CT Primary Care Payment Reform
Draft Capabilities Skeleton: Shared Medical Appointments
This Draft: July 19

Please go to the survey to rate this capability's impact as high, medium or low on the following criteria:

Aim
Health promotion/prevention
Improved quality and outcomes
Patient experience
Provider satisfaction
Lower Cost

Understanding the Need

The Problem:
Patients with complex or chronic medical conditions feel that typically brief office visits do not allow enough time to have questions answered and cover all the issues with self-management. Patients may also face social isolation, low health literacy, and cultural norms that impact their ability to effectively access care and manage their conditions. These patients may become "high utilizers" of the health care system, particularly of emergency departments and urgent care centers—which tends to make them even less satisfied with their health care experience and more likely to have poor outcomes. Clinicians seek strategies to improve access to care, cost effectiveness, clinician capacity and job satisfaction.

Proven Strategy:
Name: Shared Medical Appointments (SMAs)

Definition: Shared Medical Appointments (SMAs) are a form of group visit for patients with similar medical conditions. During an SMA, a clinical team offers physical check-ins, education about self-management, life style coaching and prevention. Participation in this group becomes part of their regular clinical treatment (AHRQ, 2017). A multi-disciplinary team includes roles such as a "behaviorist"/facilitator, a documenter, a Physician/Nurse/LPN /MA and a Care Coordinator. In this "one-stop" model, patients have more relaxed time with clinical staff and have an opportunity to ask questions about their condition and care and obtain peer support and information about community resources. SMAs allow clinicians to see patients on a regular basis and provide higher quality care with less repetition, more engagement and better insight into patients' specific needs. (Noffsinger, 2009).

SMA sessions usually last from 60 to 120 minutes. Sessions usually have part of their time set aside for social integration, part set aside for interactive education, and part committed to changes in the care plan for the common condition. The education piece is designed to improve self-management skills; educators will often be formally trained in skills such as motivational interviewing to help patients enhance their self-management. Because they involve self-management improvement along with medication intensification, SMAs have the potential to coordinate these strategies to maximize the effects of each (Edelman, 2012).

A critical component of SMAs is also peer support. Group visits with peers who have the same chronic illness can share similar life experiences and offer each other support with new behavioral and/or medical regimens, which has found be effective in helping individuals improve self-management skills and disease outcomes (Kirsh, et al., 2018).

Intended Outcomes:

- The patients and clinical staff benefit from the less formal, face-to-face interactions that are appropriate for the group, including health literacy, language, cultural and community connections.

- More convenient meeting locations can allow patients to appear at meetings and improve compliance especially for patients who do not otherwise keep appointments.
- Reduces barriers to accessing condition-specific education and support services by connecting to medical services.
- Clinical staff can work more creatively to help patients move towards better self-management of their condition.
- Provides opportunities for peer-to-peer support that may help patients overcome cultural barriers and social isolation that hinder condition management

Consumer Needs: *the following bullets are offered as a starting point for discussion.*

- More frequent access to medical/social services; adds peer supports
- Child care, availability of care givers can be a barrier to care. SMAs present an opportunity to schedule at more convenient times (evenings, weekends) than conventional medical appointments
- Consumers need support and community connections to make lifestyle changes. SMA services may include coaching and navigation; assistance connecting to community support services
- SMAs can reduce long wait times for appointments, a barrier identified by consumers

Health Equity Lens: *the following bullets are offered as a starting point for discussion.*

- SMA team may include medical translators or others with cultural insight
- May reduce health literacy barriers through Q&A discussion (rather than lectures)

Implementing the Strategy

Example Scenario: A clinician identifies patients with diabetes who have concerns about how to successfully manage the challenges of that condition. The practice identifies a team to meet with recruited patients. Preparation includes developing educational materials, updating patient records, contacting patients and organizing meeting space. Meetings last 90-120 minutes and include vital signs and other condition specific measures, educational discussions and opportunity for peer-to-peer contact.

HIT Requirements:

- EMR to record patient vitals and record of visit
- Scribe to assist with collecting information during the meeting
- Accurate patient contact information

Implementation Concerns[1]:

- SMA must set strong ground rules on privacy and confidentiality
- Needs support of entire practice, including staff training
- One of team members needs to be a facilitator
- Need a regular, private place to meet
- Must create and reinforce privacy protections with group members

[1] Payment methods to support new capabilities will be considered as part of the payment model options

- Administrative supports to help set up, prepare materials, billing, etc.

Impact

Aim	Summary of Evidence
Health promotion/prevention	• Patients treated through group visits have shown increased quality of life and improved self-efficacy (Beck, 1997; Blumenfeld, 2003; De Vries, et al, 2008; Jaber, Braskmajer and Trilling, 2006).
Improved quality and outcomes	• Patients treated through group visits have shown decreased emergency department and outpatient utilization (Beck, 1997; Blumenfeld, 2003; De Vries, et al, 2008; Jaber, Braskmajer and Trilling, 2006). • Kaiser Permanente Colorado ran a two-year randomized clinical trial of 400 older patients with chronic illnesses and found that compared to a control group, group visit patient hospitalizations dropped from 39% to 27%. In addition, there were fewer calls to physicians, an increase in the number of calls to nurses, and a drop in annual per patient ED visit rates from 53% to 35%. Kaiser also found a reduction in same-day visits. Urgent care visits fell from 0.3 to 0.24 per patient per year (Beck, A., Scott, J., & Williams, P., 1997).(Houck) • SMA interventions improve biophysical outcomes among patients with diabetes. However, there was inadequate literature to determine SMA effects on patient experience, utilization, and costs (Edelman, 2015).
Patient experience	• 75% of Cleveland Clinic SMA participants gave their visit an overall rating of “excellent” while 60% gave the same rating to their individual visit (Noffsinger 2009). • Harvard Vanguard SMA patients appear more satisfied with their care relative to patients receiving usual care. (Heyworth, 2014) • Sutter Medical Foundation pilot study found that patient satisfaction with SMAs was 4.7 out of 5 points while more than doubling the number of patients seen per week in the participating practices. Wait list times decreased by 45% overall for appointments with primary care and podiatry clinicians. (Noffsinger 2009)
Provider satisfaction	• The American Academy of Family Physicians (AAFP) believes that group visits are a proven, effective method for enhancing a patient’s self-care of chronic conditions, increasing patient satisfaction, and improving outcomes. • Better connections with patients is cited as one strategy that promotes physician well-being. (Zwack, 2013) • Especially effective for “hopelessly backlogged” physicians and those who find themselves repeating the same

	information many times a day. Physicians value the break in the day and that SMAs are a different, effective and enjoyable form of patient care. (Bronson, 2004)
Lower Cost	• A 1995 British study of SMA participants with diabetes found that overall cost of care per person per year declined by 30 pounds (about $44 in 1995 US dollars) while the cost of care for those in the control group increased by about the same amount.

Please complete the survey on this capability.

APPENDIX

Learning from Others

State and National Scan:

Case Study 1: Harvard Vanguard Medical Associates Beginning in 2009, HVMA has run 86 SMAs in 17 specialties at 12 sites, including Internal Medicine, Family Practice, Ob/Gyn, Cardio, Endo, Neurology, Dermatology, Nephrology, Physiatry with more than 13,000 patient visits. Factors leading to implementation included shortage of physicians, especially in primary care, a sense that the job is not "doable," increasing demand for care and that access will continue to worsen (Millermaier, 2009).

Lessons learned

- Build SMAS into standard work flow with clinicians inviting patients to join,
- Engage administrative support for filling all group sessions, scheduling and reminded patients, prepping materials, identifying space, establishing coding protocols
- Train staff and make a commitment the specific model
- Run a well-structured meeting that starts and ends on time, and continuously soliciting patient feedback.
- One member of the team should be responsible for documentation.

Results:

- High patient satisfaction: Patients participating in SMAs reported overall greater satisfaction with the medical practice (70%) than those who did not have an SMA (48%).
- Higher productivity at HVMA, productivity tracking suggests that internal medicine clinician productivity increases ranged from 12% up to 24% more productive per week, while OB/Gyn productivity increases ranged from 20% up to 29% per clinician per week.

Case Study 2: Hartford HealthCare Medical Group started SMAs in April 2013 for the Medicare-reimbursable annual wellness visit (AWV). No physical examination or patient copay is required and standard risk assessments make for a robust discussion. Couples have the option of a joint visit together.

The AWV SMA team at Hartford HealthCare Medical Group includes a physician, a medical assistant (serving primarily as a documenter), a nurse (obtaining vitals, administering vaccines, and facilitating checkout), and a behaviorist. The SMA is held in a large conference room with ample space to obtain vitals, and it is equipped with a telephone, wireless Internet, projector, printer, and portable copy machine.

Results:

- 95% of patients (18/19) agree or strongly agree that they would recommend a SMA. Most patients felt that their questions were sufficiently answered, were comfortable asking questions in the group environment, and learned from other patients.

Lessons learned:

- Advance preparation work is critical and includes updating medication lists, mailing out patient questionnaires, and performing a chart review to obtain background information and to anticipate the patient's needs for the visit.
- Adhere to the meeting schedule and complete screenings, initial vitals and vision/hearing tests during the SMA while still leaving time for educational and support discussions.

Case Study 3: "Juntos Podemos": A recent Health Affairs article highlighted the story of a Latina agricultural worker struggling to get her diabetes under control, and how an SMA program "Juntos Podemos" ("together we can") shaped her experience. A remote clinic in her agricultural company facilitated Juntos Podemos for patients with diabetes to provide peer-to-peer support for controlling diabetes. The patient faced many barriers to care and self-management of diabetes, including social isolation, long working hours, and low health literacy. Despite having a health coach and glucometer at home, she was not able to lower her glucose levels until joining Juntos Podemos and receiving peer support from another worker with diabetes. The story suggests that fostering interpersonal connections and relationships from peers within the same culture and community through the SMA program resulted in more effective disease management and better health outcomes for this patient (Mavrinac, 2018).

<u>Additional Reading:</u>

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