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

Diana Berger, M.D, M.Sc.
Department of Preventive Medicine
Mount Sinai School of Medicine
NYC Community Health Survey 2008
Percentage ever been told having diabetes by neighborhood

Percent of Total Frequency
- 2.0 - 9.0
- 9.8 - 10.4
- 10.5 - 18.3

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

Community
- Resources and Policies
- Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions
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>
<thead>
<tr>
<th>Study</th>
<th>Setting and Patient Demographics</th>
<th>Population and Duration</th>
<th>Intervention</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wagner et al.</td>
<td>Staffanel medical health maintenance organization; mean age 61 years; 44% female; 30% non-Caucasian; mean A1C 7.5%</td>
<td>707 patients from general diabetes population in 14 primary care practices; 24 months</td>
<td>Half-day chronic care clinics involving primary care physician, registered nurse, and pharmacist</td>
<td>Improved microalbumin testing, fewer emergency department and specialty visits; A1C and patient satisfaction better in attendees</td>
</tr>
<tr>
<td>Trento et al.</td>
<td>Mean age 62 years; 46% female; hospital-based diabetes clinic in Turin, Italy; mean A1C 7.4%</td>
<td>112 patients; analysis at 4 years</td>
<td>Systemic group education (physician and clinical educator) versus individual consultation education</td>
<td>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</td>
</tr>
<tr>
<td>Bray et al.</td>
<td>Mean age 61 years; 54% female; 72% African American; rural North Carolina</td>
<td>314 patients; 12 months</td>
<td>4-session group visit with an advanced practice nurse, registry, and case management</td>
<td>Improved foot exams, lipid testing, and aspirin use; better billable visits, increased productivity</td>
</tr>
<tr>
<td>Beck et al.</td>
<td>Group model health maintenance organization in Colorado</td>
<td>321 chronically ill older patients; 1 year</td>
<td>Health education, prevention measures, mutual support, and one-to-one consultations with physician as needed</td>
<td>Less emergency department use, fewer admissions, greater patient and physician satisfaction</td>
</tr>
<tr>
<td>Clancy et al.</td>
<td>Academic internal medicine practice; mean age 56 years; 72% female; 83% African American; mean A1C 9.1%</td>
<td>186 poorly insured patients; assessed at 12 months</td>
<td>Primary care physician– and registered nurse–led; groups of 14–17 patients met monthly</td>
<td>Greater concordance with ADA standards of care and women’s preventive screenings</td>
</tr>
<tr>
<td>Sadar et al.</td>
<td>Group model health maintenance organization; mean age 56 years; 41% female 71% white; mean A1C 9.5%</td>
<td>185 patients 10–18 patients for each cluster visit; 6 months</td>
<td>2-hour monthly cluster visits involving diabetes nurse educator, psychologist, and nutritionist</td>
<td>A1C ~1.3 versus ~0.2% in control subjects. Improved self-efficacy and reduced hospital and outpatient utilization</td>
</tr>
<tr>
<td>Look AHEAD: Pi-Sunyer et al.</td>
<td>Large multicenter U.S. randomized controlled trial; mean age 59 years; 59% female; 63% white; 16% African American, 13% Hispanic; mean A1C 7.3%</td>
<td>5,145 patients with type 2 diabetes with intensive lifestyle intervention compared to a diabetes support and education control group; 1 year</td>
<td>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</td>
<td>A1C 7.3–6.6% in intervention group, 7.3–7.2% in control subjects; significant improvements in blood pressure, lipids, and microalbumin</td>
</tr>
<tr>
<td>INITIATE: Yki-Jarvinen et al.</td>
<td>Multicenter study at academic clinics in Finland; mean age 58 years; 38% female; mean A1C 8.8%</td>
<td>121 patients needing insulin initiation</td>
<td>Initiation of insulin; counseling in groups of four to eight patients versus individually</td>
<td>Equal drop in A1C ~2% counseling time 2.2 hours in group versus 4.2 hours individually</td>
</tr>
<tr>
<td>Kirsh S et al.</td>
<td>Cleveland VA primary care clinic; quasi-experimental design; mean age 61 years; 2% female; mean A1C 10.4%</td>
<td>44 patients; 3 months</td>
<td>Up to eight patients seen by multidisciplinary team for 1–2 hours</td>
<td>Statistically greater improvements in A1C and blood pressure control relative to concurrent nonrandomized control subjects</td>
</tr>
</tbody>
</table>
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

Organizational context

- Community resources
- Self-management support
- System redesign
- Clinical information systems
- Decision support

Health care organization

Prepared activated group

Prepared proactive team with trainees

Shared medical appointment

- MD
- Trainees
- RN
- PhD (psych)
- PharmD
- NP, CDE

Patient outcomes
- Physiologic
- Satisfaction
- Functional status

Organizational outcomes
- Culture/climate/staff satisfaction
- Efficiency/cost

Uniprofessional outcomes
- Disease knowledge
- Individual self-efficacy
- Attitudes towards chronic disease

Interprofessional outcomes
- Shared mental models
- Teamwork
- Team self-efficacy
- Attitudes toward collaboration
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
- 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!