



Health gains of group visits



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Is there a role for shared medical appointments in chronic disease management?

TRADITIONALLY, primary care has been carried out in a one-to-one situation, with an expert caregiver and a patient.

The process serves us well with injuries and infectious diseases. However, it is less appropriate for the modern chronic diseases that have a predominantly lifestyle-based aetiology and require longer-term management.

Most of the modern chronic diseases have one, or a combination of, major 'causes'. Dealing with these issues is more of a process than a content issue. How do you motivate people to change unhealthy behaviours in an environment that lures them into an easy and abundant lifestyle that humans have always craved?

The individual consultation is hindered, not only by the limited time available for complex behavioural coaching, but by clinicians' frustration in trying to encourage patients to eat better, exercise more and live a healthier lifestyle. New approaches are needed.

One approach that is fast becoming a popular alternative in the US is shared medical appointments (SMAs), which are commonly referred to as group visits.

Dr Ed Noffsinger, who pioneered SMAs in the 1990s when he was experiencing his own serious illness, dared to imagine a form of care that would better his experience of long waiting times, short and impersonal clinic visits, and poor health outcomes.

He came up with the idea of SMAs, which involve fellow chronic disease sufferers all contributing experiences and peer support. These have since been defined 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, and run with 2-4 appropriate health professionals, including a GP or medical or surgical specialist".

Dr Noffsinger investigated the idea with the US Medicare system and found that, provided a GP conducted individual assessments, the group could be billed at individual rates. This allowed other health professionals to be present and covered financially due to the fact that group visits are efficient (with his models of care often increasing productivity by 200-300%). It guaranteed peer support and advice, highly interactive sessions, and the idea of healthcare as 'fun'.

Sixteen years later, Dr Noffsinger's two forms of group visits – Physical Shared Medical Appointments (PSMAs) for private physical examinations and Drop In Group Medical Appointments (DIGMAs) for follow-up or return visits – have taken off in the US, Holland and Canada. Published evaluations show improved patient outcomes, significantly reduced waiting times, increased efficiency, productivity and patient and provider satisfaction, decreased phone call volume and the need to double-book patients, and reduced costs overall.

In a trial of patients with chronic pain in Western Australia, Dr Stephanie Davies found

improved patient outcomes and drastically reduced follow-up visits. However, the Perth North Metro Medicare Local funded the trial, a practice that is not sustainable in the long term.

The question becomes whether such a system is viable under the Australian Medical Benefits Schedule (MBS). A limited survey by the Australian Lifestyle Medicine Association showed there is a general belief it is not. This is because: (a) it's thought that visits have to be in a (private) one-on-one situation; and (b) confidentiality issues preclude discussions of private medical details in front of others.

Scrutiny of the MBS 2012 schedule, and initial discussions with Medicare, show no restrictions in the MBS relating to point (a). Also point (b) can be overcome (as in the US) by confidentiality agreements. So it may be that such a process has been hindered in Australia by misconceptions.

How would it work here? A group of 10-15 patients with chronic disease would be led by their own doctor with the assistance of a multidisciplinary care team: a behaviourist (a psychologist, practice nurse or

social worker with skills in group dynamics), a specifically trained documenter, and a nurse and/or medical assistant. A GP would be involved in the 1.5-hour session – which involves group interaction, history, assessment, goal setting, behavioural interventions, and the sequential delivery of individualised medical care addressing the unique medical needs of each patient.

When a private physical examination is required, this is done by the doctor in a highly efficient manner (typically using four exam rooms and two nursing personnel) at the beginning of the session while the behaviourist leads discussions in the group room with the other patients.

Comprehensive details of the processes can be found in two books authored by Dr Noffsinger and at www.groupvisits.com.

With the chronic disease epidemic showing no sign of abating, and with healthcare emphasis swinging from short-term to longer-term chronic conditions, the time may be right for a closer scrutiny of SMAs in Australia. The US experience means we would have a template to follow.

References at medobs.com.au