STATE OF THE ART
REVIEWS

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Leveraging Time
With Lifestyle-Based
Group Visits

Abstract: Many challenges in reversing the chronic disease epidemic boil down to a lack of available time. Without time, implementing effective lifestyle medicine therapies and creating a therapeutic partnership between provider and patient is ineffectual. Although useful, the individual medical appointment model alone has not proved to “bend the cost curve” or improve morbidity. Lifestyle-based group visits (LBGVs) are extended clinical encounters that allow physicians and their patients to exchange valuable information regarding optimal chronic disease management within a supportive group format. Clinically, LBGVs improve patient knowledge scores and chronic disease outcome measures. Operationally, they reduce lobby wait times, increase available new and established patient appointment slots (ie, improving access), and improve provider and patient satisfaction measures. LBGVs simultaneously improve patient lives, disease management costs, and practice revenue when used in primary care and specialty practices. By providing personalized lifestyle education coupled with in-depth behavior modification support from a provider and a peer group with similar successes and struggles,

group visits reduce symptomatology and reverse disease progression without expensive medications, procedures, and technologies. Despite perceived obstacles, the group medical appointment model is easy to implement and provides consistent benefits in settings ranging from residency programs to cash-based boutique practices.

Keywords: group visits; group medical appointments; shared medical appointments; lifestyle medicine

administrative requirements, and increasing patient expectations have led to a lower overall quality of care and dwindling service satisfaction for patients and physicians alike. The concept of group visits, a powerful health care delivery model, illustrates that patient care can live beyond the typical one-on-one appointment. With the ability to leverage time, group visits are poised to correct major gaps in medical care delivery. A group visit, also referred to as a shared medical appointment (SMA) or group medical appointment (GMA), is an

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Whereas challenges in health care delivery continue to shift with the times, it is evident that the current state of increasing physician workloads, decreasing appointment access, increasing

extended clinical encounter that allows a physician and his/her patients to exchange valuable information regarding optimal chronic disease management within a supportive group format. Even though group visits are promoted as a

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solution for insurance-based medical settings, the group format solves the universal issue of time deficiency in multiple clinical settings (eg, out-of-network and cash-based clinical practices). Over a typical 90-minute appointment time, a selected group of patients is encouraged to listen to and reflect on each other's medical issues in order to have a better understanding of their own chronic conditions. The peer-powered interactions highlight comprehensive choices patients can make to either reduce the risks or fuel the progression of their particular illness. During a typical group visit, patients have opportunities to not only interact with their physician, but also an educator (eg, a behaviorist) and other patient peers. This added social and educational support structure is essential to the enhanced outcomes and is regrettably missing in the standard individual patient appointment. This has led to increasing patient fears and isolation while decreasing disease knowledge and self-efficacy. By concentrating on patient education and disease management, interactive meetings provide an opportunity for patients to share both successes and struggles with others experiencing similar challenges. Studies demonstrated that SMAs improved patient access, enhanced outcomes, and promoted patient satisfaction.¹

Customized for a better doctor-patient relationship, group visits are a relatively straightforward innovation that offer promise in improving efficiency and encouraging patient self-management.²

Albert Einstein stated, "We cannot solve our problems with the same thinking we used when we created them." The group visit model is a relatively new doctor-patient interaction model. Interestingly, the history of the doctor-patient relationship and the development of chronic disease over time help elucidate the mismatch that perpetuates today and the need for GMAs. For example more than 200 years ago, the typical physician spent little time tending to complex, chronic disease. Life spans were significantly shorter, and the main role of a physician was the treatment of acute

diseases in one-on-one, face-to-face settings. Infections and trauma were the primary causes of death, and managing a diagnosis from start to finish did not take decades. Physicians hardly understood the underlying causes of diseases like diabetes, nor did they manage these conditions with long lists of medications for years at a time. The prevailing lifestyle in the early 1900s and prior was solidly rooted in a diet rich in unprocessed, whole, plant-based foods with relatively low animal protein intake as compared with the current Western diet. Regular and varied physical activity was commonplace, as was strong community connections and a sensible perspective of major stressors. The doctor-patient relationship was therapeutically anchored in trust and partnership. Time was not limited, and the physicians were intimately connected to the families they managed. With no third-party payor system in place, reimbursement for services rendered was mainly fee-for-service or a bartering version of it. As time went on and industries such as food processing and mass media developed a stronghold on influencing cultural norms, society's desires for convenient, prepackaged, ready-to-eat, highly processed food began to steadily rise. In parallel to the decline of the standard American diet, the advent of technology and automation further worsened the previously healthy lifestyles of patients. Conveniences like automobiles and washing machines reduced the quality and quantity of physical activity, setting the stage for the development of chronic inflammation, obesity, and complex, chronic disease. Because of increasing political pressure, reimbursement for medical services by third-party payors was introduced just after the Great Depression when similar access and affordability obstacles were of high concern to Americans. Third-party payor programs continued to gain popularity as the cost of managing disease rose beyond what patients could privately afford.

This system persisted for decades; however, an alteration in disease patterns was soon to change the health care

delivery model once again. Beginning in the mid-1980s, the Centers for Disease Control (CDC) recognized unusual increases in certain conditions among US adults, which now, are well known as the CDC obesity and diabetes maps. The time travel maps reveal to public health leaders today that poor lifestyle is one of the main modifiable causes of the mounting chronic disease epidemics and the astronomical costs related to them. Not knowing this at the time, the health care industry released an explosion of pharmaceutical products, advanced laboratory testing options, and state-of-the-art, biomedically engineered technologies to treat diseases mechanistically similar to acute disease. Generalists and family doctors, known for prioritizing the whole systems management of a patient, became less valued by society and third-party payors. Subspecialist physicians studied the in-depth management of specific parts of the body and, by default, undervalued the mastery of the body as a wholly integrated social being. Ironically today, many of the subspecialty drugs and procedures that were intended to reverse the chronic disease burden have increased morbidity at the price of reducing mortality.

As morbidity worsened, so did the seemingly uncontrollable cost of health care delivery. Our national health care system responded, and managed care was born. The doctor-patient relationship became increasingly strained as restrictions on the use of diagnostic testing, imaging, pharmaceuticals, and access to physicians required third-party oversight prior to reimbursement for services. Although measures for cost containment were in place, little emphasis was given to lifestyle and prevention. The majority of reimbursements were allocated for reactive disease management. Rather insidiously, patients and health care providers realized that the use of time was slowly being consumed by administrative requirements, all to ensure optimal coverage and reimbursement. Today's health care offices spend far greater percentages of time in

documentation, billing, and care coordination than ever before. In addition, the expanding list of legal and contractual requirements for federal and private health insurance compliance has created a crushing burden to many smaller, private physician groups who simply cannot adapt quickly enough.

With these simultaneous clinical, operational, and financial forces at play, clinicians and patients have seen the decline of the therapeutic relationship that previously flourished in many practices, especially smaller primary care offices. Without sufficient time to establish the sacred trust and partnership needed to engage and empower patients with informed decision making, behavior modification and prevention education is difficult. The regrettable by-product of this failed model is an intensifying fear and isolation among patients who are, subsequently, ill-equipped to help themselves implement simple, effective measures to improve overall well-being and reduce the need for more and more expensive health care services. Furthermore, the gradual reduction in available time for quality doctor-patient interaction has resulted in decreased appointment access, reduced patient knowledge scores, deteriorating patient self-empowerment, rising odds for medical errors, increased physician burnout rates, and declining patient satisfaction. Reevaluating how time is used and reimbursed is paramount in bending the trajectory curve of chronic disease in the United States and other Western lifestyle-based cultures. By reestablishing a solid foundation of therapeutic partnership and education, group visits help improve the time scarcity epidemic that is overwhelmingly prevalent today.

Although time is critical to solving our chronic disease epidemic, it is equally necessary to ensure that this time is spent offering more effective therapies—namely, those aimed at disease prevention and disease reversal. The current “high cost, high tech, low touch” model of disease management has not adequately shifted cost or disease curves for the better. Fortunately,

evidence-based medicine provides a clear solution that is “low cost, low tech, high touch” and impactful. “In the United States, chronic diseases and conditions and the health risk behaviors that cause them account for most health care costs. Eighty-six percent of all health care spending in 2010 was for people with one or more chronic medical conditions.”³ Mathematically, it is evident that an increasingly sick population with complex, chronic disease is at risk for having decreasing time with health care providers within a reimbursement system that values volume of care versus quality of care. This has created today’s time-depleted medical experience. If solid evidence reveals that modifiable lifestyle choices are the primary causes of most chronic diseases, then today’s effective health care team needs time to teach patients how to successfully implement healthy lifestyle choices as the best medicine. For today’s cost and care needs, the lifestyle-based group visit (LBGV) effectively integrates the improved health outcomes of lifestyle medicine with the time-expanding group visit model as a practical health care solution that benefits patients, providers, employers, and payors.

“Physicians who make the evolutionary step to GMAs report that they can finally practice the kind of caring, holistic medicine that inspired them to become doctors in the first place. The bonus is that in addition, physicians realize substantial savings in time, energy and money.”⁴ Leading medical institutions such as Harvard Vanguard, Kaiser Permanente, Cleveland Clinic, Yale Health, and many others have long used and hailed the group visit model for clinical, operational, and financial advantages. Depending on an institution’s goal, a variety of group visit formats exist to serve unique organizational and provider needs. Physicals Shared Medical Appointment, Cooperative Health Care Clinic, and Drop In Group Medical Appointment (DIGMA) are some of the more common formats for billable group models; however, the DIGMA model most closely resembles the most common group visit

format used today. The heterogeneous DIGMA gathers patients with a variety of health concerns in one room at the same time, whereas a homogeneous DIGMA gathers patients with the same diagnosis similarly. As an example, a 90-minute SMA with 4 to 9 pediatric patients who share a diagnosis of asthma, bronchospasm, or wheeze and their caregivers can gather for group health education, a brief individual exam, and an opportunity for interaction and self-management strategies to promote positive health care outcomes. It is believed that social cognitive theory may be the theoretical framework that best explains and reinforces the benefits of the SMA.⁵ This theory postulates that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior. It recognizes the unique situations in which individuals develop and sustain behavior. All experiences, past and present, shape whether a person will begin engaging in a specific behavior and the reasons why a person continues to engage in that behavior. By sharing both successes and struggles with others experiencing similar challenges, studies demonstrated that SMAs improved patient access, enhanced outcomes, and increased patient satisfaction scores.¹

Lifestyle modification is challenging in the context of a traditional, one-on-one medical visit. Group visits not only improve clinical outcomes but also create process and operational improvements such as reduced appointment wait times, improved provider efficiency (ie, more patients seen with SMAs), high patient satisfaction (96%), and improved adherence to recommended medical monitoring (3.8 visits/year).⁶ Because more available time for education is valuable in many settings, GMAs can be implemented in many practice structures whether group or solo, insurance or cash, primary care or specialty, physician or dietician. As the business of medicine faces decreasing reimbursements, stressed bottom lines, and lack of job do-ability, group visits offer added practice management benefits. In a study done performing SMAs in a busy urology

office, appointment wait time decreased from 180 days before SMAs to 84 days after SMAs (ie, 53% reduction in appointment delays). The number of patients seen per month increased by 43%. The number of new patients (both SMA and individual appointments) who received nutrition education and intervention increased from approximately 50% to nearly 75%. Overwhelmingly (87%), patients rated their satisfaction with SMAs as excellent or very good; 90% of attendees would recommend SMAs to others. However, most impactful, posttests revealed superior knowledge when compared with controls ($P < .02$).⁷ Those who participated in an SMA did not differ significantly from the regular patient population, and both patients and health professionals reported that patients received more information during an SMA.⁸ In a study examining the group dynamic in a family medicine residency clinic, implementing SMAs was feasible and effective among Hispanic patients with diabetes, resulting in quality-of-life and diabetes knowledge scores increasing significantly.⁹

"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."¹⁰ Today's physician is under enormous stress to manage more patients in less time and for less money. Because GMAs are reimbursed exactly the same as an individual consultative appointment, physicians can increase their productive time by at least 200%. GMAs allow both physicians and their patients to adopt an attitude of abundance because there is enough time, enough energy, and enough resources for patients to get what they need and for both doctor and patient to feel good about the care that is being given.¹¹

Although the evidence is clear, physicians still hesitate because of 2 major perceived obstacles. The first perceived challenge presented by a GMA

is that of confidentiality. Patients are encouraged to discuss their concerns and questions openly with one another, and personal medical information is often shared within the group. Patients are also examined in the group room creating concerns about Health Information Portability and Accountability Act (HIPAA) violations. As the group visit model is quite modern, HIPAA does not specifically address the issue of group visits. Therefore, it is appropriate to honor the spirit of HIPAA with some basic principles of confidentiality. First, if a patient brings up any personal information in a group, this is not a HIPAA violation. If a provider or medical staff shares this information in front of others, then only does the possibility of HIPAA noncompliance exist. As the sharing of information between all present is essential for the benefits of group visits, most practices request patients to sign authorization for medical disclosure during the GMA. Offices can have patients complete one annually or have patients and their guests initial a HIPAA clause at the beginning of each group visit. Most clauses detail that (1) much of the medical care is done in the group setting, (2) the patient accepts issues being discussed in front of others, (3) safe setting with no direct identification of attendees required, and (4) no discussion of other patients once the session is over. Some choose to announce that (1) attendance is voluntary, (2) patients are free to leave at any time without repercussions, (3) individual appointments will continue to be available, and (4) group visits are an additional health care choice.

Billing and reimbursement for GMAs, the second perceived obstacle, again exists because of the relative newness of this health care delivery model. There are, however, reliable reimbursement strategies that have been used for decades by respected institutions. Group visit billing is best described as a series of individual visits with other patients as observers in a supportive, group setting. Specifically, customary Current Procedural Terminology (CPT) codes, such as 99212-99214, should be

billed based on the level of documentation complexity, not the face-to-face time spent with the patient. For example, appropriate documentation complexity with a short, targeted physical exam (eg, 5 minutes) may qualify for a 99213 or 99214 billing level. It is essential to note that time spent counseling the group as a whole is not billable, nor to be included in face-to-face time minutes. The American Academy of Family Physicians asked, "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?" Centers for Medicare and Medicaid Services replied, "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." A familiar billing scenario helps most understand how group visits are not unlike managing a young family of 4 with a viral illness. Each is seen in the same room, one by one, and billed separately an appropriate CPT code. Just like individual billing, CPT code selection is based on face-to-face time (not group time), documentation complexity, and medical necessity requirements. It is not surprising that physicians may be hesitant to adopt new systems of care such as GMAs. For years, they have been required to change their day-to-day operations with considerable strain professionally and personally. Fortunately, once properly understood and put into place, the group visit model has been shown to generate clinical, financial, and operational benefits in multiple practice settings, making it a necessary change for patients and physicians alike.

Group visit implementation involves strategic planning, as does any other operational change. To start a successful LBGV program, an office should meet 3 basic needs. First, group visits are best utilized in practices that manage a full practice panel. This represents the main marketable community of patients who will support the desired 10 to 16 patient panel per group visit. Second, an office requires an adequately sized meeting space at a time that does not interfere with routine daily operations. A lobby or conference room available at the beginning or end of a clinic day is a very practical option for most. If billing insurance, the group visit meeting location must be registered as a facility on record with the insurance company. If not restricted by health insurance, group visits may be done at unique locations such as gyms, yoga studios, churches, homes, and so on. Last, but not least, flourishing group visits utilize a team of uniquely skilled members who work to create a seamless experience for patients that is both clinically and personally fulfilling. The standard team consists of a billable provider (eg, MD, DO, NP, PA), an educator (eg, dietitian, exercise physiologist, behaviorist), a medical assistant, and a group visit administrator/champion. Each member's role is vital throughout the extended appointment, and all may need to perform various roles to cover the group's needs as they may arise. At a time where physician burnout rates rise steeply, the group visit design prevents the burden of care from falling on one person and encourages a collaborative experience from which all participants benefit.

Once the team is assembled and motivated, the next stages of planning involve designing various group visits. The complete logistics of implementing a LBGV are beyond the scope of this article; however, some components are common to the most effective ones. First, a topic (or set of topics) should be chosen. The provider and educator should be comfortable with the topic, and a sufficiently interested patient panel in need of the topic-specific education must exist. Historically, education-based

group visits were marketed by having patients with the same disease gather together (eg, diabetes or nephrolithiasis). In so doing, discussion generally focused on the disease and its specific management (eg, pharmaceutical management, the importance of follow-up testing). By default, less importance was given to seemingly unrelated chronic diseases (eg, a diabetes education group may not delve into hypertension as deeply). However, if it is scientifically understood that a majority of all chronic disease is a by-product of a small list of lifestyle choices, physicians could assemble an education-based group visit based on the unifying need for improving lifestyle and behavior modification. Furthermore, it is operationally easier to fill a group roster to the desired 10 to 16 patients if diabetic, hypertensive, hyperlipidemic, and arthritic patients could all be eligible for the same group visit, to learn and share their successes and struggles with a particular lifestyle recommendation. A LBGV, as the one described, may include in-depth discussions on a single or blend of lifestyle topics. The primary list of topics could include nutrition, exercise, weight management, stress management, and sleep optimization; however, it can be specialized to a practice's specific population or group visit theme (eg, understanding and implementing dietary plans that reduce kidney stone recurrence or sleep hygiene optimization to reduce mood disorders). Healthy lifestyle choices are central to correcting many diseases physicians manage today. Patients can understand this concept better when similar recommendations are given to a group of patients with seemingly dissimilar concerns (ie, complex, chronic disease). They begin to see the widespread impact that good lifestyle medicine can have on their many diseases, both clinically and financially. With the benefits of social cognitive theory, patients' abilities to help themselves improve and behavior change gradually becomes conceivable and, therefore, more implementable. Ultimately, patient self-efficacy and self-management improves in a socially

supportive group model, in stark contrast to the fear and isolation created in the common, time-deficient, nonempowering individual visit model of today.

Admittedly, the LBGV model requires a commitment to want to better oneself and work collaboratively within a group. It is a valuable management option for a growing group of motivated patients who deserve this option from evolutionary primary care physicians who want the same for them. The goal is simple. As with any other cultural shift on a community or on an international scale, as more patients directly or indirectly experience the benefits of lifestyle medicine, others will become more and more interested until the new belief becomes established as a primary treatment approach to managing the chronic disease epidemics.

After choosing a topic, it is imperative to create operational efficiencies that allow the LBGV team to create a seamless visit experience on one day but, for the greatest impact, allow the office to repeat the topic with ease on multiple other occasions. Consider creating a patient-driven visit documentation form. It should be uniquely designed for each lifestyle-based topic and serve as the legal, documented note. Many choose to scan this paper form into their electronic medical record (EMR) as the official visit note, entering only vitals and billing/coding requirements into the EMR for that specific visit. It is understood that in-depth, highly personalized management of a patient's condition was likely not done, whereas broad-based behavior modification strategies in lifestyle medicine were the primary therapeutic goals. The patient usually completes the HPI, ROS, PMH, FH, or other appropriate sections while waiting in the lobby and/or during the group appointment time. A well-designed visit form would also include a listing of what will be taught in the group visit in the Plan section of a typical visit note. Here, a patient may also find a list of options that are related to the group visit topic (eg, request for a follow-up visit on personalized dietary advice or a referral

Figure 1.

Illustration comparing the operational contrast between managing 8 patients through individual medical appointments in examination rooms versus managing 8 patients through a lifestyle-based group visit format in a lobby or conference room setting. Reprinted with permission from Lifestyle Matrix Resource Center.

to a physical therapist to remove an obstacle to exercising). While in the lobby, the patient may be requested by the medical assistant to have her vitals done privately, or it may be the practice's preference to perform vitals during group time. Either way, the vitals should be documented in the designated section of the patient-driven visit form for completeness. Once all patients are gathered for the group visit and it is time to start, it is recommended that the group visit champion remind patients to sign their HIPAA clause (or other legal requirements) while giving patients a preview of what to expect in a LBGV. Once the LBGV begins, the educator begins by introducing the topic of the session. To improve the educational experience, consider handing out patient-friendly handouts, teaching with PowerPoint presentations for visual learners, or inviting guest experts to demonstrate techniques. All these create a robust and transformational experience

for both patients and clinical team members. A typical LBGV has 20 to 30 minutes of education followed by 50 to 60 minutes of question and answer with the attendees. A majority of the patient engagement and personalization of the LBGV occurs during the discussion portion, so it should not be minimized in order to allow an educator or provider more time to teach. It is more important to promote factors that increase patient interest and learning, and physicians may assume that this burden is on them. In fact, the clinical team is tasked with creating the environment for patients to help each other with strategic catalysts of information given as needed.

Multiple functions of a group visit must work in parallel for all goals to be met. Whereas administrative goals have likely been handled prior to the start of the LBGV (eg, collecting copays, updating demographics, signing necessary forms), the educational, clinical, and billing functions occur simultaneously during

the group visit time itself. For example, while an educator is teaching, a medical assistant may complete vitals in a quiet corner of the same room, after which the billable provider performs the required face-to-face time while completing a targeted physical exam (Figure 1). This clinical function could also be done among the group if it is not too distracting and there is enough space. During a LBGV, the relationship between the educator and physician is dynamic. Either may be educating at any one time during the session. The other is present to support the discussion in order to make the experience engaging and practical. The physician is generally unavailable when completing billing, coding, or clinical duties at the time of the physical exam. She would need to review the patient's visit form and sign off with any added orders not listed on the plan of care section. For example, a physician may choose to approve a 3-month refill of a thyroid medication if

she feels it is appropriate for the individual patient by documenting such on the visit form in the appropriate area. It is important to note that if a patient requests management of a concern that cannot be managed during the LBGV (eg, new onset knee pain introduced during a nutrition-based group visit), the patient should be advised to set up an individual appointment at the conclusion of the visit. If this is a more common occurrence, the group visit champion should announce the guidelines on how the office will handle unrelated concerns, so as to avoid putting the physician in the position of repeating this during face-to-face time. A typical face-to-face encounter should take no more than 5 minutes if proper efficiencies and patient preparation are put into place. In the past, some physicians have used a classic scribe; however, a well-crafted, patient-driven visit note can overcome this requirement. As illustrated above, the ideal LBGV is run by 2 simultaneous leaders: 1 designated billable provider and 1 designated educator. The educator can be any supportive individual (ie, MD, dietician, community chef) because the group education time is not billable to insurance. Choosing the right individual is based on knowledge, engagement skills, and cost primarily.

Alternate solutions are available in settings where only 1 billable provider is available to conduct a LBGV. If practicing in an insurance-based setting, the following changes can be considered. First, consider reducing the number of attendees from the typical 10 to 16 patients to a more reasonable 6 to 9 participants. Once a healthy operational flow is established, a team may opt to increase attendance within its ability to continue meeting insurance requirements. Another popular timesaver is technology. The 30-minute educational section of the LBGV can be done via video to allow more time for face-to-face insurance requirements to be met during video play. Providers can either create their own with easily accessible technology on smartphones and computers or use premade education videos that mirror the practice's

treatment philosophies. The video serves as the basis for the deeper education that follows during the extended discussion phase of the LBGV. Another solution to the single provider scenario is modifying the group visit agenda. If 8 patients are being seen, invite 4 to come for the first 15 minutes where private 4- to 5-minute vitals and exams are done back to back. Begin a condensed version of the group visit with 15 to 20 minutes of education followed by 40 minutes of discussion. Afterward, the remaining 4 patients are requested to stay for the last 15 minutes to complete their face-to-face vitals and exam. This staggering can reduce the burden of all 8 patients at one time on a small office staff. Obviously, attendee volume is only limited if a face-to-face requirement is needed for insurance. Therefore, those one-provider practices that offer LBGV through a cash-pay model are not limited in the same way and can continue to see the higher volume of patients as the ideal 2-member team. Interestingly, an ideal GMA patient volume has been postulated. If attendance drops below 6 patients, the social support and group dynamic is not as suited for additional therapeutic support. Conversely, if the volume exceeds 18 or 20, the setting may begin to resemble a lecture hall, losing the intimacy needed for sharing successes and struggles to transform patient behavior.

Once the LBGV is complete, it is the responsibility of the group visit champion and/or medical assistant to collect all visit notes before a patient leaves. The team is prepared and understands that completed forms are the basis of the billable encounter and they are vital to the financial benefits of the LBGV. The collected forms are usually submitted to the clinic administrative team either the same day or the next day when they begin the task of carrying out the requested orders in the Plan of Care section. Referrals, scheduling, and laboratory or provider appointments can all be handled outside the group visit time to maximize time for group interaction. Patients are advised of this at the start of the group visit. Once

administrative tasks are completed, the physician may choose to quickly review the notes and change documentation complexity and billing codes as indicated. Thereafter, the billing and coding department handles the claims creation and collection according to office flow. A designated clinical team member may be required to input the provider's documented billing information into the EMR before the billing department can begin its services. Most physicians will bill a 99213 with appropriate documentation, but some patient interactions and follow-up needs could validate a 99214 code with proper documentation. Regardless, it is best to have a billing and coding specialist work with the provider to optimize proper compliance with applicable state and federal guidelines as usual.

There are various ways to market patients to participate in a LBGV. Most practices recruit from within the practice, with fliers, emails, newsletters, or EMR demographic extraction reports. However, the most successful strategy includes a personal request by the physician during an office visit messaged as a "prescription" or as a recommended "follow-up" appointment for optimal management of their specific chronic disease or symptom. Some practices market in the community. Others create workshop experiences with multiple group visits. In one such model, the physician explains his adaptation of the LBGV model: "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 [office]. 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.”¹⁰

There are sufficient data to support the effectiveness of group visits in improving patient and physician satisfaction, quality of care, and quality of life and in decreasing emergency department and specialist visits.¹² In addition to the well-documented advancements group visits bring to the clinical and operational arenas, it is most encouraging that physicians can equally benefit financially at the same time as patients, insurers, employers, and the community at large benefit in their own unique worlds.

Mathematically, a provider can see 16 patients in 90 minutes, giving each patient a solid 90 minutes worth of foundational lifestyle medicine with social support built in for one visit fee. Not only are more established patients seen using the LBGV model, but there is more space for new patients to be seen by the practice. In most cases, more patients are seen per session than if seen individually, leading to a total increase in billable patient visits; however, with the opening of new patient appointment slots, there are more opportunities to bill higher reimbursable codes such as 99203-99205. Both lead to conservative estimates of 200% increases in productivity by most group visit model experts and providers. Group visits are not a replacement for the individual visit. However, they are ideally suited for the majority of outpatient primary care and specialty visits. Low-acuity conditions (eg, suboptimally controlled, nonemergent hypertension or mild to moderate hyperlipidemia) that center on chronic disease management often require the same education and lifestyle change benefit. Individual visits should still be the mainstay of patient visits, especially in cases of complex decision

making, privacy needs, or risk of contagion.

Opportunity cost is defined as the cost of an alternative that must be forgone to pursue a certain action. Put another way, the opportunity cost of choosing to only offer individual medical visits are the clinical, operational, and financial benefits a practice could have enjoyed by implementing LBGVs. It has been said that the real cause of the chronic disease epidemic has little to do with access. Instead, the fundamental problem lies in the way in which we manage disease. Having more access to a system that does not work well is not optimal. The health care system of the near future must learn to adopt lifestyle medicine as a major component of the total solution. To restore health, it is necessary to invest time. The modern medical practice has the opportunity to value time once again, to restore the sacred doctor-patient relationship, and empower patients with vital social support and valuable lifestyle medicine. The value of this is beyond measure. It is imperative that the business of reversing disease is just as profitable as the business of managing disease. Without the allure of clinical and financial fulfillment, the army of future health care providers interested in investing their professional and personal futures into this most noble field of work may not present. LBGVs are poised to make a widespread and profound impact on all who desperately need the health care system to bring back both health and care once again to this noble profession.

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