LIFESTYLE MEDICINE

SHARED MEDICAL APPOINTMENT TOOLKIT

 

1. **Background to Shared Medical Appointments**

[Shared Medical Appointments](http://lifestylemedicine.org.au/shared-medical-appointments/) (SMAs), also called ‘Group Visits’, are a revolutionary way of managing chronic disease in primary care. They are “A series of consecutive individual medical consultations in a supportive group setting where all can listen, interact, and learn.” A SMA is both an individual consultation and a group education session.

Although they have been carried out in the US since 1998, Shared Medical Appointments (SMAs) were only introduced into Australia in 2014. In this year the Australian Lifestyle Medicine Association or ALMA (now the Australasian Society of Lifestyle Medicine) carried out an introductory pilot study of SMAs to test patient and provider satisfaction with such a process. The trial showed that patient satisfaction and desire for SMAs once they had tried these was extremely high.

Although they had initial reservations, mainly based around organisational and financial concerns, providers (doctors, practice nurses) also had a high level of satisfaction from involvement in SMAs. There was particular support from a small trial of SMAs with indigenous men. Unlike the American model however, it was decided that SMAs could be conducted successfully and economically in Australia with a minimum of two staff (a doctor and a Facilitator) and a patient group of from 6-12 people.

The key to success was the facilitator, and hence a training program was established by ALMA to certify allied health professionals, but mainly practice nurses, to act as facilitators for (a) general SMAs (b) more specific ‘programmed’ SMAs involving a specialist program or topic (weight control, smoking etc) over an extended period (eg 6 sessions), and (c) Shared Medical ‘Yarn-ups’ (SMYs) for indigenous health issues.

1. **Rationale for Shared Medical Appointments**

The provision of health services at the primary care level, by either a doctor or other health professional requires knowledge, skills and tools

1. *Knowledge* is information about the determinants and causes of disease:

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| --- | --- |
| **ASPECT** | **DESCRIPTION** |
| **N**utrition | Excess energy, fat, sugar, salt; malnutrition |
| **A**ctivity | Inactive leisure and/or work time; excessive sitting |
| **S**tress | Burnout; “brown out”; anxiety; depression |
| **T**echno-pathology | Adverse effects of technology, injury |
| **I**nadequate Sleep | Sleep time, disorders |
| **E**nvironment | Pollution, endocrine disrupting chemicals |
| **M**eaninglessness | ‘Learned helplessness’ |
| **A**lienation | From society |
| **L**oss of culture (identity) | Such as Indigenous or migrant groups |
| **O**ccupation | Shift work, occupational hazards, bullying |
| **D**rugs, smoking and alcohol | Iatragenesis, ‘recreational’ drugs |
| **O**ver (and **U**nder) exposure | Sunlight, skin cancers, vitamin D deficiencies |
| **R**elationships | Support, belonging, care |
| **S**ocial inequality | Trust, ratio between rich and poor |

1. *Skills* involve the techniques or processes which the provider of health care uses to affect a desired action by the patient to improve his or her health.
2. *Tools* are products, devices or services, which help the patient become an active collaborator in the patient-provider relationship.

In the past, *knowledge* has consisted predominantly of information about infectious or acute diseases or injury, the former being associated with external microbiological organisms or ‘germs’. More recently, these problems have decreased as a proportion of total presentations to primary care in favour of chronic diseases with lifestyle or environmental ‘drivers’ (‘causes’ in the case of chronic diseases are more difficult to define).

This has resulted in a change in the requirements for the *skills* of medical consultations, from the traditional 1:1 approach typically resulting in relatively simple prescriptive advice, to one where ongoing, complex, health management advice is required over an extended period.

*Tools* are usually centred around modern technologies, which provide feedback to enable an individual to quantify progress in a particular area of lifestyle or behavioural change. They include screening products such as blood pressure cuffs, HbA1c monitors, and portable spirometers, devices like computers and electronic tablets, and services such as SMS messaging and interactive websites.

Unlike the doctors of the past, modern practitioners, to be effective, have found it necessary to retrain in counselling skills like motivational interviewing, self-management, life coaching, behaviour modification etc. Usually however, this is still within the context of a single 1:1 consultation.

With the more complex, chronic diseases of today (metabolic, respiratory, cardiovascular, carcinogenic etc.), this process has several disadvantages, including the following:

* Under the usual medical reimbursement system (designed initially for quick consultations), there is not enough time for managing complex, chronic problems;
* As chronic diseases have limited lifestyle-related drivers, providers are forced to repeat advice (diet, exercise, stress control etc.) *ad nauseum* to an ever increasing stream of single patients, thus reducing provider satisfaction;
* Time limitations leave patients ‘short-changed’ on advice and unable to question providers on all issues of concern relating to their disease(s).
* Time restriction often leads providers to prescribe expensive, but not necessarily effective prescription medications rather than explore more complex, but potentially more effective behaviour changes with less potentially iatrogenic side effects.
* Providers sometimes offer advice about which they are not fully confident, but because they know the patient will not question it and probably will not act on it, they do not feel pressured to check the facts.

The 1:1 consulting model has been used since time immemorial, almost as a ‘default’ way of operating, and has rarely been questioned. Because doctors have usually been trained in this process only, they have had no reason to want to change or modify it. Yet changes in health status require changes in health management techniques. There are no supportive data in medical literature to suggest the 1:1 consulting process is more effective than any other.

1. **An Alternative Form of ‘Skill’**

All of the above has given rise to the need for consideration of a new form of managing chronic disease at the clinical level, which can:

1. Take advantage of peer support
2. Reduce patient waiting time
3. Allow more time with the doctor
4. Be less repetitive for the provider
5. Utilise the skills of other experienced health professionals
6. Provide more opportunity for learning self-management
7. Make no unfounded assumptions about patient health literacy

Shared Medical Appointments (SMAs), sometimes known as ‘Group Visits’, offer an alternative to the 1:1 consulting pattern for achieving this. SMAs are defined as “…*comprehensive medical visits run in a supportive group setting of consenting patients with similar concerns*.” As such an SMA is a comprehensive medical visit, which fits between a single clinical consultation and a group education session (as shown in the diagram below).

1. **Where SMAs Fit**



SMAs have been run successfully in the US over almost 2 decades, and now in parts of Europe. Until recently, SMAs have never been tested in Australia because it was thought that the Medical Benefits Schedule (Medicare) did not permit these because visits have to be in a (private) one-on-one situation and confidentiality issues preclude discussions of private medical details in front of others.

A close scrutiny of the MBS, and discussions with Medicare, show the restrictions are unclear in the MBS relating to (a). As written in the MBS a personal item number (23), which is for less than 20 minutes states that it is for:

“…a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.”

As SMAs are conducted in an identical fashion to a 1:1 consultation with individual patients (except with others watching and contributing), this should be no barrier to their use in Australia.

In order to overcome any possible problems with this, the Australian Lifestyle Medicine Association (ALMA) applied in November 2013 to the Medical Services Advisory Committee (MSAC) at the behest of the Commonwealth Department of Health for a special item number for SMAs.  This was ultimately unsuccessful and at the time of writing (June 2017) there is still no clear guidance from the MBS as to the best way to bill for these consultations.  Similarly, there have been no concerns raised at this stage about the use of the Item 23 x number of participants in the group.  Item 10997 is also used concurrently x number of participants in the group for the practice nurse.  This is how most practitioners are currently billing for SMAs.

Confidentiality (b) can be overcome (as in the US) by confidentiality agreements. Hence, we believe there is no impediment to implementing a billable group visits model for chronic disease in Australia.

1. **What are Shared Medical Appointments?**

Shared Medical Appointments are defined as “…*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)

SMAs provide medical care from start to finish – the same as that delivered during routine primary care visits, and often more.

When applied to chronic illness, these can be delivered as comprehensive medical visits (billable at individual rates) focusing on chronic disease, but run in a supportive group setting of consenting patients with similar concerns. The patients sign confidentiality agreements, and 2–4 health professionals are present.

1. **The SMA Team**

An SMA team can be made up of as many as 4-5 health professionals depending on the budget available and the topic being discussed. A bigger team might be used where an ‘expert’ in a particular area is brought into a group to discuss a special issue, such as a pharmacist to discuss medications.

Under the US model, the ‘team’ usually consists of a doctor, a facilitator (called a ‘behaviourist’ in the US), a nurse (to do observations where necessary), and a documenter (to keep medical records).

Because of the vagaries of the Australian health care system, a ‘skeleton’ team of a doctor and a facilitator are usually sufficient to carry out an SMA. In this case, the facilitator needs to have good people skills, be well trained in group dynamics, and capable of writing medical records. Practice nurses are ideally suited for this role and can do this within the financial limitations of the system because they are already on the centre payroll. *It is vital that the doctor not be occupied with keeping medical records so they can focus more on individual patient care*.

1. **‘Programmed’ (Structured) SMAs**

As well as ‘general’ SMAs that may be heterogeneous (e.g. different chronic diseases) or homogeneous (e.g. all diabetes, or heart disease etc.). SMAs offer a new way to deliver developed programs in specific health areas, where sequential medical consults can add significantly to what otherwise might be simply health educational, group sessions.

Lifestyle-related health areas where this could be particularly relevant include ‘Quitting Smoking’, ‘Weight Loss’, ‘Cardiac Rehabilitation’, ‘Falls Prevention’, etc. In these cases, existing ‘structured’ programs may need little modification to fit the SMA model, because the main benefits of SMAs are medical input in an environment of supportive peers.

Where such programs are available, it is vital that the facilitator be educated in the area being discussed in order to assist the doctor, who may not be a specialist in that area. This may require extra training for facilitators in each of the areas concerned (e.g. Quitting Smoking, Weight Control etc). Alternatively, an expert in these areas might be recruited and trained in the techniques of group facilitation.

1. **When should SMAs be used?**

SMAs are suitable for a wide variety of health problems, from primary to tertiary care. However, they are likely to be most valuable within secondary care (where risk factors for disease are starting to be seen, but the disease has not yet fully developed).

Areas where published evidence for SMAs exists include:

* 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)

SMAs may not be as appropriate for such problems as:

* Acute infectious diseases
* Severe mental health issues
* Intimate sexual or other matters
1. **Considerations before running SMAs**
2. **How do you know if SMAs are suitable for your clinic?**

SMAs are suitable for most primary care clinics from single doctor operations to super clinics. The main requirements are:

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***Space:*** The clinic needs to have room to seat up to 12 people at a time (15 if staff are included and the group is optimal size). Because patients and medical staff are usually seated for the duration of the session, a large area is not necessary. In some cases a medical consultation room is sufficient; hence, space should not be a limiting requirement.

***Time*:** Time needs to be provided for an attending doctor to spend a full hour in an SMA without interruptions from staff or other patients. In some cases, groups might best be run after hours or on weekends if feasible.

***Staff*:** Staff involved need to be interested and passionate in the SMA form of consultation. It requires experience, training and knowledge of the SMA procedure before committing to the process. In most instances at least one ‘champion’ for SMAs should be employed in the clinic. ‘Buy in’ really has to occur from doctors in any clinic before it is likely to take off. Hence a presentation to the medical staff by an expert in SMAs is recommended.

***Interest*:** SMA teams need to have an interest in patient satisfaction with medical procedures offered and a desire to increase employment satisfaction for themselves.

***Financial considerations*:** Although, on initial perception, SMAs may appear to be an attractive financial venture, this should not be a reason for pursuing this model of care. If structured properly, a centre should not suffer financially from running SMAs as running conventional care. Indeed, a saving in efficiency may mean that the centre could be better off. However, because Medicare item numbers were written well before a consideration of SMAs, there is a potential for over-billing, which would negatively affect the SMA process for the future. *It is strongly recommended that SMAs NOT be used for financial gain, but for increased patient care and provider satisfaction*.

1. **Selecting the right SMA model**

There are a number of different SMA models and these can be adapted (within reason) to the providing centre and team. The basic models are shown in the table below.

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1. **Perceived Barriers to SMAs**

Being a new concept in medical consultations, the idea of SMAs is usually approached cautiously by clinical staff. The usual arguments brought up against the idea are:

***Barrier*:** You can’t use Medicare item numbers to bill for a group consultation

*Answer*: SMAs are not group consultations. They are individual consultations in the presence of a group. Medicare item number 1.2.4 states that it “ …applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion”. It has been suggested that “this does not allow for services to be applied to a group of patients”. However, services are NOT being applied to a group. They are being applied by a single medical practitioner, on a single patient on a single occasion – IN FRONT OF A GROUP.

This suggests that single items such as 23, can, in theory be applied. It is important however that the system is not abused and that a range of other ineligible items are not charged.

***Perceived Barrier*:** Patients will be concerned about confidentially.

*Answer*: All patients are required to sign a confidentiality agreement before entering the SMA. In addition, there has never been an issue over confidentiality in nearly 20 years in the US, a much more litigious society than Australia. Finally, in listening to patients in waiting room discussions, there seems little concern over confidentiality.

***Perceived Barrier*:** Australians are different to Americans and are much more reticent to ‘open up’ in a group.

*Answer*: There is always some ‘settling in’ period in a group environment. However, this is usually quickly overcome, particularly by a skillful facilitator who can ‘break the ice’. And while very intimate details are not expected to be brought up by patients, and intimate medical measures are never taken in front of the group, experience has shown that once group participants gain the confidence of the group, there is no reluctance to talk – the problem is usually controlling the amount of discussion.

***Perceived Barrier*:** Doctors are resistant to changing their ways after years of operating in one fashion.

*Answer*: This is always going to be the case with some doctors. There are both doctors and patients who will not take to this procedure. However those doctors who have tried SMAs, both in Australia and overseas, become very favourable towards the process. Evaluation studies have shown that doctors who use the procedure wish to continue using this (usually not instead of, but as well as, their traditional form of consultation).

***Perceived Barrier*:** There will be special attention from Government because of concerns about over-servicing.

*Answer*: Governments, both in Australia and overseas are looking for new ways of coping with current health problems like chronic disease, because the current ways are not working. The fact that the Australian Government and Department of Health are exploring ways of funding group visits is an indication that the process will not get special attention from Government.

***Perceived Barrier*:** There will be problems attracting patients.

*Answer*: In trials of satisfaction in the US (e.g. as reported in Heyworth et al., *Annals of Family Medicine*, 2014; 12(4):324-330) and in early trials in Australia, over 90% of patients rate SMAs as very satisfying and over 60% say they would come back to an SMA. As in many situations, there will be early adopters and some who will never take on the procedure, but this is unlikely to be a limiting factor.

***Perceived Barrier*:** SMAs are not suitable for Indigenous individuals.

*Answer*: ‘Yarn-ups’, where individuals sit around in groups have been used in Aboriginal and Torres Strait Islander cultures for thousands of years. They are a means of transmitting information in a non-threatening and culturally supportive way. The introduction of western medicine with a white doctor with a patient alone in an enclosed room is often seen as ‘frightening’ and inhibiting of full disclosure by the patient. In contrast, a doctor in a ‘yarn-up’ is more likely to encourage involvement by participating individuals.

**d. Advantages of SMAs**

There are a number of advantages of SMAs for both patients and providers. A short list is provided below. (For more advantages see Noffsinger (2013) p. 14-17.)

For Patients

1. Improved quality of, and access to care
2. Extra time with own doctor and more relaxed pace of care
3. Peer support and feedback from patients with similar conditions
4. Multidisciplinary care from a range of (2-4) providers
5. Answers to questions they might not have thought to ask (because others in the group ask)
6. An additional health care choice
7. Greater self-management education and attention to psychosocial issues

For Clinicians

1. Increased physician productivity/cost effectiveness/time effectiveness
2. Better management of waiting lists
3. Reduced repetition of information/advice
4. An opportunity to get off the fast-paced treadmill of individual visits
5. Can contain costs and increase efficiency
6. A chance to get to know patients better in an interactive setting
7. Real help from the multi-disciplinary team with the opportunity in Australia to coordinate Care Plan Reviews and Team Care Arrangements (TCAs)

In an Australian trial carried out in 2014 (2) patients reported liking the following about SMAs:

* Peer support
*“I got the opportunity to tell the young ones about what had happened to me and I look forward to thinking more about that for next time.”*
* Hearing experiences and getting information from others
* *“It’s good to hear other people’s issues.”*
* The feeling of not being alone with your disease

*“Diabetes is a lonely ailment, so it’s great to have other similar people to discuss it with.”*

* Having more time with the doctor for asking questions and having questions one may not have thought to ask being asked by others
*“ I got so much out of this because I heard answers to questions that I always forget to ask the doctor.”*
* Interest in other peoples’ ailments and how they deal with these
*“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.”*
* The much greater relaxed atmosphere of the group approach to treatment.
*“For me it just feels so much more relaxed than an individual consultation.”*

Providers reported the following:

* Less need for repetition of lifestyle advice
*“Providing the same (lifestyle) advice over and over and knowing they’re not going to take any notice is one of the most frustrating things about medicine in the chronic disease era.”*
* Apparent better uptake of advice when agreed to by peers
* *“As a doctor, you’re not lecturing at people, and hence the doctor becomes more acceptable to the patient.”*
* The opportunity to better educate patients
* *“ I’ve been seeing these patients for 12 years but this is the first time I’ve got to know about their details, because we had time to discuss them.”*
* The relaxed atmosphere and ability to focus on patients, not record keeping, because of facilitator help.
* *“It’s great not to have to be looking at a computer screen all the time so you can focus more on the patient.”*

*“As a doctor, you’re not lecturing at people, and hence the doctor becomes more acceptable to the patient.”
– Sydney Doctor*

1. **Objectives of SMAs**

For the patient:

* To empower patients to become more involved in self-management of their own health
* To more effectively answer patient’s questions and concerns
* To use peer support to motivate the patient to act
* To increase the patient’s ‘health literacy’
* To increase the patient’s satisfaction and enjoyment of the medical consultation experience

Bottom line: *To improve patient health and well-being*

For the Provider (Doctor, Facilitator etc.):

* To reduce repetition (and boredom) from repeating lifestyle prescriptions
* To improve efficiency in providing health care
* To provide easier patient access
* To get assistance from other providers’
* To improve provider’s knowledge about Lifestyle Medicine
* To increase the provider’s satisfaction and enjoyment of the medical consultation experience
* To have fun!!!

Bottom line: *To improve provider efficiency and work satisfaction*

For the Clinic:

* To reduce patient waiting lists (if important)
* To improve efficiency
* To increase team involvement in chronic disease management
* To stand out as an innovative primary care practice
* To make the practice more of a ‘patient centred medical home’

Bottom line: *To improve outcomes and efficiency*

In a published review of the data, group visits 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.”* 1

1. **Appeal of SMAs**

SMAs have appeal to both patients and providers, and are generally appealing to practice managers and primary care centre owners.

* 1. **Patient Appeal**

In the initial trial of SMAs in Australia, patients were asked to rate these on 5-point Likert scales where 1= ‘poor’ and 5 =‘great’. Mean score ratings are shown in table 1:

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| --- |
| **Table 1: Initial trial of SMAs patient rating** |
|  | **Mean Score** |
| Now you have completed these Shared Medical Appointments, how do you rate this form of care for Type 2 Diabetes? | 4.55 |
| How would you rate it for other forms of care (pain, asthma etc.)? | 4.25 |

Potential use of SMAs was measured on a similar 5 point scale where 1= “definitely not” and 5= “definitely”. Mean score ratings to each question are shown in table 2:

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| --- |
| **Table 2: Potential use of SMAs patient rating** |
|  | **Mean Score** |
| Would you continue to come to SMAs if these were available at your medical centre? | 4.86 |
| Would you ever use an SMA instead of a standard medical appointment? | 4.11 |
| Do you think SMAs would reduce the number of other visits you would need with your doctor alone? | 3.81 |
| Do you think SMAs should be paid for by Medicare? | 4.68 |
| Do you think people would pay a co-payment to come to an SMA? | 1.42 |
| If yes how much do you think most people would be prepared to pay? Range: 0 – $15 | $4.24 |
| How many ordinary visits to your doctor might you *not* need over 6 months as a result of attending a Shared Medical Appointment? Range: 0 – 5 (Note: 24% of patients did not answer this or responded ‘0’) | 1.64 |

Participants were also asked to rate on a scale of 1 to 5 (where 1= “did not enjoy at all” and 5= “enjoyed very much”) how much they enjoyed each of the following about the Shared Medical Appointments they attended. Mean score ratings to each question are shown in table 3:

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| --- |
| **Table 3: Enjoyment of SMAs patient rating** |
|  | **Mean Score** |
| Having more time to ask questions | 4.84 |
| Seeing the doctor more relaxed | 4.64 |
| Having the doctor’s full attention | 4.58 |
| Getting support from other patients | 4.77 |
| Contribution of other health people | 4.77 |
| Hearing experiences of other patients | 4.90 |
| Getting information from others | 4.97 |

Patients from those groups for diabetes (N=40) were asked ‘do you do any of the following more as a result of attending these Shared Medical Appointments?’ Responses are shown in table 4:

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| --- |
| **Table 4: Patient’s subjective behaviour change as a result of SMAs. While these results are based on small numbers, they give an indication of the types of behavioural changes that might be expected from a good quality SMA.** |
| **Do you do any more of the following as a result of attending these SMAs?\*** | **Much more** | **A little more** | **No more** |
| N | % | N | % | N | % |
| Check my blood sugars | 14 | 35 | 8 | 19 | 18 | 45 |
| Am more careful with the food I eat | 19 | 48\* | 9 | 22 | 12 | 30 |
| Take my medication as required | 16 | 40 | 4 | 10 | 20 | 50 |
| Do regular physical activity | 16 | 40 | 16 | 40 | 8 | 20 |
| Follow my doctor’s advice | 18 | 48\* | 9 | 22 | 12 | 30 |
| Follow my diabetes educator’s advice | 13 | 32 | 13 | 32 | 14 | 36 |
| Take care of my own health | 23 | 58\* | 5 | 13 | 12 | 29 |
| Feel confident in managing my diabetes | 19 | 48\* | 14 | 35 | 7 | 17 |

\* % do not always add up to 100 due to failure of some people to answer some questions

* 1. **Provider Appeal**

 *“Shared Medical Appointments have given me a comfortable push to improve my knowledge. I talk with patients one-to-one. And while you always do your best, 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 situation you can’t do that. Someone in your patient group or team is going to know more than you about some things – you can’t fudge it. After the 2nd SMA, I read deeply about diabetes and am continuing to do so in preparation.” – Participating GP, North Coast NSW*

Providers like SMAs. Some typical comments from the initial Australian research were:

*“A great idea; Hugely motivational. Patients learn a lot from each other. It’s difficult to explain the problems of diabetes to individual patients, but this is easy with other people in the room.” –* GP, Western NSW

*“Very useful and a totally different approach to what we are used to. Quite natural after you start doing it.” –* GP, Qld

All GPs agreed SMAs should ‘decrease health costs in the long term’ because: *“…*(a) *they lead to an increase in efficiency and* (b) *it helps us do health promotion/education better*.” – GP, Northern NSW

Most also agreed SMAs would decrease standard medical visits: *“If done by the patient’s own GP, they would definitely decrease other visits.” –* GP, Sydney, NSW

All agreed they “would like to continue running SMAs in some form in their practice”.

The main advantages of SMAs over standard medical consultations mentioned here were:

* ‘Patients supporting each other’
* ‘The benefits of group dynamics’
* ‘Not having to repeat yourself’
* ‘More relaxing than 1:1 visits’

Disadvantages were seen mainly as organisational and administrative issues, but this was thought to be more likely in the initial stages. A second concern was getting a special MBS item number or agreement to use current item numbers with Medicare, although all agreed after running groups that this should not be an issue. All involved regarded the Facilitator as crucial to the process and were of the opinion that training for Facilitators should be mandatory, with perhaps an accreditation system available for Facilitators.

*“One of the things I realised out of doing these SMAs is that we (providers) assume medical literacy. We think we adjust our language to meet the knowledge of the patients, but obviously we don’t do it as well as we think – people in these groups still didn’t know the difference between fat, carbohydrate and protein. I assumed they would. Some didn’t understand the relationship between drinking 70 cans of coke a week and weight gain and poor sleep. I assumed they would. So I’ve been telling them things they have no hope of understanding! I’ve already changed that in my practice as a result of the SMAs.”* – GP, NSW

1. **Outcomes of SMAs**

SMAs have been used in the US for over a decade and there is now ample accumulating evidence to show their effectiveness in improving health outcomes. The effectiveness of SMAs has yet to be confirmed in Australia, but there is little reason to believe the results would differ from those overseas.

Cost-benefit studies on SMAs to date are limited but those that have been carried out do suggest benefits to both the health system and primary care centres. Economic benefits to the health system include reduced medical visits, potential reduced hospitalisation, greater self-management by patients and better ongoing management through peer support. On the basis of the original satisfaction studies carried out in Australia, it has been estimated that up to three ordinary visits to the doctor could be averted through one SMA every year. If this resulted in a net reduction of two medical visits per year amongst all diabetic and pre-diabetic patients in Australia (~ 4 million), this could result in a minimal cost saving of ~ $200 million.

1. **Roles and requirements of the team**

Team members for SMAs have both certain characteristics and roles for which they should be selected. The most important of which (and the only member who requires special training) is the facilitator.

1. **FACILITATOR**

Competencies

* Background in health sciences (minimum undergraduate degree preferred)
* Preferred experience with medical records program used in the clinic
* Some content knowledge
* Cultural sensitivities

Desired Characteristics

* Experience with groups; Knowledge of group dynamics
* Good interaction and experience with the participating GP
* Not condescending to patients
* Able to shift the discussion quickly when necessary
* A sense of humour often required to move patients on/break the ice etc.
* No conflict of interest, such as desire to sell a product/service etc.
* Acute consciousness of the time and how much should be spent with individual patients, so that all are guaranteed a consultation with the doctor
* Awareness of one’s limitations and hence not likely to provide incorrect information

Roles

* Help plan the SMA from the outset
* Act as a ‘champion’ for the program
* Have materials, documents, patient records ready on the day
* Be first in the room on the day
* Set up whiteboard discussions with appropriate patient records
* Work with the doctor/PN during the session
* Move consultations along by keeping the doctor on time for getting out of the room
* Answer patient questions before and after the session and assist the doctor if called for during the consultation.
* Limit dominant patients; Bring out shy patients
* Keep the session flowing
* Wrap up the session and provide prescriptions/referrals etc.
1. **DOCTOR**

As the attending doctor is required to do no more than their normal doctoring (except in front of a participating audience) no extra training is required. However, certain characteristics are desirable:

Competencies

* Preferably knowledge in lifestyle and behavioural determinants of chronic disease
* Preferably some experience with motivational interviewing and behaviour modification

Desired Characteristics

* Interest in change/efficiency
* Openness for discussion and willingness to learn from patients and Facilitator
* Not threatened by the knowledge of others
* Empathy and understanding of patient’s problem
* Sense of humour?
* Respectful of health literacy and need for ensuring this amongst patients

Roles

* Standard medical care
* Work with documenter/facilitator
* Refer to PN for vitals if appropriate to the group
* Answer patient questions but be prepared also to listen to others.
1. **PRACTICE NURSE**

A practice nurse (other than the facilitator) may be involved in carrying out basic observations (in a physical shared medical appointment), doing on the spot checks (e.g. foot and eye checks), adding records to the board etc.

Competencies

* Able to conduct basic observations
* Good in a potential emergency
* Good people skills
* Not easily upset

Desired Characteristics

* Needs to be engaging
* Outgoing
* Team player
* Quick in carrying out nurse’s duties

Roles

* Take vitals measurements at the start of the session if this is required (in a PSMA)
* Join in the discussion if asked or through the doctor if appropriate
* Take private measures in a separate room (if needed)
1. **DOCUMENTER**

Under normal circumstances, the documenter is the facilitator. However if the budget allows, a specialist documenter, who may be a typist, receptionist or nurse, might be used to take limited medical records.

Competencies

* Typing skills
* Able to print prescriptions, referrals on direction of the Doctor

Desired Characteristics

* Needs to be unflappable
* Knowledge of medical recording computer programs used
* Needs to have a good rapport with the doctor and facilitator
* Able to multi-task with limited effort

 Roles

* Write in medical records
* Follow the GP
* Check records with the GP after each patient preferably
* Provide prescriptions/referrals etc. to patients after the group
1. **Document templates you will need**
* Appendix I: [SMA Patient Confidentiality template](http://lifestylemedicine.org.au/wp-content/uploads/SMA-Patient-Confidentiality-template.docx)
* Appendix II: [SMA Provider Info template](http://lifestylemedicine.org.au/wp-content/uploads/SMA-Provider-Info-template.docx)
* Appendix III:[SMA Patient Info template](http://lifestylemedicine.org.au/wp-content/uploads/SMA-Patient-Info-template.docx)
1. **Planning**

The 4 P’s of Planning for SMAs are:

1. **Personnel**

You will need a ‘champion’. This could be a receptionist, facilitator, practice nurse or everyone. The champion will need to have a passion for SMAs and a need to want to drive the process within the clinic. Their motivation for doing so should come from:

* A desire to do something different
* A passion for improving patient health
* An interest in improving the image/ efficiency of the centre
* An interest in having more fun in health care provision!

Invitations to attend should come from the attending doctor

1. **Product**

The Unique Selling Points (USPs) of SMAs for patients include the following:

* peer support
* having more time with the doctor
* hearing other people’s experience
* learning from others
* having questions answered that you may not have thought to ask

The Unique Selling Points (USPs) of SMAs for providers include the following:

* less repetition
* seeing patients’ help each other
* being more relaxed in the consultation
* not having to enter medical records
* enjoying the consultation process more
1. **Price**

In the future, SMAs may be covered by a special item number, but for now, Medicare item numbers need to be used in the most appropriate way. A special fee cannot be charged for the facilitator; this person must be covered by medical payments. Co-payments can also be used for specialist programs (e.g. GutBusters, quitting smoking etc.)

1. **Place**

Although your SMA will be catering for 10-12 people (as well as 2-4 health professionals) an exceptionally big room is not required because people do not usually move around during the session. A reasonably sized consulting room can often suffice.

Seating should be arranged in a semi-circular situation with the doctor and facilitator at the front of the room and the facilitator with access to the computer or other form of medical recording as well as the white board or butcher’s paper.

1. **Marketing**

The 4 M’s of Marketing are as follows:

**a. Market**

SMAs can be run with almost any audience. They can be homogeneous or heterogeneous and cover general areas like chronic disease, pain, Indigenous health, newborn babies etc., They can also cover specialty areas such as dermatology, rheumatology, cancer rehabilitation, cardiac rehabilitation etc. It is generally though that homogeneous groups (e.g. diabetes, heart disease, asthma etc.) are the most effective and easiest to run. Homogeneous groups are preferred in the early stages of setting up an SMA program.

**b. Media**

Promotional media include:

* Brochures/flyers/handouts for patients
* Local media
* You-tube clips such as at https://www.youtube.com/watch?v=Q7tiCU0t5zc&feature=youtu.be
* SMS or e-mails sent to patients
* Posters for surgery

**c. Message**

The main message about SMAs that need to be conveyed to patients are that SMAs are:

* New
* Fun
* Interesting
* Allow more time with your doctor
* Offer support from other people with similar problems

**d. Method**

Patients can be provided information and invitations through staff. If this comes directly from the doctor, there is an 80-90% return rate of participants. If from the nurse, this percentage drops to about half, and if from reception staff, the percentage decreases even more. However, some staff do have greater abilities to attract patients and hence should never be ignored. After identifying the type of SMA and patients who may be interested, it is relatively easy to compile a list of SMA numbers or e-mails off the medical record program (e.g. all men with a BMI>35 aged 40+ etc). A message promoting the program can then be sent to ~ 10 times the number (120-150) required in order to get a group of 10-12 for the SMA.

1. **Running SMAs**
2. **Materials required on the day**

 On the day, the following is required:

* A whiteboard (or butcher’s paper + blue tack if this is not available). This can be stuck on the wall of the room to be used with the following lay-out (after permission from patients):
	+ First name   HBa1C (or FPG)   BP   Tg   Wt   WC   Issues for today
	+ Other columns may be added depending on the group.
* Non-permanent white board pen (if using white board)
* Patients booked in and confirmed
* Confidentiality agreement

 Optional:

* Tape recorder
* Patient hand-outs if appropriate
1. **The role of the facilitator**
* Do all the preparations for the group.
* Warm-up the group for when the doctor comes in.
* Prepare patient records and record today’s notes on the clinic’s medical record program (unless a specialist documenter is used).
* Set up the room for the doctor, patients and facilitator such that the facilitator can keep medical records on the computer as well as control the group.
* Direct the doctor to each patient and keep him or her on time.
* Signal the doctor in a pre-arranged fashion as to when to come into the group session.
* Advise the doctor when to leave the group.
* Control the group by politely interrupting patients who are dominating the discussion and bringing out those who may not have had a chance to talk.
* Arrange any post-clinic prescriptions, referrals etc.
* Carry out simple observations (e.g. blood pressure) if necessary before the commencement of the group.
* Keep the process running smoothly by making it enjoyable for all (preferably with appropriate humour).
* De-brief the patients and doctor and get feedback for next time.
* Have hand-outs ready (if appropriate).
* Where possible, have a summary of patient notes printed out for the doctor and arranged in the order in which patients are likely to be seen.
* When a medical records program is not used, prepare a Word file on a lap-top computer with a page for each patient that can be put into records later.
* Keep medical records to a minimum so the facilitator is not distracted from the main role of running (and possibly contributing to) the group.
1. **Tips for Facilitators**
* Do not say that you have read something somewhere – only speak up if you have information that is evidence-based.
* Do not EVER disagree with the doctor in front of the group – discuss it with him or her in a de-brief later (continuous improvement de-brief.)
* Know what you do not know – never interrupt on a topic where you can’t cite evidence or direct experience for what you say.
* Check with the doctor that it is alright to add information when you think you have something important to add.
* If people start to talk amongst themselves or disrupt the group, politely ask them to keep the conversation until later as they might be missing something.
* Try to keep the initial consultations on time to keep within the hour. If these first patients take too long, those at the end will be rushed and will feel cheated by not getting their share.
* If the occasion arises i.e. a patient has tried something that works for them, or has something unusual, ask the rest of the group if anyone else has done/had that and how they dealt with it.
* Roll with resistance – never get into an argument with a patient

Remember: *“It takes many years for someone to find out how much you know, but only one sentence to find out how much you don’t.”*

1. **The flow of a typical SMA**
* Patients book an appointment and are reminded before the day
* Group is over-booked to allow for typical drop-outs (of 10-20%)
* Patients sign confidentiality agreements (this should be done before every group and kept on record)
* Facilitator starts writing records on the board and asks each attendee as they arrive if there is something s/he would like to discuss with the doctor today. This is then written alongside that patient’s name on the board.
* Once the group is assembled the facilitator explains the ‘rules’ of the group:
	+ Turn off mobile phones
	+ no talking to others during each consultation
	+ facilitator may interrupt a consultation/discussion to move the proceedings along
	+ arrangements for personal matters to be considered at another time
* If a physical SMA, the nurse will start individual measurements 20 minutes before the doctor comes in as each patient enters the room and continues through the consultation until completed and entered on the board
* In the case of a specialist SMA (weight control, quitting smoking etc.), the facilitator may introduce topics to be discussed during that session and hand out special materials/equipment (such as a tape measure.) They may also demonstrate how to take waist circumference measures, etc.
* When this is complete, and on a signal the doctor enters the room and begins personal consultations, beginning at a point decided by the facilitator.
* The facilitator keeps the group involved if the doctor needs to get up and examine a patient.
* The facilitator or documenter records limited medical notes, prints a prescription if necessary, or writes a referral, which can be picked up at the end of the session.
* After each consultation the facilitator moves the doctor onto the next patient
* When all consultations are complete (1 hour max), the facilitator asks if there are any more questions for the doctor before they have to go.
* The doctor leaves the room and the facilitator continues the discussion or answers questions until everyone is satisfied.
1. **Preparations**

 Before the day

* Do all the preparations for the group
* Arrange a suitable room/venue
* Decide on model to be used
* Confirm availability with appropriate staff
* Decide on a date and time
* Get doctors/staff to invite appropriate patients
* Get confirmation from patients through reception
* Overbook session (i.e. 15 to get 12; 9 to get 6)
* Book names and phone numbers (SMS’s) into booking sheet
* Buy name tags/pen for writing on board/butcher’s paper
* Get patient records to write on board
* Have patient hand-outs ready (if appropriate)

 On the day

 Arrive at least 30 minutes early in order to:

* Get patients to sign confidentiality agreements before starting
* Set up white-board, butchers paper with first name and measures appropriate for the session e.g. HBA1C (for diabetes); Tg, BP
* Leave space for issues patient would like to discuss
* Arrange seating in semi-circle
* Arrange computer with patient records in centre of GP & Facilitator
* If possible have all patient records open on medical records
* Alternatively, have a list of last names to call up on screen as they are consulted
* Welcome patients into room and explain the process

**A typical introduction**

*“Hi and thanks for coming to this Shared Medical Appointment. Can I first ask you to switch off mobile phones so we won’t be interrupted in this group? A Shared Medical Appointment is a new concept in medical care, which enables you all to contribute to the care of each other, with the help of the doctor. You’ll each get a chance to ask questions of the doctor individually, just like an ordinary medical appointment – except that there will be other people watching and listening and possibly also adding their experiences to your consult. I’ll be keeping the doctor on time, which means I’ll have to cut in if you talk too much and ask if we can move on. Hopefully any extra questions you want to ask will come out later or from someone else. I’ll also try to make sure that anyone who is a bit quiet gets their turn. The only thing I ask is that you listen to everything that’s going on – contribute if you like – but don’t talk to the person next to you or shift attention away from the main consultation. I’m sure you’ll find everything interesting and will learn a lot from each other. So, let’s get the doctor in and get started.”*

Event

* (If nurse) Carry out simple observations (e.g. blood pressure) if necessary before the
commencement of the group.
* Ask each patient if s/he has anything particular to talk about and write this on the board.
* Warm-up the group for when the doctor comes in.
* Signal doctor to enter the room when ready.
* Record notes on the Clinic’s Medical Records program (unless a specialist documenter is used.)
* Where a medical records program is not used, prepare a Word file on a lap-top with a page for each patient to be later put into medical records.
* Direct the doctor to each patient and keep him/her on time.
* Control the group by politely interrupting dominating patients and bringing out those who may not have had a chance to talk. Keep the process running smoothly by making it enjoyable to all (preferably with appropriate humour).
* Advise the doctor when to leave the room.

Post-event

* Arrange any post-clinic prescriptions, referrals etc.
* De-brief the patients and doctor (separately) to identify things that may need changing for next time
* Contact patients (if necessary) to provide extra materials discussed in group
1. **Evaluating SMA Performance**

**For your centre**

* De-brief with group:

*“What did you think of this session?”*
*“What would you like to see more of?”*
*“What would you like to see less of?”*
*“Would you come again? How regularly?”*

* De-brief with doctor/staff

*“What worked? What didn’t work?”*
*“What could be done better next time?”*

**For National Records**

* Medical Records (coded):
BP, Weight, Waist Circumference; body fat %, Tg, Lipids,
HBA1C, Spirometry, Grip strength, number of visits.

**APPENDIX I – SMA Confidentiality Agreement**

Shared Medical Appointment

Confidentiality Agreement

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please tick the box at the end of the statement which reflects your response:*

*I understand that my participation is voluntary and I understand that I can cease my participation at any time.*

* *Yes □ No □*

*I agree to keep confidential the identities of people who might participate in this appointment with me and the information they might share with myself and others.*

* *Yes □ No □*

*Participant’s Name:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Participant’s Signature:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX II – SMA Provider Information Sheet**

 **Shared Medical Appointments: Provider Information sheet**

***About Shared Medical Appointments (SMAs)***

SMAs (also called ‘Group Visits’) are: “*a series of consults sequentially attending to each patient’s unique medical needs individually, but in a supportive group setting where all can listen, interact, and learn*.”SMAs are popular in the US and Canada, and are starting to take off in Europe and other parts of the world.

***Rationale***

Traditionally, health care has been in a 1:1 consult situation. And while this has worked with infectious disease, it is less appropriate for the ~70% of primary care visits now due to chronic diseases. **Shared Medical Appointments** were started in the US in the 1990s ([www.GroupVisits.com](http://www.GroupVisits.com)) as a way of providing better care for patients with chronic diseases or conditions.

***How SMAs work***

The health care delivery team for SMAs is typically led by a general practitioner (GP), or Practice Nurse. The team includes a group facilitator (e.g. psychologist, nurse, diabetes educator) and sometimes a pharmacist, dietitian, exercise physiologist or other allied health professional (AHP). A documenter may be included to record medical notes as care is being delivered. Throughout the session (typically about 90 minutes), GPs are involved in the usual tasks of history-taking, examination, medical decision-making and advising patients in conjunction with AHPs. As such, an SMA is a comprehensive medical visit, not just a group education session, where added value comes from peer interaction, particularly around aspects of self-management and empowerment.

***Patients benefit from SMAs through -***

• Improved quality of, and access to care

• Extra time with their 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

***Clinicians benefit from SMAs through -***

• Increased productivity and cost/time effectiveness

• Better management of waiting lists

• Reduced repetition of information/advice

• An opportunity to get off the fast-paced treadmill of individual visits

• A chance to get to know patients better in an interactive setting

• Real help from the multi-disciplinary team with the opportunity to coordinate multi-disciplinary care plans

**References**:

There are over 400 peer-reviewed articles on SMAs most of which show the superiority of these over 1:1 consultations in a range of disease conditions. See <http://lifestylemedicine.org.au/shared-medical-appointments> for up to date references and resources.

**APPENDIX III – SMA Patient Information Sheet**

 **Shared Medical Appointments: Patient Information sheet**

You have been invited by your Doctor to participate in a new and exciting medical consultation called a ***Shared Medical Appointment (SMA)****.* Instead of seeing your doctor alone, you’ll be with 8 to 12 other people with similar health issues. The consultation will last for 90 minutes, and can include other health professionals, like your Nurse or Diabetes Educator.

***What are Shared Medical Appointments (SMAs)?***

SMAs (also called ‘Group Visits’) are: “a series of individual consults sequentially attending to each patient’s unique medical needs in a supportive group setting where all can listen, interact, and learn.” SMAs are popular in North America, and are now becoming popular in other parts of the world.

***Why should I try a Shared Medical Appointment?***

• You get longer to talk to your doctor in a relaxed environment;

• Others with similar health issues support you and each other;

• You (or someone) gets to ask the question(s) you might not have otherwise thought of;

• It’s fun – for you and your health care providers!

***Can I get my usual prescriptions/medical advice this way?***

• Yes. A **Shared Medical Appointment** is exactly the same as an individual appointment – except there are other people there, so it’s more helpful and more satisfying – for you and your doctor.

***What about confidentiality?***

• Anything personal can be discussed with your GP or Nurse in a private ‘break out’ room;

• All attendees are asked to sign a confidentiality agreement such that anything that is said in the consultation is not spoken about outside;

***What does my doctor/nurse think of this?***

• Health professionals love SMAs because they have more time with you and don’t have to repeat themselves to individual patients. They’re more relaxed and can help you more.

**APPENDIX XXXXX – SMA: Technical Information**

 **Shared Medical Appointments: Technical Information**

***Billing***

Billing in the US is through individual billing through Medicare and Medicaid. Discussions are continuing with the MBS in Australia about billing individuals under an item 23 and/or other item numbers in the MBS.

***Confidentiality***

Patients are asked to sign a confidentiality form before attending the group session to agree to not discuss issues outside the group. In over 100,000 consultations in the US, confidentiality has never been an issue.

***Provider Personnel***

The group facilitator is usually the only provider in the room who is required to do anything different to a normal consultation. Because the Facilitator is responsible for controlling the group dynamics, this person must be skilled in group processes. The medical record Documenter is also important for the group (if used) but needs only to be a trained, efficient typist. Special training (e.g. through the Australasian Society of Lifestyle Medicine) is advised for Medical Centres planning to run SMAs, and particularly for selection and training of Facilitators before planning an SMA. A Diabetes Educator, Exercise Physiologist, Nurse, Dietitian or Psychologist is recommended as a Facilitator because of group skills and billing options.

***What your clinic will need to run SMAs?***

*•* An open area big enough to seat 12-15 people, preferably with a break off consulting room nearby

• Comfortable chairs to seat up to 15 people

• A trained Facilitator and typist (if Medical Records are to be kept in real time), GP and Practice Nurse

• Some healthy refreshments (nibbles, drinks etc.). These are optional.

***For shy Providers***

GPs who may not be comfortable in groups, usually find SMAs even more comfortable than 1:1 consults over time. It is imperative that the Facilitator be trained and experienced in working with groups.

**An Example of an SMA in practice**:

Ten Type 2 diabetic patients who have care plans in place have opted to attend a SMA for 90 minutes in a multi-disciplinary medical centre. Patients are seated in a circular arrangement in a room with a white board and computer facilities. One small examination room is adjacent in which a practice nurse (PN) can take basic observations. Light refreshments are offered. All patients have received a package of information explaining the group consultations and what to expect. All have signed confidentiality agreements.

The session is explained by the appointed Facilitator (nurse, psychologist or diabetes educator etc.) and questions answered. The GP enters the room and proceeds to consult with patients one at a time providing advice, explaining significant findings from records and taking questions and input from others, with the process managed through the facilitator. Self-management education is discussed with the whole group and individual prescriptions and pathology requests are printed out as needed. Medical records, including the diabetes cycle of care requirements, are kept by the Documenter. If Privacy is needed the patient is taken into an exam room by the GP or PN while the facilitator or GP continues the discussion with the remaining group.

All patients can interact with the GP, peers and other health professionals present over 60 minutes, after which the GP leaves the room and any further discussion is finalised with the PN and facilitator.

MBS items claimable vary depending on time taken with each patient. However either an item 23 or 36 is billed and care plan reviews (732) and the monitoring and support nurse item number (10997) may be used. If ECGs or additional procedures are required these items can also be claimed.

Follow up visits are made according to individual requirements and patients are given the opportunity to book in to further SMAs or regular DIGMAs (‘Drop in Group Medical Appointments’) if desired.

**APPENDIX XXXXX – Article: The doctor will see you ALL now**

The Australasian Society of Lifestyle Medicine (ASLM) has been pioneering Shared Medical Appointments (SMAs) in Australasia for some years, including conducting pilot trials and advocating for the concept to be recognised within the current Medicare reimbursement system.

Also known as ‘Group Visits’ or ‘Drop in Group Medical Appointments’ in the US, an SMA is, “A series of consecutive individual medical consultations in a supportive group setting where all can listen, interact, and learn.” As such an SMA is a both an individual consultation and a group education session.

There are numerous studies into the SMA model around the world, consistently pointing to improved patient outcomes, increased practitioner and patient satisfaction, and overall cost and resource effectiveness, but only a handful of studies in Australia to date.

Traditionally, medical consultations have been carried out in a 1:1 situation; an ‘expert’ (doctor) consulting with one patient. This has served us well, and still does with injuries and infectious diseases. But the rise in chronic diseases with the modernisation of society has dramatically altered the clinical landscape.

No longer is a pharmaceutical prescription, a doctor’s advice, or surgery, sufficient or necessarily appropriate to manage what can amount to complex, lifetime, metabolic, cardiovascular, respiratory or carcinogenic disorders.

In the past, attempts have been made to address this by the development of education sessions (e.g.: diabetes education), usually involving one health ‘expert’ and a patient group of say, 10-20 people.  But group education lacks medical input and the 1:1 consultation lacks an education component. Hence another model was still needed.



The minimal ‘team’ for an SMA is a doctor and a trained facilitator. In an SMA, the doctor carries out his/her doctoring, but with other patients watching.  The facilitator introduces the group, writes records and questions on a board, assists the doctor with information, controls the group dynamics, and in some cases writes the medical records.

Other personnel can include a documenter (to keep medical records), a Practice Nurse (for carrying out pre-group observations) or other allied health professionals according to the group needs and financial availability.

Importantly, ASLM has developed an SMA Protocol, provides training for doctors and potential facilitators, and a system of ongoing review and peer support for those delivering Shared Medical Appointments.

Billing however, is not yet clear with lack of clarification from Medicare as to whether individual consultations held in the presence of others can be billed under an Item 23, yet an SMA is even less suited to group education item numbers given that a series of consultation takes place in the session. Despite this uncertainty, uptake of SMAs is gaining pace with numerous medical centres requesting training and putting SMAs into practice in their clinics.

Finally, it’s worth noting that with the advent of the government’s ‘Health Care Home’ trial, the system of Medicare reimbursement is clearly under review, and likely to move towards a system which rewards doctors and their practices for proactively managing chronic disease and improving health and wellbeing in their patient populations. Subject to any future model not further disadvantaging doctors, such as been happening with the current Medicare rebate freeze, ASLM cautiously welcomes this direction.

The SMA is ideally suited to be the mainstay of the Health Care Home. It represents a quantum leap forward in chronic disease management and a step towards a more modern, effective health care system.

Doctors, practice managers and stakeholders wanting to hold SMA facilitator training in their practice or Primary Health Network should get in touch with ASLM.  Feedback from a recent SMA training workshop is shown below.

**APPENDIX XXXXX – SMA Facilitators**

**Pre-requisites for SMA facilitators**

* Tertiary training in an appropriate health sciences field or as considered on application
* Excellent language and communication skills
* Some group dynamics experience
* People skills
* Basic knowledge in chronic disease management

Only those wanting to go on to become certified by ASLM as an SMA facilitator (usually allied health practitioners) need go through the whole process below, however doctors and other personnel not intending to become facilitators, should still complete the first three dot points below.

It is highly recommended for doctors intending to participate in SMAs, other practitioners and staff in the practice, especially the practice manager and nurses, to ensure that everyone understands the protocol and is able to explain and promote it to patients.

**The usual process for SMA facilitator certification is**

* Attend a workshop, or for those who can’t attend a workshop, watch all the videos
* Read through all the other pages in this section
* Complete a short exam at the end of the workshop or the online version (coming soon)
* At this stage, you become ‘provisionally certified’ as an ASLM SMA facilitator
* Plan and conduct your first SMA
* Submit a brief report of the SMA, especially in respect of any challenges faced, what you learned and where improvement is needed, for peer review. A format will be provided for this
* On receipt of our reply to your review, you will be fully certified for three years
* Continue conducting SMAs, keeping aggregate data as you go (a format will be provided for this), especially:
	+ Date and location (eg: XYZ medical centre)
	+ Duration and topic area, eg: diabetes group, overweight group, etc
	+ Names of doctor, facilitator (yourself), documenter, etc
	+ Number of participants
	+ Summative comment as to the success or otherwise of the group, learnings, etc
* Submit a brief annual report of the SMAs you have conducted using the aggregate data above along with a reflection as per your report of your first SMA
* Keep in touch with us and let us know of any challenges or problems you encounter
* Expect to re-certify after three years – this will be a brief online refresher module (to be developed) which will also continue your access to this section of the website. This is where updates and the latest resources will be posted as they come to hand.

**APPENDIX SSSSS - Case studies from the initial research**

Pete

Pete is a 48 year-old overweight, insulin dependent, truck driver. At his first SMA, Pete refused to sit, but stood near the exit door, arms folded, obviously ready to make his escape. “I don’t know why I’m here”, he said angrily when asked if he wanted to sit down in a spare chair. When given a chance to talk, Pete explained that there was no point in medical treatment for him as no one listened to him anyway. He had told several doctors about his phobia of needles and how he could not inject, but told he had to manage his own diabetes anyway. “I really couldn’t give a shit if I die,” he told the facilitator. “ No-one else does – and I’ve been to doctors and specialists all over the place – so why should I? By the end of session one, and after listening to others and becoming more interactive, Pete was seated and making the occasional funny interjection. He stayed after the group to tell to the Facilitator that he had learned more in this session than he had in all his other medical appointments and was keen to come back. For session 2, Pete was one of the first to arrive. He was jovial and expressive and responded well when the doctor referred him to a psychologist to deal with his needle phobia.

Dave

Dave turned up to his second diabetes SMA with a sugar free cake that he had cooked especially for the group. Dave is in his early 40s and has had HIV and all its complications for 10 years. He had a cancerous scrotum removed, a heart attack two years before that, suffered serious kidney problems, and type 2 diabetes. After confiding all this to the group during session 1, Dave was asked at the end the session whether he had enjoyed the SMA process and why. He responded, “It makes you realize you’re not so badly off when you hear everyone else’s problems.”

Susan

In their first SMA, Susan heard John admit to the group that his blood sugars sometimes rise to the mid 20’s at nighttime and that his insulin use was erratic. The GP’s response was surprise: “You never told me that,” he said. John’s response was lackadaisical: “ I didn’t think it really mattered.” Susan complained of lack of sleep, but only in her second SMA did she admit she solved the problem, which was caused by drinking 70 cans of full strength coke each week. In a post group de-brief, the doctor admitted: “I would never have found this out in a single consultation.”

Frank

Frank, a 50 year old Type 2 diabetic was sheepish when asked about his insulin management in his first SMA in regional NSW. In a soft voice and with head bowed he told the doctor that he had stopped taking insulin. When questioned about the effect of this, he said his blood sugars were within the normal range and much lower than before. When asked what he had done differently that might have had this effect Frank almost apologetically told the doctor: “I started lifting weights.” When told by the Facilitator, who is experienced in exercise prescription, that this was one of the best forms of exercise for type 2 diabetes, Frank straightened up in his chair, appeared suddenly quite pleased with himself and started confidently contributing more to the rest of the group session. He told the group organizer after the group: “This was the best medical appointment I’ve ever been to.”

Kerry

As the last to be consulted in a group of overweight and obese men, Kerry, an IT consultant, admitted to a good diet, but an anxiety problem that prevented him from exercising because he feared having a heart attack. At the end of the session, Kerry was approached by Bob, who explained that he and a couple of the other men had a walking group and they’d be happy to come around and get him to go for a walk with them. Kerry agreed to it, because, he claimed: “ As long as I’m not left alone to think, I’m OK.”

Chris

Chris lost 7.5 kilos in one month (from 145 kg). “I wish I had got onto these groups earlier when I was first diagnosed with diabetes because you get blasé about your medication. This would have helped me know what I was in for earlier.” He now has a long-term goal of getting his waist down from 138 to 102 even though he was told that just a 10% drop would be enough for him at this stage. The eczema on his leg went away.

Bill

Bill was a typical recalcitrant at his first SMA. Suffering from bipolar, as well as Type 2 diabetes he was in line for a cardiac bypass which he said he could not be bothered having. He was more animated at the end of this first session and quite excited to be at the second. By the third SMA he had had his bypass and was exuberant about the fact that this would never have happened if he had not come to the first SMA, which he said was the most informative health session he had been in.

Mike

As an ex top level Rugby player, Mike almost did not accept his diabetes. It was only after a discussion and demonstration by the doctor on feet in his first group session that it clicked that the pain under his instep could be related. After he purchased a ‘foot ball foot support’ as advised by the Doctor, he appeared at the third group and was happy that he was able to walk again, and his diabetes was under better control.

Ken

Ken had a head injury and claimed to not understand much of what was going on in session 1 of a GutBuster program. However, he took to meal replacements and discovered a cheap supply of Optislim from Chemist’s Warehouse. He also went onto ‘Lite’N’Easy’ foods as he lives alone. By session 2 he had lost 3 kg, his blood pressure was down and he understood things more clearly. He claims to have a lot more energy now and is motivated to keep losing weight.

Referrals

In one group of Indigenous men from a Northern NSW town, three were aware of problems that needed further medical attention which they had ignored for some time. Group and peer pressure from other men encouraged all three to book an appointment at the local Aboriginal Medical Service that afternoon for tests, which could prove to be life, and  ultimately cost-saving.

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* <http://lifestylemedicine.org.au/about/lifestyle-medicine/>

**SMA videos**

* [Creating Opportunities for Group Medical Visits (https://www.youtube.com/watch?v=mCmj2ygPeyo)](https://www.youtube.com/watch?v=mCmj2ygPeyo)
* [Drop-In Group Medical Appointments (https://www.youtube.com/watch?v=vVYopUNxf78)](https://www.youtube.com/watch?v=vVYopUNxf78)
* [Group Medical Visits Need a Reimbursement Code (https://www.youtube.com/watch?v=6jGlUZHT7LI)](https://www.youtube.com/watch?v=6jGlUZHT7LI)
* [What to Expect From Shared Doctor Appointments (http://www.wsj.com/video/what-to-expect-from-shared-doctor-appointments/1136B25B-14FC-42FB-9546-706A95661123.html)](http://www.wsj.com/video/what-to-expect-from-shared-doctor-appointments/1136B25B-14FC-42FB-9546-706A95661123.html)
* [Shared Medical Appointment Overview (https://www.youtube.com/watch?v=YUcGhfGbjSY&feature=youtu.be)](https://www.youtube.com/watch?v=YUcGhfGbjSY&feature=youtu.be)
* [Shared Medical Appointments (https://www.youtube.com/watch?v=3Mq7QjuuaoI)](https://www.youtube.com/watch?v=3Mq7QjuuaoI)
* [Shared Appointments for Diabetes Education (https://www.youtube.com/watch?v=d9jKqXoEGvs)](https://www.youtube.com/watch?v=d9jKqXoEGvs)
* [Diabetes Program at Grant Creek Family Medicine in Montana (https://www.youtube.com/watch?v=N1s](https://www.youtube.com/watch?v=N1s-eGAYGL8)