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A user assessment of the potential for shared medical appointments in Australia

Background

In some countries, shared medical appointments (SMAs) have been shown to be more effective than single consultations for managing chronic diseases. Our study was designed as the first stage of a Royal Australian College of General Practitioners (RACGP) funded project to assess potential patient and provider support for SMAs if they were to become available in Australia.

Methods

We conducted focus groups with healthcare providers and patients with diabetes in four large regional health centres in NSW. The data were analysed using rigorous qualitative processes.

Results

Healthcare provider participants appeared overwhelmingly in favour of SMAs, while patients were divided on the process. Where opposed, patients cited concerns about confidentiality and their satisfaction with the status quo.

Discussion

There appears to be a groundswell of interest in SMAs that warrants further investigation in the Australian healthcare system. Issues of reimbursement, homogeneity of groups and training need further consideration.

Keywords

delivery of health care; chronic disease, general practice

Traditionally, medical consultations have been on a one-to-one basis between a health practitioner and a patient. The increased demands of chronic disease management suggest a need for longer involvement of care providers, better self-management by patients and greater opportunity for peer support from fellow patients.¹

We have previously reported on the viability of shared medical appointments (SMAs) or group visits in an Australia context to better support the demands of the rise in chronic diseases.² SMAs 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'.³ As such, an SMA is a comprehensive medical visit, not just a group education session, where significant added value comes from facilitated peer interaction, particularly around aspects of self-management and empowerment.

SMAs were developed in the US in the 1990s and have been successfully trialled in several countries.⁴ There are several SMA models, but the basic approach involves a general practitioner (GP) carrying out personal consultations, a practice nurse assessing vitals on individuals before and during the session, a facilitator controlling the group interaction and a documenter recording medical records for the GP in real time.

Differences between health systems, and patient-provider cultures, suggest that SMAs may not work at the same level in all countries. Therefore assessment is required before the introduction of such a process into the Australian

healthcare system. We report here on the first phase of an RACGP-funded trial to assess attitudes and opinions of healthcare providers and patients towards the concept of SMAs in Australia. The aim was to qualitatively assess patient and provider interest in and attitudes towards SMAs in the Australian primary care context before extending the concept to further testing.

Methods

Focus groups of 8–12 healthcare providers and 8–14 patients with diabetes or pre-diabetes concerns were conducted in four large regional NSW medical centres. These centres were primarily located in lower socio-economic regional and remote areas, which are believed to provide the biggest challenge for implementation of a new medical delivery system. Focus groups were used to gather ideas, gauge opinions and determine attitudes of patients and care providers to SMAs.

Focus groups were largely open-ended but discussion was aided by a set of question prompts and a 3-minute youtube video describing SMAs in the USA (www.youtube.com/watch?v=9_4T-Z6tWnk&feature). Two experienced qualitative researchers were present in each group (one facilitator; one observer). The researchers' recordings and conclusions were compared and reviewed by an experienced external researcher. Field notes were taken by the non co-facilitating researcher in each group to provide data about the non-verbal behaviour of participants and other observations that were unlikely to be recorded. Data from field notes and group discussions were thematically analysed by each researcher in isolation. Evidence to articulate each theme was collected by way of quotes and/or notes and used to support each of the emerging themes.

Researchers then compared analyses and considered only converging themes. An external researcher reviewed audio recordings and the researchers' report of findings. Only themes ultimately agreed on by both researchers and in the audit were then included in the final report. Ethics approval was provided by Southern Cross University Human Ethics Research Committee (Approval number ECN 13-270).

Findings

In total, there were 46 healthcare providers and 49 patients in a total of eight focus groups. The composition of the groups is shown in *Table 1*. All participants were 30–70 years of age.

Findings are summarised in *Table 2* and *Table 3*. Section 1 elaborates on the healthcare provider findings and Section 2 describes the patient findings.

Section 1: Healthcare providers

Typical questions included, 'What do you find most difficult about treating lifestyle-related chronic diseases?', 'Would you be interested in being involved in SMAs in your clinic?', 'What do you see as the major advantages/disadvantages of SMAs in Australia?' and others.

There was overwhelming interest in SMAs among providers. This could have been indicative of an attendance bias. However against this, there was only one GP who declined to attend the focus group. As expressed by one participant: 'I'm heading towards retirement, but this might make it interesting for me to carry on at some level.' (GP1)

Perceived advantages

The three most commonly perceived advantages of SMAs by providers were:

- The importance of group support and contact for patients.
- Less need for repetition by the GP (and hence less 'burn out' of doctors), meaning more effort can be put into lifestyle prescription.
- More time for patients to hear answers to questions, which they may not have thought to ask.

Other perceived advantages are described in *Table 2*.

The use of a documenter (a staff member trained to document medical notes in real time) was seen as a definite advantage. The idea of seeing patients with pre-diabetes and those with diabetes in the one group was also appealing, as the latter may more adequately influence the former. One GP conceded that 'complacency' with the current system and initially not knowing how to set up an SMA were possible limitations; 'I like the idea, but changing what you're used to is hard.' (GP2). Unprompted suggestions for settings for SMAs were with Workcover, nursing homes, and 'repetitive' processes like licence checks for older drivers.

'We have to try something like this because nothing else is working with chronic disease.' (GP3).

Perceived disadvantages

The most commonly discussed disadvantages were:

- Confidentiality – in small communities in particular, although concerns about this were

lessened when it was explained that this is dealt with through a signed confidentiality agreement.

- The need to ensure economic viability.
- Possible lack of desire of patients to share their views among other patients (who are less 'outgoing' than Americans), although it was suggested by a practice nurse in one group that: 'If you listen to patients in the waiting room, there's no problems with confidentiality!' (PN1).

Less mentioned disadvantages are listed in *Table 2*.

Funding and operations

It was unanimously agreed that current, individual Medicare item numbers may not be sufficient to cover the nuances and costs of SMAs. Dedicated group item numbers could be developed in conjunction with Medicare, and a dedicated item number might be needed to get the best outcomes and provide a viable return. The process was, however, seen as little different to many other consultations: 'We see families together and are able to charge individual item numbers. I don't see how this is any different.' (GP4). Cost–benefit analyses are required urgently to assess the extent of claimable funds. Accreditation/training for clinics using SMAs was proposed as a means of alleviating misuse of the process.

The role of the facilitator was thought to be crucial to the successful operation of the group, and selection and training for the facilitator was seen as crucial to success. Practice nurses, allied health professionals or those with a health background were most often proposed as

Table 1. Group compositions

Group A – Providers	GP	Nurse	Practice manager/admin	Diabetes educator	EP	Other	Total
Male	10	1	2			2	15
Female	7	5	10	3	1	5	31
Total	17	6	12	3	1	7	46
Group B – Patients		Aboriginal and Torres Strait Islander		Non-Indigenous		Total	
Male		4		24		28	
Female		1		20		21	
Total		5		44		49	

GP, general practitioner; EP, exercise physiologist

facilitators. ‘Diabetes Educators would be good for this as they already have experience in groups.’ (DE1).

The feasibility of a consultation in the presence of others was also discussed, although no-one stated this would be a problem; ‘Seeing (sic) other people’s views would be good learning for others.’ (PN2). However, one consideration was how

far the doctor should go in discussing personal matters in front of others and whether this would be an issue in the group. This will need a cultural change and reassurance the doctor is available for discussion of personal matters. One clinician suggested, ‘You could widen the confidentiality agreement for patients to consent to wanting (and even preferring) their consultation in a group

visits setting.’ (GP5). It was also proposed that the process needs to be accompanied by an education program explaining this to patients.

Section 2: Patients

Typical questions included ‘If SMAs were available in your clinic would you attend – why or why not?’, ‘What do you see as the major advantages/disadvantages of SMAs?’, ‘Who do you think SMAs would be best suited for?’.

Overall, patients were less enthusiastic about SMAs than providers, although opinions were divided; around 70% were in favour and 30% against. While most in two centres were strongly positive, there was a significant number in the other two centres who were opposed (50% in each), mainly citing their contentment with the current relationship with their doctor. ‘I don’t want to share my doctor with anyone.’ (Male 1). As these were not randomly sampled individuals, this was not consistent in all groups and should not be seen as a quantitative assessment of patient attitudes. While some who were opposed to the process could see definite advantages (for others), they indicated that they, personally, would not be early adopters in such a process. ‘I’m not really a group person, but I’ll wait and see what happens.’ (Female 1). Support was particularly strong from those with previous health-related group experience.

Perceived advantages

The main advantages to the patient were seen as:

- peer support and shared experiences from other patients
- reduction in waiting time to see the doctor
- time available for asking more questions and hearing other’s views.

The latter view was popular except for those (usually opposed to the idea) who admit to taking a written list of questions in to a consultation. An Aboriginal and Torres Strait Islander man thought that ‘...yarning with others could help the healing process’.

Generally, the perceived advantages to patients were restricted to themselves. There was bemusement among some when asked the leading question, ‘Do you think doctors get frustrated with their job?’. On further discussion, most agreed that it must be frustrating for doctors when patients won’t comply with lifestyle prescriptions. ‘We tend

Table 2. Perceived advantages and disadvantages of SMAs among healthcare providers

Advantages	Disadvantages
<p>Most frequently mentioned</p> <ul style="list-style-type: none"> • Peer support for patients • Less repetition for clinician • More time for patients • Better for health education • Advantage of a ‘real time’ documenter 	<p>Most frequently mentioned</p> <ul style="list-style-type: none"> • (Perceived) confidentiality • Need to make economically viable • Time and co-ordination involved • Possible lack of desire to share information
<p>Also mentioned</p> <ul style="list-style-type: none"> • More relaxed/less rushed consult • Greater efficiency • Reduced waiting time for patient • Reduced need for pharmacotherapy • Reduction in return visits • More fun for clinician • Advantage for patients with pre-diabetics to hear from those with diabetes • Advantages with certain groups (eg WorkCover; licence checks) 	<p>Also mentioned</p> <ul style="list-style-type: none"> • Desire to have own doctor • Control of group dynamics • Some doctors may be threatened sharing patients • Possible cultural sensitivity, ie in Aboriginal and Torres Strait Islander groups

Table 3. Perceived advantages and disadvantages of SMAs among patients

Advantages	Disadvantages
<p>Most frequently mentioned</p> <ul style="list-style-type: none"> • Peer support/shared experiences for patients • Reduced waiting time • Time available for asking questions 	<p>Most frequently mentioned</p> <ul style="list-style-type: none"> • Sharing information in public • Difficulty keeping some people quiet • Desire to have own doctor
<p>Also mentioned</p> <ul style="list-style-type: none"> • May be good for younger people • ‘Yarning’ with others • Hearing experience of other patients • Inspirational to other patients • Gives you more time to think of questions • Might help those who are intimidated 	<p>Also mentioned</p> <ul style="list-style-type: none"> • Not interested in other’s problems • Control of group dynamics • Cultural sensitivities in Aboriginal and Torres Strait Islander peoples • 90 minutes is too long • Problem with infections • Patient’s lacking confidence • Need good facilitator • How far can the doctor go?

to forget that doctors are people and probably get bored, like the rest of us' (Male 3). 'This might explain why (some) doctors resort to medication themselves.' (Male 4). Other perceived advantages are described in *Table 3*.

Perceived disadvantages

While some initially thought sharing information in the group situation was a problem, a concern over privacy tended to drop away after talking about this. 'I suppose you don't have to disclose what you don't want to.' (Female 2). Those generally against the process agreed it may be more popular among younger people; may be useful for a care plan review and where attendees all had a similar health problem (eg diabetes).

Although most welcomed the idea of an extended time period with the doctor, a small number thought 90 minutes is too long to be in a consultation. One male stated he was 'too busy' to be sitting around in a doctor's surgery for 90 minutes, although agreed that the total time taken for a consultation, with waiting time, etc, may equal this. See *Table 3* for other perceived disadvantages.

Summary

While there is a healthy range of views among healthcare providers about the value of SMAs, all those who attended the focus groups were receptive and, in most cases, very positive to the idea. Among patients the idea is more polarising, with strong positive and opposing views among a few. Patient views might be expected to change after hearing of more experiences with the process. However, as an adjunct form of consultation, it is expected there will always be a cohort of patients who do not wish to change their current pattern of consultations. This is also possible with providers, although the general frustration of dealing with chronic disease and a desire for greater work satisfaction may mean that the driver for SMAs will come more from interested providers than from patients.

Recommendations

On the basis of experience from other health services and feedback from this study, we propose the following recommendations.

- The process should be trialled and evaluated in Australia before introduction.

- Modifications should be made to meet Australian conditions.
- SMA training should be provided by an accredited training program to ensure consistency of knowledge/presentation in different centres.
- Cost–benefit analyses should be carried out to justify item payments.
- Facilitators should be trained to drive the process.
- Documenters should be trained to keep medical records in real time.
- Patient education should be developed for medical centres and the community.

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