Shared Medical Appointments: An Innovative Practice Model to Improve Outcomes in Your Patients with Diabetes

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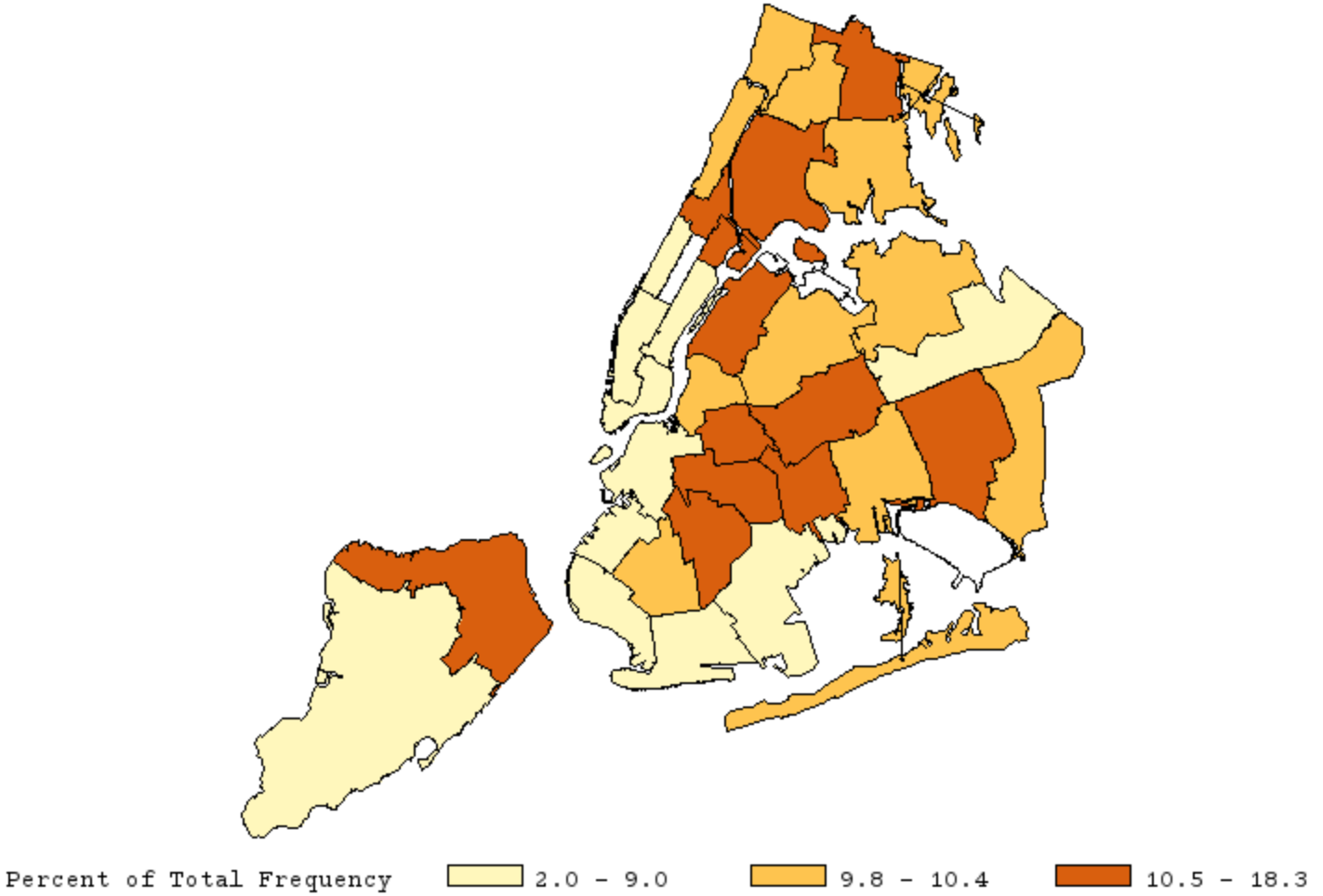
NYC Community Health Survey 2008
Percentage ever been told having diabetes by neighborhood



Bureau of Epidemiology Services, NYC DOHMH

Goal of the Webinar

To inspire you to design, implement, and evaluate shared medical appointments for your patients with diabetes in your practices

Learning Objectives

By the end of the webinar, you will be able to:

- Access resources to set up shared medical appointments (SMAs) in your practice
- Identify patients who would benefit from SMAs
- Bill and document for SMAs efficiently
- Use SMAs as a forum for teaching nurses, medical students, and residents

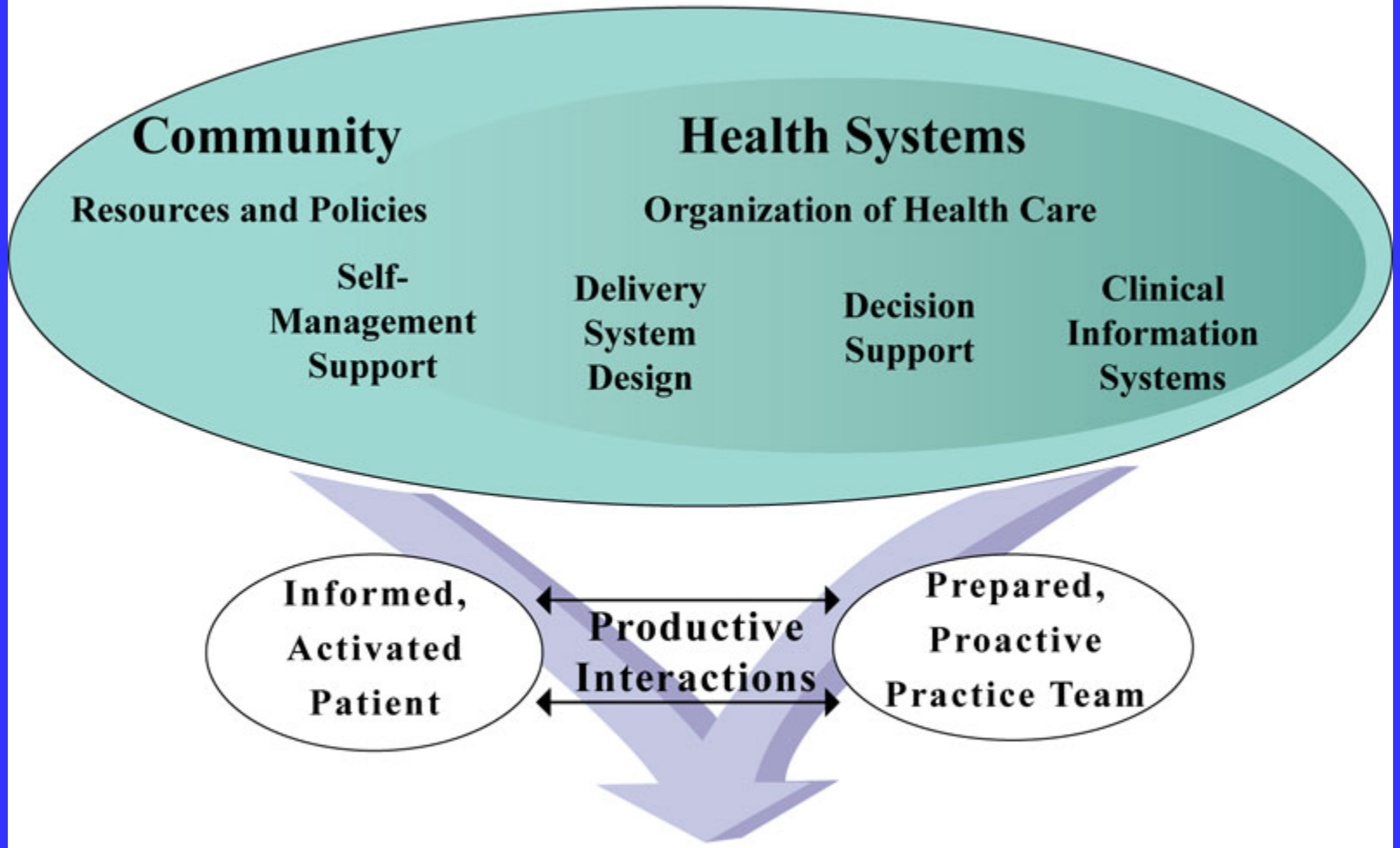
We will explore…

- Types of shared medical appointments
- Evidence base for clinical effectiveness
- Logistics of setting up SMAs
- Billing for SMAs
- Successes and challenges with Dr. Molina-Ortiz, Diabetes Medical Director of Institute of Family Health
- Experience with being in a SMA with one of Dr. Molina-Ortiz's patients with diabetes
- Questions from the audience (type in or call in)

What is a shared medical appointment?

- Often referred to as a “group visit”
- Distinctly different from diabetes education classes
- A group of 12-16 patients meets with a physician, behaviorist, medical assistant, nurse, and dedicated documenter for 90 minutes
- For a diabetes shared medical appointment, the care team should have at least one member who has training and expertise in diabetes self-management

The Chronic Care Model



Improved Outcomes

Why do Shared Medical Appointments?

- Improve diabetes-related clinical outcomes
- Improve quality of visit
- Improve access to care
- Addresses population management
- Boost productivity by 300-500%
- Increase patient and clinician satisfaction
- Have fun!

Types of Shared Medical Appointments

- Drop-In Group Medical Appointments (DIGMAS)
- Cooperative Health Care Clinics
- Physicals Shared Medical Appointments

Studies show:

- Increased patient satisfaction
- Improved health behaviors
- Improved doctor adherence to ADA standards of care
- Improved doctor-patient relationships
- Improved quality of life
- Reduced obesity
- Reduced A1C, blood pressure and cholesterol
- Decreased in emergency and urgent care visits
- Decreased referrals to specialists
- Improved medication adherence
- Increased self-efficacy

Table 1. Selected Literature Review of Group Visits in Diabetes

Study	Setting and Patient Demographics	Population and Duration	Intervention	Results
Wagner et al.[12]	Staff smodel health maintenance organization; mean age 61 years; 44% female; 30% non-Caucasian; mean A1C 7.5%	707 patients from general diabetes population in 14 primary care practices; 24 months	Half-day chronic care clinics involving primary care physician, registered nurse, and pharmacist	Improved microalbumin testing, fewer emergency department and specialty visits; A1C and patient satisfaction better in attendees
Trento et al.[13] Trento et al.[14]	Mean age 62 years; 46% female; hospital-based diabetes clinic in Turin, Italy; mean A1C 7.4%	112 patients; analysis at 4 years	Systemic group education (physician and clinical educator) versus individual consultation education	A1C −0.3% versus +1.3% in usual care (UC). Weight decreased 2.6 versus 0.9 kg in UC; less retinopathy; better diabetes knowledge, problem-solving ability, and quality of life
Bray et al. [15]	Mean age 61 years; 54% female; 72% African American; rural North Carolina	314 patients; 12 months	4-session group visit with an advanced practice nurse, registry, and case management	Improved foot exams, lipid testing, and aspirin use; better billable visits, increased productivity
Beck et al. [11]	Group model health maintenance organization in Colorado	321 chronically ill older patients; 1 year	Health education, prevention measures, mutual support, and one-to-one consultations with physician as needed	Less emergency department use, fewer admissions, greater patient and physician satisfaction
Clancy et al.[16]	Academic internal medicine practice; mean age 56 years; 72% female; 83% African American; mean A1C 9.1%	186 poorly insured patients; assessed at 12 months	Primary care physician– and registered nurse–led; groups of 14–17 patients met monthly	Greater concordance with ADA standards of care and women's preventive screenings
Sadur et al.[17]	Group model health maintenance organization; mean age 56 years; 41% female 71% white; mean A1C 9.5%	185 patients 10–18 patients for each cluster visit; 6 months	2-hour monthly cluster visits involving diabetes nurse educator, psychologist, and nutritionist	A1C −1.3 versus +0.2% in control subjects. Improved self-efficacy and reduced hospital and outpatient utilization
Look AHEAD: Pi-Sunyer et al.[18]	Large multicenter U.S. randomized controlled trial; mean age 59 years; 59% female; 63% white; 16% African American, 13% Hispanic; mean A1C 7.3%	5,145 patients with type 2 diabetes with intensive lifestyle intervention compared to a diabetes support and education control group; 1 year	Group behavioral programs adapted from the Diabetes Prevention Program; months 1–6: three group visits; months 7–12: meetings every other week with dietitians, psychologists, and exercise specialists	A1C 7.3–6.6% in intervention group, 7.3–7.2% in control subjects; significant improvements in blood pressure, lipids, and microalbumin
INITIATE: Yki-Jarvinen et al.[19]	Multicenter study at academic clinics in Finland; mean age 58 years; 38% female; mean A1C 8.8%	121 patients needing insulin initiation	Initiation of insulin; counseling in groups of four to eight patients versus individually	Equal drop in A1C ~ 2%; counseling time 2.2 hours in group versus 4.2 hours individually
Kirsh S et al.[20]	Cleveland VA primary care clinic; quasi-experimental design; mean age 61 years; 2% female; mean A1C 10.4%	44 patients; 3 months	Up to eight patients seen by multidisciplinary team for 1–2 hours	Statistically greater improvements in A1C and blood pressure control relative to concurrent nonrandomized control subjects

Some Places Where SMAs are Being Done
8.4% of docs offer SMAs in 2009

- Institute for Family Health in the Bronx
- Bellevue Hospital Center
- Cleveland Clinic
- Dartmouth Hitchcock Medical Center
- Harvard Vanguard
- Kaiser Permanente
- VAs across the country

Setting up a Shared Medical Appointment

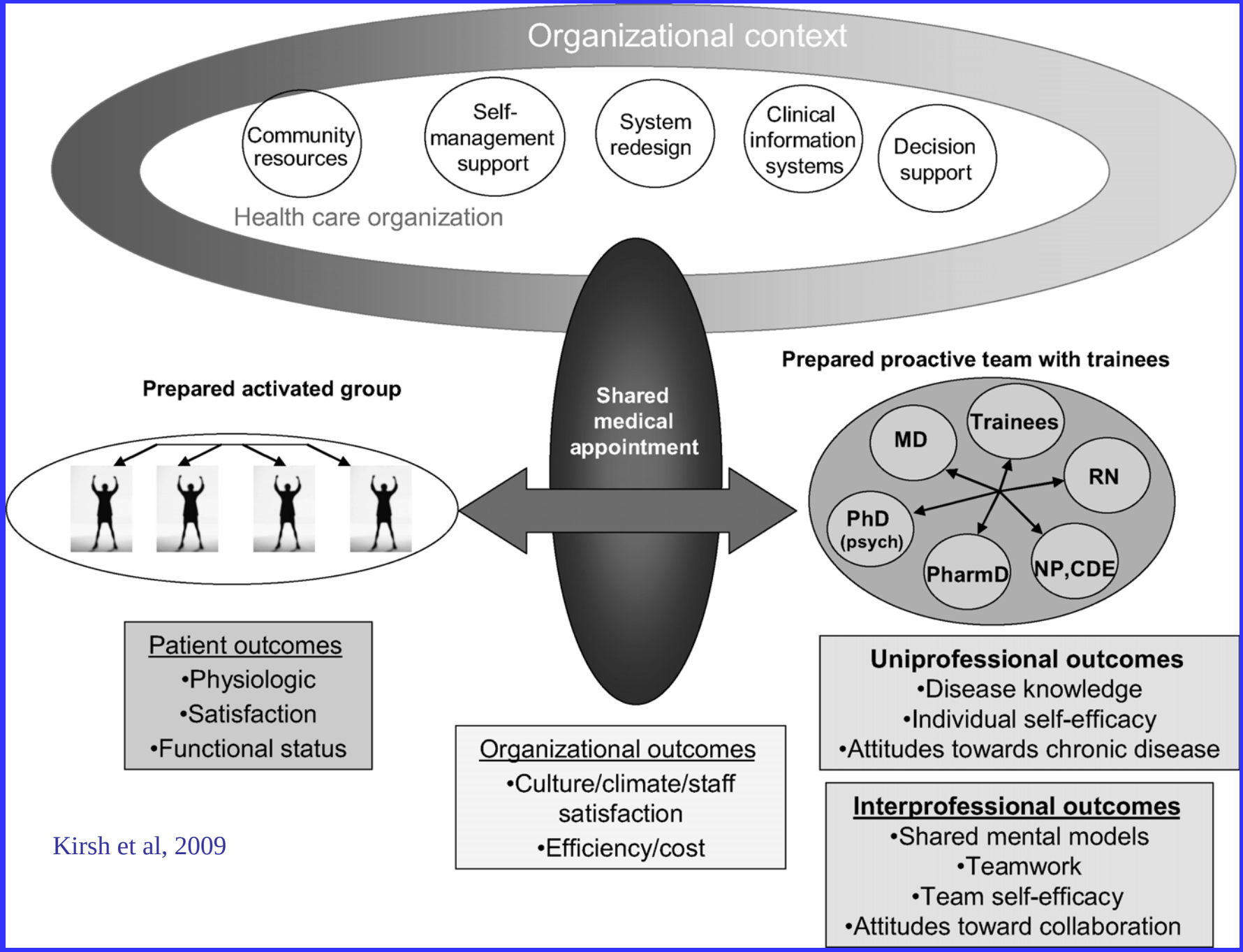
- A clinician champion for the program
- A scheduler who knows about the power of SMAs
- A conference room that holds 15+ people
- A nurse to do vitals and point of care A1C and lipids
- A certified diabetes nurse educator or behaviorist to co-facilitate the group
- A medical assistant or medical student to assist with documentation and charting

Confidentiality

HIPPA and Voluntary Disclosure
of Personal Medical Info in a Group

Billing

- Bill each patient individually as a CPT level 3 (99213) or 4 (99214) depending on the complexity of the medical decision making.
- No need to mention that the care was delivered in a group setting.



Kirsh et al, 2009

Keys to Success

- Secure senior administrative support
- Identify a clinician champion
- Maintain groups with 12-16 pts to maximize efficiency
- Harness the power of peer support and professional partnership
- Listen, Don’t Lecture
- Document and bill efficiently
- Plan groups carefully!

Resources

- Running Group Visits in Your Practice by Dr. Edward Noffsinger
- A Guide to Group Visits for Chronic Conditions Affected by Overweight and Obesity: www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/pub_health/aim/groupvisits.Par.0001.File.dat/GroupVisitAIM.pdf
- Planning Group Visits for High-Risk Patients -- Family Practice Management, June 2000
- E-mail Dr. Diana Berger at diana.berger@mssm.edu to let me know if you plan to design, implement, and evaluate shared medical appointments at your practice in the future!