dietitians, nurses, psychologists, and nurses can bill utilizing their National Provider Identification (NPI) number.[15] Working with a billing specialist can help to ensure proper billing to optimize reimbursement.

DOCUMENTATION

Complete and accurate documentation promotes safe patient care while also providing justification for billing and compliance. Each visit should be documented in the individual patient's health record. This documentation will support the level of evaluation and management code submitted for reimbursement. The documentation should still include an appropriate history and physical that evaluates the chronic medical condition(s) being treated via the LMSMA as well as any pertinent medications being utilized and recent laboratory results. The assessment and plan should describe the content delivered during the group portion of the visit as well as concerns addressed during the private individual time, including medication adjustments, refills, and laboratory evaluations.

CONCLUSION

SMAs have demonstrated many positive attributes that make them a credible option within the treatment regimen of multiple common chronic diseases. LMSMAs are uniquely positioned to provide evidence-based lifestyle counseling, including motivational interviewing and health behavior goal setting, to address these chronic diseases. While these require

TABLE. **Billing code options**[15]

Type of code	Number
Evaluation and management	99212-99214
Medical nutrition therapy	97804
Behavioral therapy for cardiovascular disease	G0446
Intensive behavioral therapy for obesity	G0447
Health and behavior assessment and intervention	96164
Diabetes self-management training	G0109

thoughtful planning, training, and engagement of staff, healthcare leaders, and participants, the efforts may result in improved costs, improved satisfaction of both patients and healthcare workers, and other positive outcomes. As our healthcare system rapidly changes, the LMSMA model can offer solutions to the many family medicine providers who are searching for ways to maximize the use of their time while having the potential to improve patient outcomes and decrease costs. ●

REFERENCES

1. Noffsinger E. Will drop-in group medical appointments (DIGMAs) work in practice? *Perm J*. 1999;3(3):58-67.
2. Egger G, Stevens J, Volker N, Egger S. Programmed shared medical appointments for weight management in primary care: an exploratory study in translational research. Aust *J Gen Pract*. 2019;48(10):681-688.
3. Cohen S, Hartley S, Mavi J, Vest B, Wilson M. Veteran experiences related to participation in shared medical appointments. *Mil Med*. 2012;177(11):1287-1292.
4. Schneeberger D, Golubic M, Moore HCF, et al. Lifestyle medicine-focused shared medical appointments to improve risk factors for chronic diseases and quality of life in breast cancer survivors. *J Altern Complement Med*. 2019;25(1):40-47.
5. Menon K, Mousa A, de Courten MP, Soldatos G, Egger G, de Courten B. Shared medical appointments may be effective for improving clinical and behavioral outcomes in type 2 diabetes: a narrative review. *Front Endocrinol (Lausanne)*. 2017;8:263.
6. Znidarsic J, Kirksey KN, Dombrowski SM, et al. “Living Well with Chronic Pain”: integrative pain management via shared medical appointments. *Pain Med*. 2021;22(1):181-190.
7. Kirsh SR, Aron DC, Johnson KD, et al. A realist review of shared medical appointments: how, for whom, and under what circumstances do they work? *BMC Health Serv Res*. 2017;17(1):113.
8. Thompson-Lastad A, Gardiner P. Group medical visits and clinician wellbeing. *Glob Adv Health Med*. 2020;9:2164956120973979.
9. Noffsinger EB, Scott JC. Understanding today’s group visit models. *Perm J*. 2000;4(2):99-112.
10. Clancy DE, Dismuke CE, Magruder KM, Simpson KN, Bradford D. Do diabetes group visits lead to lower medical care charges? *Am J Manag Care*. 2008;14(1):39-44.
11. Sidorsky T, Huang Z, Dinulos JG. A business case for shared medical appointments in dermatology: improving access and the bottom line. *Arch Dermatol*. 2010;146(4):374-381.
12. Seesing FM, Groenewoud HJ, Drost G, van Engelen BG, van der Wilt GJ. Cost-effectiveness of shared medical appointments for neuromuscular patients. *Neurology*. 2015;85(7):619-625.
13. American College of Lifestyle Medicine. Accessed July 27, 2021. http://lifestylemedicine.org
14. Noffsinger EB, Scott JC. Potential abuses of group visits. *Perm J*. 2000;4(2):87-98.
15. Lacagnina S, Tips J, Pauly K, Cara K, Karlsen M. Lifestyle medicine shared medical appointments. *Am J Lifestyle Med*. 2021;15(1):23-27.
16. Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, Hamman RF, et al. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet*. 2009;374(9702):1677-1686.
17. Medicare Diabetes Prevention Program (MDPP). National DPP Coverage Toolkit. Last updated April 21, 2021. Accessed July 27, 2021. http://coveragetoolkit.org/medicare-advantage/mdpp-final-rule/
18. Frates EP, Morris EC, Sannidhi D, Dysinger WS. The art and science of group visits in lifestyle medicine. *Am J Lifestyle Med*. 2017;11(5):408-413.

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