

UNDERSTANDING SHARED MEDICAL APPOINTMENTS

AN INTRODUCTION TO
GROUP VISITS



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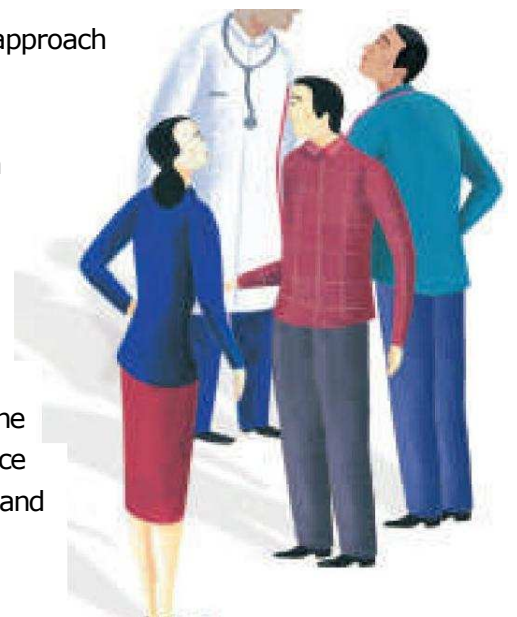
OVERVIEW

The complex needs of today's patients present a challenge to medical group physicians who try to meet patients' needs within the constraints of the traditional office visit. Studies show that the median length of a patient's face-to-face time during an office visit with a primary care physician in a managed care setting is only 13.4 minutes.¹ This time is often too short to deliver comprehensive quality care, considering the following factors:

- An aging population has increasingly complex medical needs. Between 2010 and 2030, a 78% projected increase in the population 65 years and older will result in 72 million people being in this age group.² Older adults tend to have multiple illnesses and, on average, fill 30 prescriptions per year at retail pharmacies.³ They may also have psychosocial issues and exhibit other characteristics of high-risk patients.⁴⁵
- Today's informed patients arrive in the physician's office with many questions, often from the Internet or consumer advertisements⁶
- There is an increasing need for patient education due to the complexity of today's medical treatments and patients' desire for informations

This combination of factors can stress the system, and may result in:

- Poor clinical outcomes due to:
 - Weak physician-patient partnerships'
 - Incomplete communication between the physician and patient, including basic education about diet, nutrition, exercise, and the importance of complying with recommended treatments'
 - Lack of a comprehensive, holistic approach to care, including issues with caregivers, family problems, and possible undiagnosed illnesses such as depressions
- Reduced patient satisfaction: patients are not happy if they cannot get an appointment in a timely manner, and physicians are likely to have patient visit overload. Neither the patient nor the physician is satisfied with a rushed office visit that may not allow for a complete and thorough discussion of symptoms or treatment options'



- Reduced physician satisfaction: physicians may experience stress when appointment time does not permit them to deliver the quality care they want and their patients need'
- Inappropriate utilization of resources: for example, patients who are placed on a waiting list for an appointment may get worse, perhaps ending up in the emergency department or using the emergency department as a source of primary care

We have to find new ways to meet these needs. Shared medical appointments may be part of the solution.

SHARED MEDICAL APPOINTMENTS (SMAs)

A shared medical appointment (SMA) or group visit is a periodic medical appointment held by a physician for 90 minutes or longer to provide routine or follow-up care for groups of his or her own patients.^{4,8} They are well-suited to patients with chronic conditions, such as diabetes, asthma, arthritis, and obesity; high utilizers; patients with extensive emotional, informational, or psychosocial needs; and the "worried well."⁸ The physician is supported by other professionals in conducting the SMA.

SMAs share these features. They are⁸:

- Voluntary
- Interactive
- Care delivery systems (ie, not classes)
- Designed to enlist patients in their own care
- Efficient and effective

SMA BENEFITS

Group visits can offer the following benefits:

- More time and a more relaxed pace of care^{4,8}
- Increased patient education and more opportunity for patients to ask questions^{4,8}
- Peer support, help, and encouragement from other patients in the group^{4,8}
- More time and more discussion; the SMA team can possibly identify psychosocial issues or previously unnoticed medical issues and take steps for appropriate follow-up^{4,5}

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- Private time with the physician for patients who request it^{4,5}
- Family members and caregivers at some types of group visits to gain the information they need in support of the patient^{4,5}
- Care delivered by a health care team that includes one or more nurses and may include a mental health professional who serves as a facilitator=¹⁶
- Greater efficiencies by providing the physician with the opportunity to relate the same information to a group that might otherwise be delivered in several one-on-one appointments⁶
- Better management of busy, backlogged practices^{4,6}
- Improved customer focus for the organization, an important consideration for those medical groups seeking recognition as a Patient-Centered Medical Home^{4,6}

PATIENT-CENTERED MEDICAL HOME

The Patient-Centered Medical Home (PCMH), an approach to delivering comprehensive primary care, includes shared medical appointments among the ways in which PCMH concepts can be implemented.⁹ The PCMH concept establishes a personal physician and his/her care team as the patient's "medical home." Care is coordinated across all elements of the health care system, and allows for reimbursement for the coordination of a patient's medical care.¹⁹ The basic goals of the PCMH approach include improving the quality of care for those with chronic illness or preventive needs, mitigating the rate of rise in health care usage and cost, and improving the patient experiences of care in the ambulatory care setting. PCMH has the potential for better health outcomes for patients. This can be achieved through better access to coordinated care that focuses on prevention and wellness, disease management strategies, and adherence to appropriate therapies. Its patient goals are consonant with SMA goals.¹⁹

PCMH is of interest to health plans, employers, states, and the federal government, who are testing it as one way to transform the way primary care is delivered and reimbursed.¹⁹ In addition, the National Committee for Quality Assurance (NCQA) is now recognizing physicians and their practices who meet PCMH standards.¹¹

SMA MODELS^{4,5}

There are three shared medical appointment models, with subtypes of each. While they differ in design, the three complement each other and work well together in actual practice.

1. Cooperative Health Care Clinic (CHCC): The same group of 15 to 20 high-utilizing multimorbid patients meets periodically, generally monthly, with the doctor in an interactive group session for follow-up care. The CHCC is co-led by the physician and his or her nurse. Outside speakers address such topics as medications, nutrition, exercise, advanced directives, home safety, and the use of emergency care services. Education, motivating patients to self-care and adherence to treatment plans, social support, and reducing the need for specialist care are a means by which costly hospitalizations and emergency department visits can be avoided. A second model, the Specialty CHCC, is used for a group of patients with a similar diagnosis.
2. Drop-in Group Medical Appointment (DIGMA): The DIGMA model was created for different groups of 10 to 16 patients who attend a session with the physician when they need care (heterogeneous model). The DIGMA is conducted by a multidisciplinary team that typically includes one to two nurses, a behaviorist (facilitator), a scheduler, and a documenter. Alternative DIGMA models are the homogeneous model, in which groups of patients with a similar condition attend a session with the physician when they need care, and the mixed model, which combines patients from the two groups described.
3. SMA for Physical Exams (Physicals SMA): This model was originated to serve patients who require timely access to a physical examination. All the patients spend one-on-one time with their physician, as well as meet with the whole group, in which setting they can raise health questions, receive patient education, and/or learn about preventive health measures. As with the DIGMA, there are two similar Physicals SMA subtypes. This model targets six to eight female or seven to nine male patients in primary care, and 10 to 13 patients in medical and surgical subspecialties.

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The following charts offer an overview as to how each SMA model is conducted. Note how they differ in length and flow.

CHCC"	
8:45 AM	Patients begin to arrive, check in, and sign confidentiality document
9:00 AM	Physician and facilitator welcome patients and conduct warm-up exercise
9:15 AM	Educational presentation is provided by physician, facilitator, or guest speaker
9:45 AM	Working break — Patients socialize with refreshments, while physician provides one-on-one care in the group room; additions are made to patient notebooks
10:15 AM	Physician leads Q&A
10:35 AM	Group members decide on educational topic for next session
10:30 AM-11:30 AM	Physician provides individual care for 4-7 patients in adjacent exam room
11:30 AM	CHCC group session ends

DIGMA ^{4,5}	
8:45 AM	Patients begin to arrive, check in, and sign confidentiality document
8:50 AM	Nurse begins taking patients' vital signs, one by one, in exam room
9:00 AM	Facilitator and physician welcome patients
9:05 AM	Physician provides one-on-one care, offering education in the context of individual patient care; physician signs off on documenter's chart notes after each patient
10:20 AM	Physician provides individual care for 1-2 patients in adjacent exam room
10:30 AM	DIGMA group session ends

PHYSICALS SMA^{4,5}

8:45 AM	Patients begin to arrive, check-in, with 4 patients placed in exam rooms
9:00 AM	Physician provides exams, one by one; documenter records physical findings in exam room or, subsequently, from physician's notes. Each examined patient returns to the group room, with a new patient roomed. In group room, facilitator runs the rotating group of patients, noting medical concerns on flip chart or whiteboard and discussing handouts and psychological issues
9:45 AM	Physician enters group room at completion of all physical exams; physician addresses individual patient concerns and lab results
10:30 AM	Physicals SMA session ends

SHARED MEDICAL APPOINTMENT OUTCOMES

Because a CHCC-model SMA includes the same patients at each session, conducting trials that track patient clinical outcomes with this model is somewhat easier than with DIGMA or Physicals SMAs, where different patients may participate in each session.' Randomized trials have shown that patients participating in CHCC model SMAs had fewer hospital admissions and fewer emergency room visits than patients not participating in SMAs.^{12,13} With the DIGMA and Physicals SMA models, studies have tracked the positive impact of group visits on physicians' productivity⁴⁵ and on access.⁴⁵ Preliminary data on the impact of a DIGMA on clinical outcomes is also beginning to emerge; a study from the VA system demonstrated better scores on relevant measures for patients with diabetes who participated in DIGMAs.^{4,5} A study undertaken at Borgess-ProMed of patients with diabetes revealed that those who participated in SMAs had significant improvement in microalbumin, pneumonia and influenza vaccines, and foot and eye exams.^{4,5}

Because participation by patients and physicians in group visits is voluntary, satisfaction ratings from both groups may reflect some bias. Nonetheless, surveys of patients who participated in SMAs have indicated higher levels of satisfaction with their experience than patients having individual medical visits.^{4,5,7} Similarly, physician satisfaction with SMAs has been high.^{4,5,7} Physicians report looking forward to their group visit sessions, using such words as "fun" and "joy" when describing the experience.'

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TEAM APPROACH⁴⁵

Whichever shared medical appointment model(s) your organization may decide to implement, it will require a team to carry out an SMA program successfully. Setting up a group visit program requires considerable advance planning, with most team members involved throughout the planning process. Each member needs to fully understand his or her role and responsibilities as part of the team. Any questions or concerns about the initiative need to be raised during the early planning stage. That way, any doubts or issues can be resolved before the program is launched. By the time recruitment of patients for an SMA arrives, it is critical that all members of the team be working together in a coordinated manner. Patient recruitment is a key factor to the success of an SMA.

Each group visit program must reach and maintain its patient census. That requires ongoing effort by each member of the SMA team to project a positive and enthusiastic attitude whenever they discuss the group visit concept with patients.

Shared medical appointments are being offered to patients by more physicians each year. Both patients and physicians like them. Now your medical group has an opportunity to add SMAs to its array of patient services—to the benefit of both patients, physicians, and your organization.



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NEXT WEEK: GETTING STARTED



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