BUSINESS OF LIFESTYLE MEDICINE

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Developing an Academic Lifestyle Medicine Clinic Model

Abstract: *An introduction to lifestyle medicine as a patient, has led to the development of a lifestyle medicine program, website and practice. Having the advantage of practicing in an academic setting and a part time endoscopy practice has allowed for exploration and experimentation of different models of delivery of lifestyle medicine, the goal being to provide affordable accessible lifestyle medicine in a manner that is reproducible and sustainable for medical residents and students.*

Keywords: CHIP; shared medical appointment; medical coding; health education; chronic disease

Having come to lifestyle medicine through my own experience as a patient, I recognized the value of food, exercise, and stress management in achieving health.¹ Wanting to learn more, and to share the benefits of lifestyle medicine with our community, my wife and I signed up for a Complete Health Improvement Program (CHIP) facilitators class.²

Facilitating CHIP classes placed me in the clinical laboratory where I directly observed the power of healthy lifestyle

change repeated again and again, resulting in published reports of what we witnessed.³⁻⁵ As my confidence and experience in lifestyle medicine grew, being mentored by Hans Diehl, John Kelly, and others, and as a faculty member at Ohio University Heritage College of Osteopathic Medicine in Athens, I invited students to observe and

grant to cover the cost of tuition for CHIP. We were encouraged to find that people who made the effort to attend CHIP via a scholarship had similar results to others who paid out of pocket, or who had the course funded by their employer.⁴

Armed with these data, as an employed physician, I approached my hospital administration, requesting that they

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participate in CHIP classes and in research, and began introducing lifestyle medicine into our medical school curriculum.

As a general surgeon in rural Appalachia, my practice was focused on underserved people living in poverty, who greatly needed lifestyle change. Even though CHIP is very affordable, the tuition cost for people living in poverty was out of reach. Wanting to demonstrate that they too could benefit, we obtained a

consider incorporating CHIP into their community benefit program and into patient care. Not seeing a clear financial benefit, instead of paying for a CHIP franchise, they encouraged me to develop my own curriculum.

The foundation of the curriculum we developed was based largely on PCRM (Physicians Committee for Responsible Medicine)/Neal Barnard's online curriculum and freely accessible materials from Full Plate Living.^{6,7} Other

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resources utilized include many of the CHIP videos on Vimeo, and Michael Greger's NutritionFacts.org.⁸

Our curriculum, The Lifestyle Medicine Clinic, took shape, and continues to evolve.⁹ Data from our first community classes were comparable to results we had seen in CHIP.¹⁰ The program has expanded into multiple formats; a free community class, a clinic-based shared medical appointment group class, and individual clinic visits.

My goals are (a) to provide affordable, accessible lifestyle medicine to all members of our community, especially those living in poverty. In the clinical setting, we have struggled with using the new preventive codes developed under the Affordable Care Act, seeking to receive meaningful reimbursement without patient copays. This has not been very successful, leading us to revert to the standard clinic visit codes with copays. We continue to dialogue with others who are attempting to find the optimal billing mechanism. (b) To develop a clinical model that is transferable to the practices of our students and residents who have embraced lifestyle medicine, and need to make it work financially in order to sustain it in their clinical practices.

My employment scenario has made it possible for me to explore a practice in lifestyle medicine without the need to make a livable income from it. I am employed part-time by Ohio University, with dedicated time for lifestyle medicine research, and I maintain an active part-time endoscopy practice as a hospital-employed physician. Seeing patients with gastrointestinal problems is actually a good match for lifestyle medicine, since most of the patients who are referred for endoscopy have specific complaints that can benefit from lifestyle medicine.

Our program and web sites are bare bones, without bells and whistles, and in a state of continual change, as we attempt to put information together that will better serve patients, students and providers. A companion web site was created to deal with the common questions that arise, as well as a place to

catalog the evidence for providers and those who want to examine the science directly.¹¹

Currently, my lifestyle medicine practice takes several forms. Every patient that I see for an endoscopy consultation receives a handout on "The Optimal Lifestyle," which they often begin reading before I enter the room. This frequently generates a conversation on the principles of lifestyle medicine and how they apply to the patient's particular problems. Often, by the time I later see the patients for their endoscopic procedure, they report having made some positive changes that have helped control their blood sugar, blood pressure, and weight, supporting the idea that some patients just need a gentle nudge and clear direction. As I review endoscopic findings with my patients, I give them additional disease specific handouts that focus on lifestyle changes to address their particular problems. I often encourage them to consider one of the lifestyle medicine program options offered in the community.

As an employed physician, I offer free community lifestyle classes as part of the community benefit program provided by our hospital. This initially consisted of a weekly series of 6 or 12 two-hour class sessions, with a healthy meal, prepared to my specification, provided by the hospital. This has transitioned into a monthly "Wednesday Wellness" class, which covers a featured topic and serves as an introduction to lifestyle medicine. Participants are encouraged to explore other lifestyle medicine options available.

Early on, I began seeing some patients on an individual basis, who could not or preferred not to attend a group class. I continue to see some patients individually in follow-up, but have been impressed that people who do this in a group setting seem to do better. In addition, the "no show" rate was relatively high in my patient population, which for 45- to 60-minute individual appointments is very significant, and not sustainable.

Currently, for the majority of my individual patients, I offer an, initial 1- hour consultation. I receive referrals

from primary care physicians, cardiologists, an endocrinologist, and a sleep medicine specialist, as well as a growing number of self-referred patients. To help decrease the "no show" rate, I require that patients complete and return a fairly extensive questionnaire before we schedule the appointment. This seems to help screen out those who may not be all that serious about the appointment.

During the visit, I identify the specific needs and desires of the patients and give a PowerPoint-based overview of lifestyle medicine from my laptop computer, highlighting how it can address the patients' particular concerns. I then offer a series of options: (a) use my web site and work through the materials on their own, preferably with a "buddy"; (b) if their employer covers CHIP tuition, I urge them to take advantage of this; (c) a shared medical appointment series that I teach; and (d) individual appointments with me where the patients will work through the web site as homework, meeting regularly to review what they are learning and doing, setting new goals at each session.

Recently, we began offering shared medical appointments to a small group of up to 15 people. Group visits soften the blow of "no shows," and provide the benefit of group dynamic and efficiency of time. Our first series consisted of 6 one-hour classes over 8 weeks, based on the materials on our web site. One hour seemed insufficient, so subsequent groups have been for 90 minutes. Even this seems insufficient time to allow good group discussion.

Before the series begins, participants have an initial intake appointment with a nurse to get baseline data and fill out consents and questionnaires. We initially required blood work to be done within 30 days of starting and again after completion of the program; however, this became a financial hardship for some, so we no longer require laboratory testing. I am exploring a less expensive mechanism to add routine laboratory tests to the program allowing us to better evaluate our results.

After the 6 classes, we encourage an individual follow-up consultation to evaluate individual results, discuss successes and obstacles, and set future goals. At this point, I offer continued individual appointments spaced conveniently for the patients, suggesting 2 to 4 weeks between visits. At the next several individual visits, they will be given web-based homework, and continue to review and set goals.

As an employed physician, my employer, who would much rather I do procedures than lifestyle medicine, has graciously allowed me to experiment with developing a lifestyle medicine practice model. Prior to April 2016, my lifestyle medicine classes and individual visits were all credited toward my contracted hours. Currently, I am compensated on a relative value unit (RVU) basis, which makes accurate coding more important, and my financial model more representative of the average physician practice.

Coding and billing continues to be a difficult issue that proves to be a hindrance to an active lifestyle medicine practice. As mentioned, neither the preventive codes have been reimbursed consistently nor do the insurance companies offer much help in understanding how to best utilize these codes. Therefore, for individual patients, we have defaulted to using the standard clinic codes, 99204 for a new patient, 99214 or 99215 for established patients. We base the charges on face-to-face counseling time. For the shared medical appointments, we are using 99212 or 99213. We have been advised that to be safe, avoiding the fraud gray zone, this should be based on recorded elements, and not on time. With these codes,

however, many patients are required to pay copays and coinsurance, which is a major deterrent for my low-income population, hindering their access to needed services.

As I began this journey 5 years ago, I was reluctant to give up my identity as a general surgeon, having worn that badge for more than 25 years. The closure of my small critical access hospital, where I had a predominantly outpatient surgery practice, required me to move to a larger hospital that would not allow me to limit my practice to ambulatory surgery. Doing emergency room call and inpatient consultations in that setting would not have allowed me to reliably dedicate time to develop a lifestyle medicine practice, or to dedicate much time to academics. The hospital did however allow me to limit my practice to endoscopy. It took me about a year to get comfortable with my new practice identity of "Endoscopy and Lifestyle Medicine." Recently, however, I began shifting my letterhead to "Lifestyle Medicine and Endoscopy," as I move toward embracing lifestyle medicine as my primary specialty. I have a lot more to learn and a long way to go, but daily am encouraged by patients I see in the community who thank me for introducing them to the life-transforming power of lifestyle medicine. **AJLM**

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