



# Shared medical appointments: Increasing patient access without increasing physician hours

## DAVID L. BRONSON, MD

Regional Medical Practice Division and the Department of General Internal Medicine, The Cleveland Clinic Foundation

## RICHARD A. MAXWELL, MD

Department of Pediatrics, Cleveland Clinic Wooster, The Cleveland Clinic Foundation

### ■ ABSTRACT

Shared medical visits are a new concept in patient care. Doctors perform a series of one-on-one patient encounters in a group setting during a 90-minute visit and manage and advise each patient in front of the others. Patients benefit from improved access to their physician and significantly increased education, while providers can boost their access and productivity without increasing hours. Such group visits are voluntary and for established patients only.

**Y**OU'RE IN A BUSY PRACTICE—so busy that the next available appointment for a physical examination is 6 months away. Your established patients complain about the difficulty in getting to see you. Despite the busy practice, the budget is stretched thin, and you and your colleagues often put in extra hours. What can be done to help patients gain access and keep physicians from burning out?

An increasing number of medical practices are looking to a new concept: shared medical appointments. We will describe The

Cleveland Clinic's efforts in this area, how appointments are conducted, and who the best patient and physician candidates are for them to work well. We will also review the literature and discuss the impacts on office backlog, productivity, finances, patient care, and access.

### ■ ACCESS IS THE PROBLEM

When resources are readily available, the best way for a full and busy practice to improve patient access is to add another physician. But this necessitates finding the right physician, extra support staff, more office space, and associated expenses. Solutions such as advanced access scheduling (also known as “open access scheduling”: same-day access for every patient) can help doctors see their patients on a more timely basis but do not improve productivity or efficiency. Advanced access assumes a fixed “panel size” of patients, an approach to practice that is not always practical.

### ■ SHARED APPOINTMENTS ARE INCREASINGLY OFFERED NATIONWIDE

Shared medical visits, in which multiple patients meet simultaneously with their provider, may be a practical way to improve patient access and physician productivity. It may also offer enhanced patient satisfaction and better health outcomes. The concept was originally developed by health psychologist Dr. Edward Noffsinger at Kaiser of Northern California and was designed to improve both access and the quality of care through

**Practice costs  
are rising  
while  
reimbursement  
is falling**

Medical Grand Rounds articles are based on edited transcripts from Division of Medicine Grand Rounds presentations at The Cleveland Clinic. They are approved by the author but are not peer-reviewed.

enhanced patient education and support. At first, the approach was designed for “drop-in” care, but most encounters are now scheduled.

This approach is being used at many centers. Stanford Health Partners at Stanford University reports a shared-appointment program that they promote as a model for chronic disease care.<sup>1</sup> They assert that with the increasing number of people living with chronic disease, the patient-provider model as it now exists is unrealistic in today’s health care environment.

Other organizations using or exploring the role of shared appointments include Palo Alto Medical Foundation, Dartmouth Hitchcock Medical Center, University of Virginia, Christus Medical Group, University of Michigan, Massachusetts General Hospital, and the US Department of Defense.

The Cleveland Clinic began experimenting with group visits on October 15, 2002. As of February 29, 2004, 19 physicians have seen a total of 3,123 patients in 385 shared medical appointments: 501 patients in 85 shared medical appointments for physical examinations, and 2,622 patients in 300 shared appointments for follow-ups.

#### ■ MODELS OF GROUP CARE

Some practitioners avoid the term “group visits,” which may connote impersonal care and a lecture-style format. Instead these are truly shared medical visits, in which each patient has an individual appointment in which other patients are also present in the room as observers. These visits must be done correctly so that they provide the appropriate standard of medical care; otherwise they become simply a class. The enhanced learning as well as the increased efficiency occur because each patient benefits from hearing the doctor’s advice and management of the other patients. More time can be spent by the physician educating about a specific topic (eg, hyperlipidemia) because it may be an issue for several participants.

There are two models for shared medical appointments. Both last for 90 minutes and are led by a physician, a behaviorist (eg, a social worker, nurse practitioner, nurse, or health psychologist), and occasionally a per-

son dedicated only to documentation. Both types of groups are voluntary and for established patients only.

#### Shared medical appointments for follow-up care

Shared medical appointments are designed for follow-up visits for a variety of medical conditions. Any physical examination needed takes place in the group setting, within the limits of patient comfort and privacy. We are presently using the model for such problems as cardiac risk factor follow-up, hypertension, diabetes, weight loss and lifestyle management, movement disorders, asthma, fibromyalgia and chronic pain management, hematology (leukemia, lymphoma, and chronic anemia), women’s health care, and bariatric surgery patients.

Ten to 16 patients form a group with the physician, behaviorist, and possibly a documentation specialist. Their responsibilities differ.

##### The physician:

- Evaluates, examines, and treats patients just as in an individual appointment
- Documents medical information if no documentation specialist is present.

##### The behaviorist:

- Manages confidentiality—reminding patients of rules and collecting confidentiality forms
- Runs the discussion when the physician is documenting or performing private examinations
- Makes sure patients leave with referrals, prescriptions, and appointments for follow-up visits
- Keeps the group on schedule so all patients have their needs met
- Makes sure no one dominates the conversation.

#### A sample session

Here’s how a shared follow-up appointment might run: Patients check in for their appointment and are immediately escorted to the group room. As each patient arrives, vital signs are taken by a nurse in a nearby examination room (this can continue after the discussion begins, as necessary). Refreshments may be served to promote a relaxed atmos-

Shared visits may improve access, productivity, satisfaction, and outcomes

phere, and patients wear name tags with their first names. Patients sign confidentiality waiver forms, write down medical concerns that they want to cover, and turn in their papers to the behaviorist.

The patients, doctor, and behaviorist sit in a circle or semicircle as the group visit begins. There are a few introductory remarks of welcome. Then the provider concentrates on the first patient:

*Doctor:* “Mrs. Maxwell, let’s talk about your hypertension. I notice you are having sleep problems, and wonder if sleep apnea may have something to do with your poorly controlled hypertension.”

After a brief discussion with Mrs. Maxwell about the nature of her sleep problems, the physician states: “Let’s order a sleep study while you continue on your medications. Do you have any other questions?” The doctor documents information and writes referrals and prescriptions.

*Behaviorist:* “Do any of the rest of you have sleep problems? Let’s talk about how to deal with them.”

The behaviorist discusses typical contributors to poor sleep such as caffeine and lack of exercise.

When the doctor finishes documenting the first patient, the discussion winds down and the doctor focuses on the needs of the second patient. By the end of the 90-minute session, each patient’s problems have been managed, a variety of health topics have been discussed, and all documentation is complete.

If shared medical appointment groups are large enough, they can afford to add an extra staff member devoted to documentation, freeing up the provider to participate more in the discussion. Whichever method of documentation is used, it is important to fully document patients within the 90-minute session. If the physician must spend another hour charting, the model becomes much less efficient.

### **Shared medical appointments for physical examinations**

Shared medical appointments for physical examinations are similar to those for follow-up, but the physical examinations occur privately. Discussion and medical management still take place in the group. These appoint-

ments are designed for complete yearly physical examinations, although they may also be used for other health conditions that require a private physical examination.

The groups are usually about half the size of those for follow-up appointments: women are typically seen in groups of 6, and men in groups of 8 or 9. Same-gender patients of a similar age are seen together so that common issues can be discussed. For example, a group with men over 50 years might include a discussion of cardiac risk factors, prostate-specific antigen levels, and colonoscopy. Women either under or over 45 years are typically seen together, but in large practices, groups may be broken up further for women less than 45 years, 45 to 60 years, and over 60 years old.

### **Running a shared appointment for physical examinations**

Half the group is brought into the group room, while the others are taken to individual examination rooms. The physician examines each patient individually without detailed medical discussion.

The documentation specialist may follow the physician to facilitate an efficient physical examination, documenting all pertinent information that the physician says aloud (eg, tympanic membrane normal, throat clear). Many physicians are able to document during the physical exam, but occasionally employ documentation support for the evaluation and management discussion.

While the physical examinations are taking place, the behaviorist elicits the health concerns of the remaining patients that will need discussion when the physician returns. Patients who have been receiving physical examinations move into the group room as their examinations are finished, and the other patients move out to have their examinations. The behaviorist, frequently an advanced-practice nurse, also reviews lab results, determines need for prescription refills, and initiates group discussion of common health concerns.

After another 45 minutes, the group comes together in the discussion room along with the physician. Then the physician spends time with each patient in turn, managing individual problems in front of the others.

**If you repeat the same information many times a day, group visits may work for you**

There is no more general discussion from the behaviorist between managing patients. As groups mature, behaviorists frequently take over documentation, making staffing more efficient.

When the model was first developed, the group discussions were run before the private physical examinations. This led to problems: some patients would “save up” their real concerns until they were alone with the doctor, diminishing the effectiveness of the group process.

### ■ THE NUTS AND BOLTS OF GROUP VISITS

For group appointments to work well, the model should be adhered to as closely as possible. You need:

- A designated room to accommodate a minimum of 15 people
- Designated staff available for the 90-minute time slot
- A regular location, day, and time each week for groups to meet.

#### Bill for level of care

Shared medical visits are billed as an individual appointment and are coded according to the level of care. It's important not to bill for time spent: even though the patients are in the group for 90 minutes, each one has the individual attention of the doctor for perhaps only 7 or 8 minutes. In addition, there is no billing for the time of the behaviorist. To bill for the service, the appropriate level of care must be provided and documented.

#### Don't skimp on personnel

Both models require extra personnel, but enough patients are seen to cover this extra cost. For example, normally an adult physical is allotted 30 to 45 minutes; with the shared medical appointment, 6 to 9 people are seen during 90 minutes.

#### Insist on confidentiality

All patients and support staff sign a shared medical visit waiver form before the group begins. Patients consent to discuss their personal medical information in front of the group and agree not to disclose personal information of the others. This message is con-

tained in the letter of invitation from the physician and in the scripts for schedulers, and is reinforced by behaviorists.

### ■ GOOD PHYSICIAN CANDIDATES

#### Heavily backlogged schedule

The group models work well for physicians with patients who must wait weeks or longer to be seen. The physician should feel “hopelessly backlogged.” A full but not overwhelmed practice will quickly reduce any backlog, often to the point of leaving open slots in the schedule.

#### Repetitive advice

Physicians who find themselves repeating the same information many times a day to different patients are also good candidates. In group visits, the key information can be more effectively delivered because more time is available and other important issues can then be covered.

### ■ PATIENT BENEFITS

#### Chronic disease management may be enhanced

This is a new approach and there are few published studies about its effectiveness. The early research has had encouraging results, showing no harm and sometimes modest gains for patients in group care.

One 24-month trial involved 707 patients with type 2 diabetes, on oral medications or insulin, who were randomly assigned to either shared visits or usual care.<sup>2</sup> The patients who participated in shared visits had fewer emergency room visits, fewer disability days, and better general health status. There was no difference between groups in glucose control as measured by hemoglobin A<sub>1c</sub>.

A similar randomized control study<sup>3</sup> of 112 patients with type 2 diabetes not treated by insulin compared shared visits to usual care for 4 years. The mean hemoglobin A<sub>1c</sub> level was 7.4% at baseline: it decreased to 7.0% in the shared-visit cohort and increased to 8.6% with usual care, a statistically significant difference. Weight decreased in the shared-visit patients by an average of 2.6 kg compared to only a 0.9-kg decrease in the control group.

**For group visits, you need staff and a regular location, day, and time**

The patients who had shared visits were able to decrease their dosages of hypoglycemic medications and had more slowly progressing retinopathy than the usual-care patients.

### Prompt access

Patients can see their physician much sooner by joining a group than by waiting for an individual appointment. One of our physicians does 14 physicals a week, and before starting shared visits, his third available appointment for a physical exam was 5 months out. Within 3 months, he reduced his third available private appointment from 150 days to 66 days out, and patients could get an upcoming group appointment within a week.

A second physician went from a third-appointment availability of 105 days to 30 days out, and patients could be seen in a group within 1-1/2 weeks. The physician began group visits in October with an 8-week backlog, and his backlog was gone by Christmas.

### Greater patient satisfaction

We have been pleasantly surprised by our patients' satisfaction with group visits. All patients are given the option of an individual appointment or group appointment for their next visit. For shared follow-up medical appointments, 85% of patients seen in groups opted for another shared visit for their next visit, and 79% of patients in shared medical appointments marked "excellent" for overall visit satisfaction on a survey.

Even though patients may only get 7 or 8 minutes of individual attention from the physician, most patients gain greatly through the extended time spent listening to similar issues discussed by and with other patients. Patients in groups also often bond to one another: one group of women patients decided to coordinate their subsequent annual physicals so that they could stay together.

Patients typically report feeling more relaxed than during a regular appointment. It's surprising how willing they are to discuss personal health problems in front of a group.

### More education

Patients learn from the management of others in the room. Much more information can be covered in 90 minutes than during a short

visit. If a patient forgets to ask about a specific concern, chances are someone else will bring it up. Patients frequently support and advise one another based on personal experience. It is very powerful to be held accountable by a peer group for efforts to improve lifestyle and adherence to recommended treatment programs.

## PHYSICIAN BENEFITS

### Improved productivity

Productivity is difficult to assess: it should not be measured only in more patient visits per month because some physicians have used their extra time for administrative, teaching, research, or personal responsibilities. Nevertheless, productivity has increased by as much as 31%, with corresponding financial results.

### Increased satisfaction

Physicians who run groups have typically reported that they are a great "break" in their day: it is a very different, effective, and enjoyable form of patient care.

## PITFALLS

### Low census

The key to continued effectiveness of the program is in maintaining a full census for the sessions. Shared medical appointments with a low census are less efficient and can be more costly than routine care. The key to having successfully full shared medical appointments lies in effective promotion by the physician and the physician's staff. These visits should be viewed as enhanced care, not less care.

### Running a class

Physicians need to remember that these are regular medical encounters with individual patients done in a group setting. Avoid the temptation to turn these into a "class."

### Patient selection

Care must be taken to ensure that the right patients are seen in the group. There are always a few patients for whom this setting may not be appropriate, especially those who can or will not maintain confidentiality, the

**85% of patients seen in groups opted for another shared visit**




hearing impaired, patients with cognitive impairment, and those who require an interpreter.

### Low levels of support

Having a behaviorist and dedicated administrative help in ensuring adequate space and scheduling support will keep the shared medical visits within the 90-minute time frame. Having less help will lead to less efficiency and inadequate documentation. The support of the practice's administrative leadership is essential.

### SUMMARY

Shared medical appointments are an effective way to ensure patients' access to the busiest physicians and enhance overall productivity. Both patient and physician satisfaction have been high with these encounters, and we continue to expand their use at the Cleveland Clinic. The key to success is to follow the requirements of the process carefully and ensure that each patient receives the most appropriate care for his or her individual medical issues. 

### REFERENCES

1. **Wellington M.** Stanford Health Partners: rationale and early experiences in establishing physician group visits and chronic disease self-management workshops. *J Ambul Care Manage* 2001; 24:10–16.
2. **Wagner EH, Grothaus LC, Sandhu N, et al.** Chronic care clinics for diabetes in primary care: a system-wide randomized trial. *Diabetes Care* 2001; 24:695–700.
3. **Trento M, Passera P, Bajardi M, et al.** Lifestyle intervention by group care prevents deterioration of type II diabetes: a 4-year randomized controlled clinical trial. *Diabetologia* 2002; 45:1231–1239. Epub 2002 Jul 11.

### SUGGESTED READING

**Noffsinger E.** Increasing efficiency, accessibility, and quality of care through drop-in group medical appointments. *Group Pract J* 1999; 48:12–18.