



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)



Where SMAs Fit

**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**

PROFESSIONAL



Shared medical appointments
An adjunct for chronic disease management in Australia?

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Background
The incidence of chronic disease continues largely unabated in modern western societies. While the content (physiology, determinants) of these diseases is well studied, processes of dealing with them at the clinical level have been less well considered. Shared medical appointments (SMAs) or group consultations (also often referred to as group visits) are 'a series of individual office visits sequentially attending to each patient's unique medical needs individually, but in a supportive group setting where all can listen, interact and learn'.¹

incidence suggests that new approaches in primary care might also need to be considered.

Primary care consultations have traditionally occurred in a one-on-one situation between clinician and patient. This is appropriate for acute disease and injury, but may not be optimal for chronic diseases that need complex, extended and ongoing treatment. Chronic disease management also requires extensive

"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)

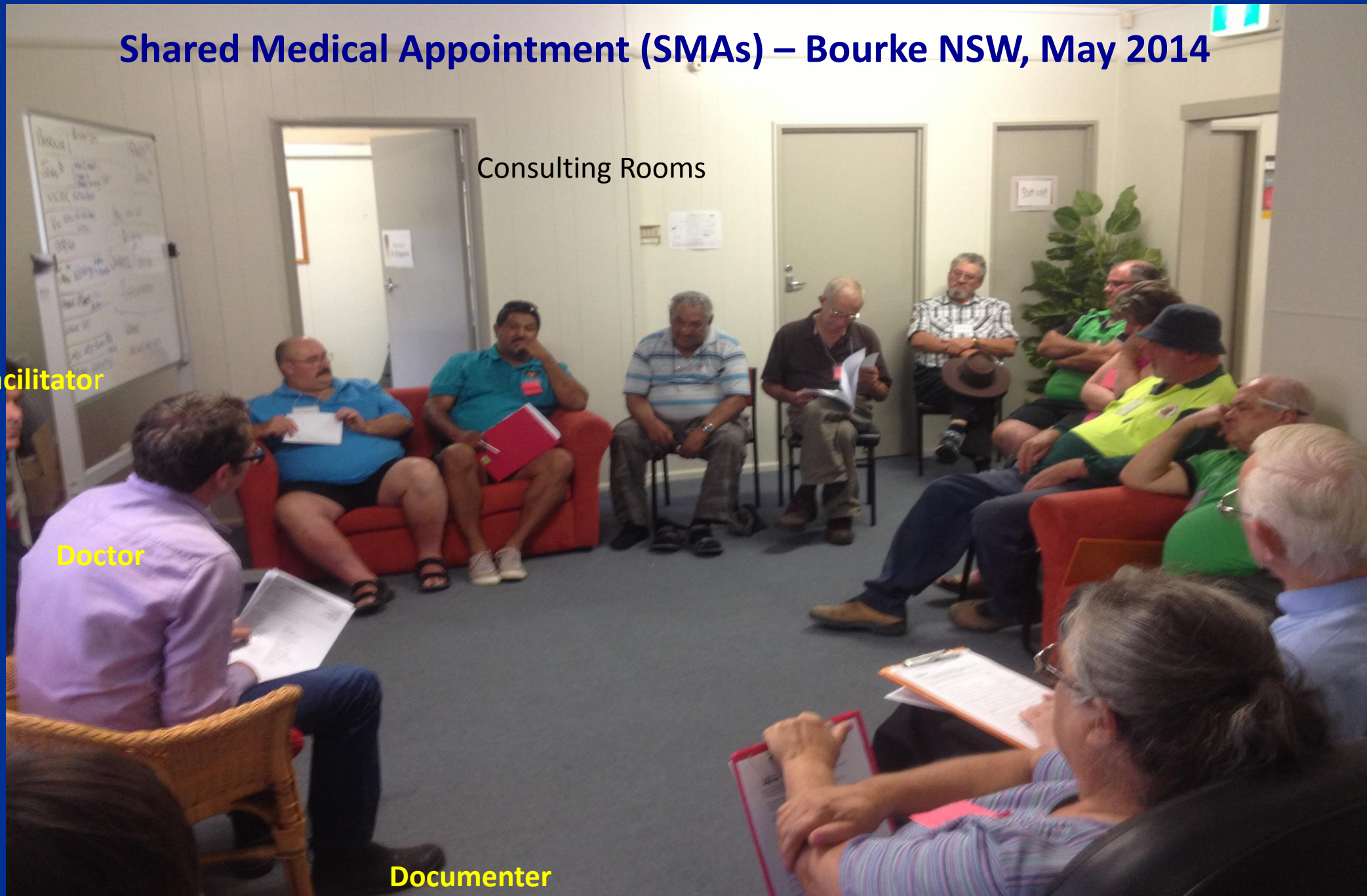
Shared Medical Appointment (SMAs) – Bourke NSW, May 2014

Consulting Rooms

Facilitator

Doctor

Documenter



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)

SMA Objectives

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 in to my practice and desire to improve my knowledge and skills for real. I like the spotlight on me – it energizes me to perform better."

Obesity in the US: what is the best role for primary care?

Jamy Ard

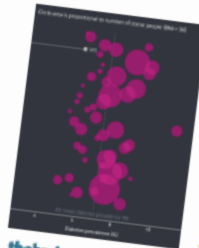
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Cite this as: *BMJ* 2014;
349:g6666

ABSTRACT

The increasing prevalence of obesity...

“Overall, the evidence suggests that obesity treatment delivered in primary care has limited effectiveness.”

...with a minimum follow-up of six months in which at least one member of a primary care team helped deliver comprehensive behavioral obesity treatment to adults with overweight or obesity. Overall, the evidence suggests that obesity treatment delivered in primary care has limited effectiveness. Questions remain about the optimal role of the primary care provider in the treatment of obesity and the prevention of weight gain, as well as potential systems approaches to the treatment of obesity.



thebmj.com
Use our interactive graphic to explore the association between the prevalence of obesity and the increased prevalence of diabetes.

Introduction

Recent and emerging trends in the United States suggest that the prevalence of obesity will continue to increase and that this will have important consequences.¹ The prevalence of diabetes and other conditions associated with increasing body weight has already risen. Increased body weight is disproportionately affecting key demographic groups in the US population, including black people, those of Hispanic origin, and older adults.²⁻³ The drivers of the population increase in body weight are myriad. From increases in per capita food supply to increases in sedentary activities, there is a shift in the environment that now consistently promotes a positive energy balance.⁴⁻⁵ As the environment continues to support weight gain, it is becoming evident that robust solutions are limited. These limitations are apparent when considering the possible roles for primary care providers in the management of obesity.

SOURCES AND SELECTION CRITERIA

PubMed search
(Therapy/Broad(filter)) AND (obesity treatment primary care adults United States)
Filter: English language
PsycINFO and CINAHL search
Boolean/Phrase: obesity AND adults AND primary care AND United States
Limiters: Peer reviewed, English, age groups: adulthood (18 years and older)
Inclusion and exclusion criteria
Inclusion
Randomized controlled trial
Overweight or obese adults
Comprehensive review

(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.”

...possible roles for primary care providers in the management of obesity.

...systematic review (publication January 2010 to July 2014)
Exclusion
Studies of children
Studies of non-asthmatics

'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."

Programmed shared medical appointments

A novel procedure for chronic disease management

Garry Egger, John Stevens,
Christopher Gancars, Bob Morgan

Background
In 2003, the Australasian Society of Lifestyle Medicine (ASLM) introduced Lifestyle Medicine (LSM) shared medical appointments (SMAs) for managing chronic disease in clinical practice. The popularity of SMAs has increased with the shift towards a Health Care Homes model. Programmed shared medical appointments (pSMAs) are an extension of the standard SMA model, designed to help manage more complex and specific chronic disease issues.

Objective
The objective of this article is to describe the process of pSMAs and consider their use in primary care.

Discussion
pSMAs combine sequential medical consultations with peer support and interaction in a semi-structured group education arrangement. SMAs are ideally suited to the Health Care Homes model of clinical care currently proposed by the federal Department of Health. Proof of concept is currently being tested for pSMAs. Conditions suitable for future trials include overweight and obesity, diabetes, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease, emphysema, chronic pain or arthritis, mild anxiety or depression, perioperative management and cancer survival.

AS LIVING CONDITIONS CHANGE, so do the diseases that afflict human societies. With economic development, for example, countries experience an 'epidemiological transition' that results in a shift from a predominance of acute, infectious diseases to one of chronic, non-infectious ailments.¹ This is reflected in the fact that 60–70% of all visits to a doctor are now thought to have a predominantly lifestyle-based cause.² Several studies have shown that these chronic, non-infectious ailments can be improved by lifestyle-related changes.^{3–5} Hence, a lifestyle-related change has arisen in the discipline of lifestyle medicine has arisen to help manage these conditions at the clinical level.⁶

Lifestyle medicine had its genesis towards the end of the last millennium. Its formation was based around health problems associated with our modern ways of living. These included inactivity, poor nutrition and overnutrition, smoking, drugs and alcohol abuse, inappropriate medication, stress, sexual behaviours, inadequate sleep, risk-taking and environmental exposure (ie sun, chemical, built environment). Lifestyle medicine has been defined as 'a form of health promotion and branch of medicine targeting prevention and management of lifestyle-related diseases'.⁷ Associations in lifestyle medicine have arisen around the world (eg www.lifestylemedicine.org.au), and postgraduate training is currently offered in several institutions, and a growing number of texts are now available.^{8–10}

A structure and methodology for lifestyle medicine (explained in detail elsewhere)¹¹ has been outlined under four categories:

1. Epidemiology (the science)
2. Skills (the art)
3. Tools (the materials)
4. Processes (the actions).

Shared medical appointments (SMAs)¹² have been developed as a specific and appropriate clinical process for lifestyle medicine. This article expands on SMAs to consider 'programmed' shared medical appointments (pSMAs) as a proposed additional process with potential benefits for chronic disease management.

SMAs as a process in lifestyle medicine

The standard clinical interaction in medical care has typically occurred on a one-to-one basis: one clinician with one patient. This is largely a product of history, with a logical base in transmission of information and possible treatment options from expert to patient. However, a trawl through the literature yields no evidence for the superiority of this model over any other. While the standard clinical interaction has intuitive value for acute treatment, it is less suitable for the extended and ongoing management required for dealing with chronic disease.

SMAs on the other hand are 'consecutive individual medical visits carried out in a supportive group or of similar patients where all can "learn, and learn"'.¹³ SMAs involve a medical practitioner (eg general practitioner (GP) or specialist practitioner (CPI) or specialist) with patients sequentially and the consultation, under the direction of a trained health professional, 'issues arising from the group consultation format, such as confidentiality and peer dynamics, have been dealt with in previous manuals and articles'.¹⁴ Other issues such as 'no show' are considered in the same fashion as a standard consultation.

ANALYTIC REVIEW

Establishing Proof of Concept for Clinical Processes in Lifestyle Medicine

Garry Egger, AM, MPH, PhD, John Stevens, PhD, RN, and Christopher Gancars, MBBS, BMedSci, MPH, FRACGP

Abstract: Lifestyle medicine is a relatively new discipline, designed to improve the management of lifestyle and environmentally induced chronic diseases. As such it is evolving new ideas, tools, and procedures. This new discipline is being applied for ever potential proof of concept (PoC) is an initial stage of process development in the commercial world. It can be equally applied to new processes and practices in lifestyle medicine.

Keywords: lifestyle medicine; proof of concept; shared medical appointments; medical procedures

Introduction: The Structure of Lifestyle Medicine

We have previously proposed a structure and methodology for lifestyle medicine (LM) in this journal that encompasses the epidemiology (the science) of modern chronic disease, as well as the evolving skills (the art) tools (the materials) and procedures (the actions) that are appropriate for clinical practice.¹¹ The latter (processes or procedures) are fundamental to LM.

... evaluation of a certain method or idea to demonstrate its feasibility, or purpose is to demonstrate in principle, whose concept or theory has practical potential. (<http://researchgate.net>)

in that they can vary from, and add to, conventional clinical procedures, for example, medication, surgery, physical therapies, and so on. On occasion, however, they are introduced without verification of their potential benefit in chronic disease management (eg, self-help websites, targeted programs for weight loss and other conditions, shared care, etc). Proof of concept (PoC) testing could validate a new idea before it is proposed for widespread use.

com/definition/proof-of-concept/PoC

The intention of PoC testing is to provide documented evidence that a potential product or service can be successful, with minimal risk, and a determined scope and effort. PoC testing is not to be confused with pilot testing, which is a test of a final process, albeit on a smaller scale, before full commitment to a scale-up and roll-out to a target audience.

Proof of concept (PoC) testing could validate a new idea before it is proposed for widespread use.

Proof of Concept Testing

Used as a standard procedure in the commercial world for new products or processes, PoC is defined as:

... demonstration in feasibility, or purpose is to demonstrate in principle, whose concept or theory has practical potential. (<http://researchgate.net>)

In the medical sphere, PoC is a standard practice in the development of new drugs and medical devices. It is often absent in the development of lifestyle prescriptions, however, that are required to keep up with new patterns of disease in rapidly evolving societies.¹ This is typical of the moment since LM is emerging as a discipline in chronic disease management.¹⁴ Although there are efforts to define a structure for LM,¹¹

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?



How useful has the program been for you?



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



SMA Trial Evaluation Preliminary Results (cont)

How much did you enjoy the following about the program?

1 _____ 2 _____ 3 _____ 4 _____ 5
Did not enjoy _____ Enjoyed very much

	Males (N=39)	Females (N=56)	Total (N=95)
Having time for asking questions	4.5	4.4	4.5
Seeing the doctor more relaxed than usual	4.3	4.2	4.3
Having the doctor/staff's full attention	4.5	4.5	4.5
Contribution of other health professionals	4.2	4.2	4.2
Hearing experiences of other patients	4.2	4.3	4.2
Getting information from others	4.3	4.1	4.3

Preliminary (6 month) results from SENSW Weight Loss PSMAs

	Males N=38	Females N=54
Number Losing weight	30 (79%)	36 (66%)
Number with no loss or gain	8(21%)	18 (34%)
Average loss in kg	4.55kg	2.36kg
Average Loss in %	4.16%	2.51%
Weight loss range (kg)	-14.8 to +1.1	-23.4 to +6.7
Weight loss range (%)	-16.4 to +0.8	-21.7 to +2.6
Number losing >5% of starting weight	17(45%)	12 (22%)

Proof of Concept (PoC) check list related to PSMA's for weight control			
QUESTIONS RELATED TO THE PROCEDURE	Y	N	MEASURES
1. Is it structured around sound evidence-based principles?	✓✓		Evaluative research; Expert advice
2. Does it do what it claims to do for representatives of the target population?	✓ ✓		Outcomes measures; Questionnaire responses
3. Is the retention rate over time adequate?	✓✓		Data records
4. Does it result in positive changes in health parameters?	?* ✓		Outcome measures; Questionnaire responses
5. Is it enjoyed and valued by participants?	✓✓		Questionnaire responses
6. Is it enjoyed and valued by providers?	✓✓		Semi-structured interviews
7. Would participants recommend the process to others?	✓✓		Questionnaire responses; Focus group evaluations
8. Do patients rate this, at least as highly for this problem, as the standard comparative process?	✓✓		Questionnaire responses; Focus group evaluations
9. Is it cost and time effective for the clinic and participants?	?*	D1	Economic analysis
10. Are other health care providers likely to adopt it?	✓✓		Survey analysis
11. Is the target audience big enough and the potential demand great enough to justify and sustain it?	✓✓		Market analysis
12. Does it reach a wider patient audience than the standard comparative process?	✓✓		Demographic/psychographic analysis
13. Does it incorporate the advantages of a standard comparative process?	✓✓		Process analysis
14. Does it reduce any disadvantages of a standard comparative process?	✓✓		Process analysis
15. Is it time efficient for participants and providers?	✓	D2	Questionnaire responses

<https://vimeo.com/241762452/0162cf7d4c>