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Shared Medical Appointments
Part 2: Operationalizing
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Hello and welcome to Part 2 of Shared Medical Appointments: Operationalizing. I'm Karen Ten Cate from the Quality Innovation Network National Coordinating Center who is facilitating this Webinar. The learning objectives for Part 2 is physicians will be able to describe the planning, execution and evaluation of successful Shared Medical Appointments.

Here are the topics for today. We will discuss three key considerations: Purpose, Patients and Providers. We will also take you from initial planning and kick-off to what a session agenda might look like. Then we will cover key logistical details you will see on the right, and wrap up with views of a session debrief with your staff.

With me to explain the ins and outs of these logistics are two experts, Dr. Robert Schreiber and Dr. David A. Guggenheim. Dr. Robert Schreiber is Medical Director of Evidence Based Programs at the Hebrew Senior Life Department of Medicine, and Medical Director of the Healthy Living Center of Excellence. He is also a Clinical Instructor of medicine at Harvard Medical School, all in Boston, Massachusetts. He served as Physician in Chief and CMO of Hebrew Senior Life in Boston from 2004 to 2012. He helped to develop the strategic direction of Hebrew Life Medical Group in home and community based services, long term care and post-acute care. We will call him Rob from this point.

Dr. David A. Guggenheim earned his Bachelor's Degree from the University of Connecticut and Master of Arts and Doctorate of Clinical Psychology from the American School of Professional Psychology in Washington, DC. He began his career at Community Health Center Incorporated, a statewide Federally Qualified Health Center in Connecticut and served as Associate Chief Behavioral Health Officer. Dr. Guggenheim is trained as a coach in the Dartmouth Clinical Microsystems Approach to Performance Improvement and worked closely with research institutions to provide collaborative treatment for chronic pain and addiction. He has led a team in development of shared medical visits for patients living with diabetes and other chronic health conditions. He is also a Geiger Gibson Capstone Fellowship graduate and regularly presents to healthcare teams about integrated mental health and primary care service delivery, and the delivery of care to LGBTQ populations. In his recent role as Chief Mental Health Officer at Callen-Lorde in New York City, Dr. Guggenheim works to expand patient access to integrated LGBTQ sensitive and affirming integrated primary care and mental health services.

I will turn it over first to Dr. Schreiber, after this referred to as Rob.

Dr. Robert Schreiber
Thank you Karen for setting the stage for today's presentation. We're going to now discuss identifying a champion and other stakeholders at the Shared Medical Appointment.

Dave and I both recommend having a physician champion to head up the Shared Medical Appointment initiative at the beginning to help determine which group of patients to target to improve their care and

management. You can also leverage this champion's support at other various levels, including colleagues, other specialists, and even other sites in your organization. At the same time you have to have support and develop a strong team to pull off SMAs, so you need to identify other key stakeholders who will be either on your core team or strong supporters of the effort to enable adequate participation. So this includes other staff members of the healthcare team; but patients and their families and other caregivers can be really instrumental in advocating for these programs with their peers.

Planning the team timeline. The team needs to start meeting at least two months prior to when you want to host your first SMA. Teams need to meet weekly until you agree on the major aspects of your strategy and structure. You need to have a project plan with objectives, time frames, and assign people who will be responsible for carrying out the work. In particular, who is on the planning SMA team? How are you going to identify patients; what criteria do you use? How are you going to enroll them and what's the strategy behind it; the frequency of these sessions; the length of each session; the structure of the session; and the group and one-on-one spaces that would be needed?

I'm going to turn this over now to Dave to discuss how to select a group.

Dr. David A. Guggenheim
Thanks Rob. So you and your healthcare team want to identify a condition of interest and select like individuals to be in the group. For instance, you might choose men with Type 2 diabetes. The patient registry is a great place to start for those of you with an electronic health record; you can take advantage of some database features.

Determining the number of patients. A suggestion that's been widely used for SMAs is taking on the number of patients you normally see in one hour and multiplying that by four. So taking the number of patients you would typically see in an average in your workday and multiplying by four. If you see three patients an hour, you'd want twelve in your group. Rob and I both agree that ten to fourteen is large enough to make it worth your while but not so large that patients feel slighted. And there is literature to back this up.

As I've mentioned in our previous Bite Sized Learning Webinar, I've successfully run groups of twenty to twenty-five patients but it's an undertaking worthy of lots and lots of prep time.

Dr. Robert Schreiber
So now that you have the number of people that does present a problem, only in the sense that you need to really have a goal of what this SMA is going to be. You have now twelve people who may or may not know each other in the room. So we need to create a group situation in which members feel safe, they're able to bond together and feel valued by each other and the group as a whole; and we need to be clear on what the goals and expectations are for themselves and others in the group. If all these things occur, then the patients can relax and concentrate on the subject matter and maximize the benefits they can receive from this group format.

Planning in advance. This is really about planning, planning, planning. Plan every detail in advance to ensure your team is successful, and even run through the flow of your SMA structure in real time prior to your first live visit. Seasoned SMA teams highly recommend this first line event and doing it real time.

You do this to catch unexpected issues, to help the team feel more comfortable, and to ensure that the timing is intact.

Dr. David A. Guggenheim
Yes, as Rob said, planning is a very important part of the process. In my experience running SMAs I've always found that the time spent prepping pays off tenfold. By running through the flow you find out, as Rob said, some unexpected bumps and fix them before you're live.

Dr. Robert Schreiber
Remember, you're doing this in a novel way. A lot of the stakeholders and the health professionals you're working with have never done this before, so it is good to actually go through the process so they have least have a sense of what is coming that first session.

Inviting the group. The first step in setting up these sessions is to have office staff and letters be sent out to eligible patients for the condition of focus. As the time gets closer however, these contacts should be more personalized, and phone calls work better than letters. You want to promote SMAs as an enhancement to the patient's one-on-one office visits and not a replacement, so they see it as more time with their medical provider. The primary care practitioner can recommend these visits also in their continuity visits.

Think about managing no-shows however from the beginning, for these sessions oftentimes will have this as a challenge. When there are no-shows, there should be contact with the patients such as a phone call from office staff to find out what the challenges or barriers were. Motivational interviewing is important in these situations and is critical to help the individuals overcome the issues they face so they can rejoin the group at the next meeting. Have a plan in place to manage these no-shows. You want the group size and content to make it worth your time and the patients'.

Dr. David A. Guggenheim
Yes, and as Rob said accounting for no-shows is crucial. In my experience with SMAs we've always overscheduled based on a no-show rate of about 25-30%. If you have the data you might want to plan based on the number of patients who typically cancel or no-show for their regular appointments in your average workday.

Dr. Robert Schreiber
Now we're going to talk about allowing patients to bring others to the Shared Medical Appointments. As Dave mentioned, you want ten to fourteen patients per group session. But additionally you should allow a patient's spouse, caregiver or significant other to come with them. It's well established that caregiver support can be crucial for health maintenance and helping individuals adopt positive behavior change. This will also allow you as the provider to find out key information from this individual which helps you to help your patient. Whether you explicitly invite the caregivers to a given group is up to your team. You do want to direct your care and teaching to the patients primarily; but caregiver participation, such as questions they may have, can be very helpful to the whole group.

Dr. David A. Guggenheim
So identifying individual patient needs. Before the visit you want to identify individual patient needs by doing a chart review. You might have certain patients that need screenings, vaccinations, behavioral

health consults the same day, or referrals for other services. When I've run these we've had a card system set up. Patients are given materials in a folder, which we'll talk about in a bit, and inside this folder is also a card with the services needed such as blood glucose or vaccines. When the patient sees the nurse or MA they review the cards, see what's needed for the patient, and provide the care as appropriate. It's an easy way to identify and meet the patient needs while they're on site. It's also helpful to have staff update patient demographics at check-in; checking the phone number, making sure it's working, and their insurance or anything else that needs updating.

The roles of each team member. Make sure to establish the role of each team member who's going to take part in your SMA ahead of time. The provider is generally the team champion, but this could also be an RN or an MA or a behavioral health provider as well. And make sure you have a detailed agenda. It's also crucial that you keep a detailed agenda of the one to two hour session to minimize confusion for the team and keep things flowing for the patients.

Dr. Robert Schreiber
Next on the checklist is the room setting. This one may seem obvious, but you will want to plan to have a large enough room available during each scheduled session to accommodate ten to fourteen patients, any significant others, and space for the physician and at least one other practitioner or educator to perform their group interventions. Think through the equipment or teaching materials needed for each session. And you may want space in the back of the room for one person to be charting while the other is talking, such as ideas that come up or parking lot issues. You may have to schedule the room or clear out a space in an existing room to do the SMAs.

So let's now talk about the time frame and parts of the SMA. The time frame is typically two hours and it's composed of five basic parts and one optional part. The first part involves private triage in a separate exam room by an RN. This happens either before the SMA starts or during the SMA.

The second part involves a moderator doing introductions, housekeeping, review of the rules of the road, and making sure certain confidentiality forms and other forms are completed. The third part involves the provider and what they have to say or do in their E&M visits. The fourth part involves the educator and detailed lesson plans are not recommended. These are really more general topics; with specifics but not getting into that specificity.

And the fifth part is really the wrap-up where the moderator comes back, wraps up the session, and then sets the next SMA date. What you also need to build into the sessions is optional time; or private, one-to-one time provider time, specifically to deal with specific issues or challenges the individuals may be having at that time.

Dr. David A. Guggenheim
Thanks Rob. So patient arrival. Ask your patients to arrive about twenty minutes prior to the visit. Your office staff should register the patient, give each patient their HIPAA notice, confidentiality agreement, and also a diabetes follow-up assessment which can be created by the team and be as brief as you want. This will be the forms that your MA or RN can review and address with the patient if needed during the time they're also doing vitals and perhaps checking blood glucose.

Confidentiality. As you would for any one-on-one visit, have patients sign a confidentiality form. But also you need to inform them that what they hear from other patients should stay in the room. This might seem obvious to us as practitioners, but it's a needed step to ensure patients maintain confidentiality for one another.

Setting the mood. Get patients to interact by facilitating and not by talking to them. You can start with some easy, open-ended questions if you have a timid group, and overall you want to make sure most of the questions that you ask are open-ended. Often a patient's caregiver question can lead you to explain what they are most interested in. So a patient or caregiver might bring up a specific topic that interests them and many times that's of interest to the whole group. Try not to lecture, and make sure that you try to keep participation balanced between participants.

You want to employ motivational interviewing techniques to achieve audience engagement. As you're probably aware, motivational interviewing is successfully linked to many positive outcomes for patients. Practitioners who have used MI say it feels like less work for them. They're not as drained at the end of the day. There are resources available for training online, including some great courses that are specific to using motivational interviewing in primary care.

Many who use SMAs recommend their facilitator sit in a circle or half-circle to promote open two-way communication and problem solving. Again, you don't want to lecture; you want to make sure that this is sort of a conversation between participants; so sitting in an audience style row isn't the most effective way to do that. You want to try to make it a conversation using sort of maybe a circle or semi-circle format.

Dr. Robert Schreiber
Thanks Dave. So let's talk about beginning the SMA. Welcome your patients, introduce your team members, and have the patients introduce themselves. Explain the day's agenda and establish if anyone needs to leave early so you can do their one-to-one time or address their issues if needed before they sneak out.

The provider visit. The status quo is that you will do your individual E&M visits in front of the group. So this is something different and new. This allows the group to learn from your clinical information and interaction with the patient, since they often have similar issues. Make clear to patients ahead of time that they have the option of doing a private visit where you take them out during the group time, or a separate time if they so choose. And you may want to continue to interject that at least one other time during your time with them.

Also, if the nature of this SMA necessitates five minutes of private time with each person, then plan to take each one out for five minutes. Most of the chronic conditions you might choose to do an SMA on will not require this. If you are able to budget a scribe, they can chart while you do each E&M. Otherwise you will chart as efficiently as you can during and after the visit. I would say that chart time for a group of ten patients if done all afterwards should not take longer than 50 to 90 minutes, if you need to do this by yourself. Some practices have scribes that are employed for these visits as I mentioned, and this is recommended to help the primary care practitioner be as efficient as possible.

The educator visit or behaviorist really helps furnish the behavior change and intervention after the provider completes the individual E&M visits, and after the provider leaves the SMA. The educator should welcome people and discuss the common problems or prevention strategies for the condition that has been identified by the group or the educator as being important. The educator needs to ask patients what topics they want to discuss that day and at the next SMA visit. Even if you have an agenda, if you put this on a parking lot issue and deal with this at the end of the meeting it will provide you examples and topics of things to be discussed at the next visit. This parking lot list needs to be continually updated so you will be sure to cover all the topics of interest that are brought up.

I'll turn it back to Dave now.

Dr. David A. Guggenheim
Thanks Rob. So after the SMA. At the end of the visit, like with any visit, the physician finished charting. The educator also charts on their service for each patient. The provider conducts team care conferencing for this group of patients, which may be billable too if it's charted. As Rob mentioned, some practices utilize scribes which typically pay for themselves in terms of the number of patients that can be seen and the efficiency. A scribe is a great resource for both individual and group practice.

Evaluation and debrief. Each patient packet should have an evaluation form, which may include length of the session, physical and emotional comfort, if the patient learned something useful to them, and suggestions for future groups. Evaluations are important because they help not only empower the patient, but help us make improvements in our work flows. In my experience we've taken suggestions and made them happen; such as having the nutritionist talk a bit more about affordable food options when trying to eat healthy. That was a suggestion from a patient that we implemented during the next SMA.

It's also important to debrief with the team and to identify what went well and what areas need improvement, and of course celebrate if it was successful.

Some team norms. So this slide points out some more abstract concepts about our groups. You want to be sure the group is run in a way that is relationship centered and patient centered; so you're focusing on the patient and your relationship with them. And you want it to be task oriented; you want to make sure to get through everything that you planned to get through. Keep in mind that the leader is privileged to have that role but that the group belongs to the attendees. The group should pick behavior and change education topics. As I said, when you're asking the group or facilitating open-ended questions, certain topics may come up. Diabetes and oral hygiene, affordable healthy food options; those sorts of things will come up within the group and you'll want to focus on them.

Try not to hog the airways during group interaction, and make sure explanations of certain topics don't get into more detail than necessary. For example, someone might ask about measuring A1C; and you might want to explain the normal levels and how to control A1C rather than the long answer including medical jargon. And make sure to finish on time. Patients and staff expect this.

So some common mistakes that occur when SMAs are run. So one problem is inadequate meeting room space, and as Rob said you want to make sure there is plenty of room. Sometimes team members are

scheduled for an SMA, or not enough of them are scheduled for an SMA. And you want to make sure your team is free and blocked to participate; so block those schedules early.

A lack of administrative support. There is some administrative burden, especially on your first SMA, so you want to make sure you have enough support. You want to make sure you have an adequate, disease specific patient registry. As I said, it's an easy way to identify patients. If you're using an electronic health record you want to use it optimally by being able to pull patient data and identify those patients. You want to make sure you keep topics fresh. Another common mistake is allowing any patient to monopolize the discussion. There are blocking techniques that you can use to help avoid having the group taken over by a single patient.

And you want to make sure you're meeting your census. So you have to do that by making sure that you're overbooking for no-shows. That's a common mistake which is not booking enough patients to account for no-shows and cancellations.

Lastly, lack of staff training. So staff need to be aware and knowledgeable of the topic; not just providers, but all staff.

Dr. Robert Schreiber
So just to add to what Dave said, these are common mistakes and no matter how well you plan these will occur. So it's really important to, one, be aware of them; but also to seek feedback. As Dave mentioned, there is a debriefing and evaluation done by the patients; but it's also not a bad idea to ask patients sort of what went well and what could be improved next time, and just going around in a round-robin sort of way. And then it's important that as you find these areas of opportunity to assign staff to follow up on these issues and report back to the group at the next visit.

So let's talk about the number of SMAs for one group. Note that there is not a requirement or standard; so there's a lot of free rein here. Typically one SMA occurs every two to three months and serves as a supplement to providers' traditional visits in the exam room; as we said, not a replacement.

However, you have to be aware that billing insurers for a large number of providers' individual E&M follow-up visits during the year can trigger an audit by the insurer. So just be prepared and expect this, but it should not be an issue with appropriate documentation.

Karen Ten Cate
This [*inaudible*] the process of operationalizing Shared Medical Appointments, Part 2 of our series. If you have a burning question for Dr. Guggenheim or Dr. Schreiber, they've graciously made their emails available. Here are the references we used to bring you this key information today. We also added in some YouTube videos so you can see other providers in action.

Thank you for participating in this Bite Sized Learning. We hope you found Part 1 and Part 2 useful to your practice. We value your feedback, so please click on the Survey Monkey link in the slide deck that accompanies this recording. Additionally, if you have any feedback you'd like to email us directly, please use this email link: QINNCC@area-d.hcquis.org. Thank you.