Shared Medical Appointments (SMAs) in Chronic Disease Management

Background, Rationale and the SE NSW Example
Shared Medical Appointments (SMAs)

“..individual medical consultations carried out sequentially with a number of patients, administered by a skilled Facilitator, with others with similar concerns listening and contributing.”

(eg. see www.groupvisits.com)
Clinical care (1:1)
1 Doc; 1 Patient

Shared Medical Appointment
1 Doc; 1 Facilitator
6-12 patients

Group education (1:X)
1 Educator; 15-20 patients

Where SMAs Fit

“SMAs are like ‘Medical Moais’” – Dr Rob Lawson, CEO; BSLM
(Moai is Japanese for ‘meeting for a common purpose’. The term comes from social support groups in Okinawa)
Increasing Outcomes

Evidence for Improvements of Group Visits over 1:1 consults for:

• Type 2 diabetes (Riley and Marshall, 2010)
• Heart disease (Masley et al., 2001)
• Hypertension (Kawasaki et al., 2007)
• Arthritis (. Shojania and Ratzlaff, 2010)
• The Disadvantaged (Clancy et al., 2003)
• Metabolic syndrome sufferers (Greer and Hill, 2011)
• Cancer recoverers (Visser et al., 2011)
• Children and their caregivers (Wall-Haas et al., 2012)
• COPD (Fromer et al., 2010)
• Obesity (Paul-Ebhohimhen and Avenell, 2009)
• The inadequately insured (Clancy et al., 2007)
In a published review of the data, SMAs have been shown to:

‘...lower direct medical costs, improve clinical outcomes, improve patient satisfaction, engage patients powerfully, provide peer support and maximise the value of patient time spent at the primary care office. In addition, they improve health care providers’ satisfaction and enhance teamwork, collaboration and communication across disciplines (Edelman et al., 2012).
Advantages of SMAs

A. For Patients

• Extra time with own doctor and more relaxed pace of care;
• Peer support and feedback from patients with similar conditions;
• Multidisciplinary care from a range of (2-4) providers;
• Answers to questions they might not have thought to ask (because others in the group ask)
• Greater self-management education and attention to psychosocial issues

**Bottom line:** *Improved patient health and well-being* and enjoyment of the experience
Advantages of SMAs (cont)

B. For Clinicians

• Increased physician productivity/cost & time effectiveness;
• Real help from the multi-disciplinary team with the opportunity to coordinate Care Plan Reviews and Team Care Arrangements (TCAs);
• Reduced repetition of information/advice;
• A chance to get to know patients better in an interactive setting;
• More fun and more relaxing;

**Bottom line:** Improved provider efficiency and work satisfaction.
Advantages of SMAs (cont)

C. For the Clinic

• Reduce patient waiting lists /Faster appointments
• Improved efficiency
• Be an innovative primary care practice
• Increased team involvement in chronic disease management
• Make the practice more of a ‘patient centred medical home’

Bottom line: Improved outcomes and efficiencies
Testimonials from Australian SMAs

“It’s good to hear other people’s issues. It makes you realise you’re not alone and you’re not as bad off as you think.” 42 man with HIV, scrotum removed, cancer, etc.

“As a result of this group I’m more aware of my condition and therefore managing it with more confidence.” 70-y.o. ex-Nurse.

“I got so much out of this because I heard answers to questions that I always forget to ask the doctor.” Indigenous man

“For me it just feels so much more relaxed than an individual consultation.” GP Adelaide

“(in 1:1 consult) it doesn’t matter that much if I get my facts wrong or advice slightly off as I won’t see them again for ages – and they have no one to check with anyway. In the SMA you can’t do that. Someone in your patient group or team are going to know more than you about some things – you can’t fudge it.” GP, Qld

“It’s novel and breathing life into my practice and desire to improve my knowledge and skills for real. I like the spotlight on me – it energizes me to perform better.”
“Overall, the evidence suggests that obesity treatment delivered in primary care has limited effectiveness.”

(.but) “...given the influence and reach of primary care providers we cannot afford for them to be sidelined in the treatment of obesity in larger populations.”
‘Programmed’ Shared Medical Appointments (pSMAs)

“... a sequence of Shared Medical Appointments in a semi-structured form providing discrete educational input relating to a specific topic.”
Potential Cost Effectiveness

- In one systematic review, 11-26 visits over 1 year lead to 4-7kg more weight loss than controls after 1 year (Ard et al., 2015)

- Assuming MBS items 23’s & 36’s (and an average of 18 visits of 15 mins), this would cost ~$1072/patient, and require 9 hours/patient

- If the same result can be achieved using 6 PSMA sessions (10 patients/session)

- Assuming MBS items 23’s & 10991’s, this would cost ~$360/patient

  BUT

  would save the GP 37 hours of his/her time

  AND

  the patient would have twice as long with the doctor + peer support
pSMA Trial Evaluation Preliminary Results

How do you rate the program you have attended here?

1______________ 2______________ 3______________ 4______________ 5
Poor Fair OK Good 4.3 Great

How useful has the program been for you?

1______________ 2______________ 3______________ 4______________ 5
Definitely not Probably not Perhaps Probably 4.2 Definitely

How did the program compare with other weight loss methods you have tried?

1______________ 2______________ 3______________ 4______________ 5
Definitely not Probably not Perhaps Probably 4.0 4.2 Definitely
<table>
<thead>
<tr>
<th></th>
<th>Males (N=39)</th>
<th>Females (N=56)</th>
<th>Total (N=95)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having time for asking questions</td>
<td>4.5</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Seeing the doctor more relaxed than usual</td>
<td>4.3</td>
<td>4.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Having the doctor/staff’s full attention</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Contribution of other health professionals</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>Hearing experiences of other patients</td>
<td>4.2</td>
<td>4.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Getting information from others</td>
<td>4.3</td>
<td>4.1</td>
<td>4.3</td>
</tr>
</tbody>
</table>
## Preliminary (6 month) results from SENSW Weight Loss PSMAs

<table>
<thead>
<tr>
<th></th>
<th>Males N=38</th>
<th>Females N=54</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number Losing weight</strong></td>
<td>30 (79%)</td>
<td>36 (66%)</td>
</tr>
<tr>
<td><strong>Number with no loss or gain</strong></td>
<td>8 (21%)</td>
<td>18 (34%)</td>
</tr>
<tr>
<td><strong>Average loss in kg</strong></td>
<td>4.55kg</td>
<td>2.36kg</td>
</tr>
<tr>
<td><strong>Average Loss in %</strong></td>
<td>4.16%</td>
<td>2.51%</td>
</tr>
<tr>
<td><strong>Weight loss range (kg)</strong></td>
<td>-14.8 to +1.1</td>
<td>-23.4 to +6.7</td>
</tr>
<tr>
<td><strong>Weight loss range (%)</strong></td>
<td>-16.4 to +0.8</td>
<td>-21.7 to +2.6</td>
</tr>
<tr>
<td><strong>Number losing &gt;5% of starting weight</strong></td>
<td>17 (45%)</td>
<td>12 (22%)</td>
</tr>
</tbody>
</table>
## Proof of Concept (PoC) check list related to PSMAs for weight control

<table>
<thead>
<tr>
<th>QUESTIONS RELATED TO THE PROCEDURE</th>
<th>Y</th>
<th>N</th>
<th>MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is it structured around sound evidence-based principles?</td>
<td>√√√</td>
<td></td>
<td>Evaluative research; Expert advice</td>
</tr>
<tr>
<td>2. Does it do what it claims to do for representatives of the target population?</td>
<td>√√</td>
<td></td>
<td>Outcome measures; Questionnaire responses</td>
</tr>
<tr>
<td>3. Is the retention rate over time adequate?</td>
<td>VV</td>
<td></td>
<td>Data records</td>
</tr>
<tr>
<td>4. Does it result in positive changes in health parameters?</td>
<td>{?*}</td>
<td></td>
<td>Outcome measures; Questionnaire responses</td>
</tr>
<tr>
<td>5. Is it enjoyed and valued by participants?</td>
<td>VVV</td>
<td></td>
<td>Questionnaire responses</td>
</tr>
<tr>
<td>6. Is it enjoyed and valued by providers?</td>
<td>VVV</td>
<td></td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>7. Would participants recommend the process to others?</td>
<td>VV</td>
<td></td>
<td>Questionnaire responses; Focus group evaluations</td>
</tr>
<tr>
<td>8. Do patients rate this, at least as highly for this problem, as the standard comparative process?</td>
<td>VV</td>
<td></td>
<td>Questionnaire responses; Focus group evaluations</td>
</tr>
<tr>
<td>9. Is it cost and time effective for the clinic and participants?</td>
<td>{?*}</td>
<td>D1</td>
<td>Economic analysis</td>
</tr>
<tr>
<td>10. Are other health care providers likely to adopt it?</td>
<td>VV</td>
<td></td>
<td>Survey analysis</td>
</tr>
<tr>
<td>11. Is the target audience big enough and the potential demand great enough to justify and sustain it?</td>
<td>VVV</td>
<td></td>
<td>Market analysis</td>
</tr>
<tr>
<td>12. Does it reach a wider patient audience than the standard comparative process?</td>
<td>VV</td>
<td></td>
<td>Demographic/psychographic analysis</td>
</tr>
<tr>
<td>13. Does it incorporate the advantages of a standard comparative process?</td>
<td>VVV</td>
<td></td>
<td>Process analysis</td>
</tr>
<tr>
<td>14. Does it reduce any disadvantages of a standard comparative process?</td>
<td>VVV</td>
<td></td>
<td>Process analysis</td>
</tr>
<tr>
<td>15. Is it time efficient for participants and providers?</td>
<td>V</td>
<td>D2</td>
<td>Questionnaire responses</td>
</tr>
</tbody>
</table>
https://vimeo.com/241762452/0162cf7d4c