SMAs: Implementation

1 Introduction

The burden of Long Term Conditions continues to rise and patients attending secondary care will carry this burden with them.

Specifically, the complexities of patients with chronic multiple conditions in the context of changing demand requires the development of new models of both primary and secondary care delivery which involve collaboration among professionals from different professional disciplines.

Team-based interventions are associated with better patient outcomes. For example, the involvement of nurses in assessment, treatment, self-management support and follow-up has been linked to improved professional adherence to guidelines, patient satisfaction, clinical health status, and use of health services.

This document focuses on one innovation in care delivery designed to help address these issues: shared medical appointments (SMAs).

2. Definition, conceptual roots and current literature on SMAs

2.1 SMA definition

Multiple patients have an appointment at the same time (typically about 90 minutes in length) with a team of healthcare professionals representing differing professions. During an SMA, participants receive education, participate in group discussion with other patients, and interact with a multi-professional healthcare team. An individualized management (e.g. medication) and treatment plan are developed through collaborative interaction between the patient and the healthcare team. In addition to clinicians (specialists or generalists) or other care providers, e.g., nurse practitioners, other healthcare professions such as psychology, nutrition, clinical pharmacy, exercise physiology and nursing. The appointment incorporates patient education into a problem-solving and patient-activating environment. While patients and the professional team discuss core education, it is done in such a way as to foster patient (and family) participation in their own care management and often provides support for others in the session. Patients also receive individual management. Within this definition there is room to vary the type of patient populations targeted for participation and the types of health professionals on the team.

2.2 Conceptual Roots of SMAs

The broad frameworks and service delivery models proposed to help address existing challenges in health care delivery for treatment and management of chronic conditions.

In this model six major elements: delivery system; clinical information systems; healthcare organization; self-management; decision support; and community, are viewed from the perspective of their abilities to support productive interactions between a motivated proactive patient and a prepared proactive health care team.
Column one of Table 1 summarizes the six components and provides a brief description of each as initially set up in a local context.

<table>
<thead>
<tr>
<th>Chronic Care Model Components</th>
<th>Enhanced Dimensions and Practices for SMAs</th>
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<tbody>
<tr>
<td>1. <strong>Self-management support:</strong> Provide methods and opportunities for patients to be empowered and prepared to manage their health conditions and health care.</td>
<td>Tools and information utilized in group format for teaching self-management. Health topics covered during patient-led discussion to enhance self-management. Multi-disciplinary team and continuity of team. Patient-centred group dynamics. Peer support (helps with problem solving for self-management). Reinforced by team members. Motivational interviewing.</td>
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<tr>
<td>3. <strong>Delivery system design:</strong> Promote proactive delivery of clinical care and support of self-management within the system.</td>
<td>Debriefing huddle after each session. (Continuous Quality Improvement/Evaluation) and continuity of team. Register to review and plan. Multi-disciplinary team with roles and tasks are defined and overlapping. Individual patient (one-on-one) sessions. Cross-training and spread of care practices back to (other) Primary Care Professionals.</td>
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<tr>
<td>4. <strong>Community Resources &amp; Policies:</strong> Identify and mobilize community-based resources to help meet health care management needs of patients.</td>
<td>Significant others invited and encouraged to participate. Peer support group structure with possibilities for linking outside of group.</td>
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<tr>
<td>5. <strong>Organizational support:</strong> Leadership at all levels provides mechanisms to enhance care and improvements.</td>
<td>Personnel time-committed for multi-disciplinary team to participate. Resources and infrastructure (e.g., designated space and staff, and endorse guidelines). Continuous Quality Improvement/Evaluation (feedback and goal-setting).</td>
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<tr>
<td>6. <strong>Clinical information systems:</strong> Organize and utilize data to promote efficient and effective care.</td>
<td>Documentation (consistent with evidence-based guidelines) Utilize a register, other database for identifying patients.</td>
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**Table 1. Application and Enhancement of the Chronic Care Model to SMAs**

SMAs are a form of planned visit. For example, at the heart of SMAs is the notion of patients interacting and helping each other (e.g., patient-centred group dynamics and peer support). At the same time, the team will incorporate motivational interviewing expertise to help guide those discussions to further support self-management and skill development. This type of appointment allows patients to see differing perspectives in problem solving, and productive interactions with other patients and healthcare professionals at one medical appointment.
2.3 Evidence for SMAs

SMAs have been gaining in popularity over the past 10 years, in part based on efficacy similar to or better than ‘usual care’.

Other outcomes shown to have been improved by participation in SMAs include patient satisfaction, specialty visits, emergency room visits and patient quality of life. The SMA approach has been applied successfully to the management of various patient populations including those with hypertension, heart failure, hepatitis C, dyslipidaemia and other conditions such as urology visits, bariatric surgery, rheumatoid arthritis and geriatrics. By extension modified SMAs could be applied to secondary care specialties.

3. Implementing SMAs for patients

1) Preparation Phase, 2) Early Implementation Phase, and 3) Sustaining Phase.

3.1 Preparation Stage: Initial ground work and decisions

Initially, the components of SMAs include identification of a targeted population, a healthcare team, administrative support, methods to identify patients and track outcomes, and techniques and processes for conducting the visit.

Figure 1 overviews initial issues to be addressed and decisions to be made and how to develop them. Thus, they are recommended as a starting point for making decisions within the local setting. First, a target population needs to be identified.
3.1.1 Target population

Identification of patients is a key initial decision. SMAs may be used for patients with well controlled conditions to improve access, or targeted to those with poorly controlled conditions, or a mixture of the two.

Starting with once or twice a month SMA sessions may be more manageable in a setting depending on number of patients in need. Among the reasons to focus on Urology would be the desire to meet performance measures, the availability of a clinical waiting list and interested clinicians. The choice of the target population determines the stakeholders and the members of the team. Of note, in setting up goals for patients, ensure that they are concordant with guidelines in your local setting.

3.1.2 Garnering support

Among the most important early steps are securing buy-in from those staff and administrative sponsors who will be directly involved, rallying stakeholders, and identifying a local champion. It is important to obtain support from all stakeholders - from administration to patients because change is always challenging.

A champion of the process is essential to garnering resources for the SMA, both at its inception and in the future. The ideal is someone who can leverage support at various levels, and who has a solid understanding of the population and the associated challenges. Although this approach flattens the hierarchy with the clinical team, the typical bureaucracy may deal more comfortably with a clear hierarchy. Again, it is important to recall that it is the solid core of the team that will keep moving the process forward.

It is also important to remember that the clinician does not need to be visible during the entire appointment, does not have to oversee the day-to-day management, or even be the leader of the team once the resources are garnered and team becomes successful in regular SMA visits. The team remains central to the success of the SMAs, but like all changes, needs a liaison with enough status and influence to get support and resources. A reasonable aim is to achieve a context to have SMAs recognized and prescribed (even mandated?) as an important management option. Local administration support still is essential and proceeds better if some initial planning and decisions have been made and have been played out to demonstrate feasibility.

Starting with the high-risk patients provides us with the opportunity to obtain initial buy-in from administration and other providers since many recognize that the traditional approaches are not working. Most of the doubts about starting SMAs came from lack of familiarity and uncertainty about the initial high amount of resources. Locally, these may be addressed by sharing published findings and providing the opportunity for non-team members to observe and participate in a SMA. Non SMA providers participating in a few SMAs also provides an opportunity for them to observe motivational interviewing techniques with challenging patients and reinforces the most evidence based approach to care.

Securing provider and staff support helps with informing patients and family members about the new care option. Recognize that patients and family members may seek reassurance and encour-
agement from their primary care provider. Patients provide a source of buy-in for other patients and family members. Word then travels back to their primary care providers, who then are more likely to refer/encourage other patients to participate.

**3.1.3 Team members: Main roles and core expertise for each session**

After securing leadership support, it is advantageous to focus on deciding who will be part of the team so that other decisions reflect the team working together. The actual size of the team may vary, ranging from 2 members (1 RN and 1 physician or clinical pharmacist or nurse practitioner) to 5 or 6 members. Optimally it is recommended that there are three team members but better to recognize that the composition of the team can also vary and reflect different options for fulfilling expertise requirements, available clinicians and the condition being targeted.

Table 2 provides an overview of the roles. The three main roles are further defined by the core or critical expertise that may be found necessary to have present at each session for successful diabetes SMAs. The roles may vary slightly based on the setting or identified disease.

**Facilitator:** The facilitator takes main responsibility for facilitating the group session and there are a number of potential staff members who could fill this role. This may be a health psychologist, or nurse with motivational interviewing experience/group facilitation experience.

The core expertise needed from the facilitator is to elicit group discussion and use Motivational Interviewing skills when needed. This technique creates a patient-centred discussion. The facilitator helps guide patient generated questions, discussion of challenges and/or educational topics in the group session. It is important to recognize that even though the flow of the discussion is derived from patients and their issues, the facilitator and team help ensure that all patients get basic education on physiological goals, familiarity with medications used to achieve goals, and complications of their disease. The advantage of this context is that the facilitator and team build on the discussions so that the information is pertinent to the patient and permits other patients to discuss and make suggestions about common barriers to achieving care management goals.

<table>
<thead>
<tr>
<th>Role and core expertise</th>
<th>Possible team members to fill the role</th>
<th>Responsibilities</th>
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</table>
| **Facilitator** (Motivational) | Clinic Nurse. | Facilitate discussion related to various aspects of patients’ condition or disease  
Answer clinical questions that arise during patient discussion  
Give recommendations to Clinician as to which order patients should be taken back for their individual physical exam if needed.  
Provide details or consult with other health services for smoking cessation classes, weight loss counselling, depression, post-traumatic stress disorder (PTSD), insomnia, erectile dysfunction etc.  
Obtain basic clinical information and assist with check-in process, if necessary.  
Assist patients with completion of symptom ques- |
### Table 2. Core roles and suggested distribution of responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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</thead>
<tbody>
<tr>
<td>Clinician (Provider)</td>
<td><strong>Complete</strong> individual patient physical examination if needed, assess functional capacity to engage patient in exercise program. <strong>Discuss</strong> patients’ symptoms, adverse drug reactions, and follow-up on patient response to symptom questionnaire, if needed. <strong>Adjust</strong> patient specific pharmacotherapy, if appropriate and as indicated. <strong>Agree</strong> follow-up appointments, as clinically appropriate. <strong>Provide</strong> patient option to return to the group for continued discussion or opt-out. <strong>Record</strong> provider and patient goals for therapy and treatment plan for documentation into the patient’s records (documentation usually occurs during individual patient visits). Partial or complete progress note documentation of the subjective, objective, assessment and plan (eg SOAP) for each patient. <strong>Complete</strong> take home instruction sheet.</td>
</tr>
<tr>
<td>Content Experts</td>
<td><strong>OPTIONAL</strong> May call patients out for individual consult (e.g., regarding diet), Can help with documentation, Understand medical terminology or have clinical background experience, Assist with group facilitation.</td>
</tr>
<tr>
<td>Documenter</td>
<td><strong>Note that documentation of the assessment and plan can be delegated, an individual effort or a collaborative effort with the team after the clinic visit</strong></td>
</tr>
</tbody>
</table>

**Clinician (Provider):** Medication changers in SMAs include doctors (GPs) nurse practitioners (NPs), registered nurses (RNs) with primary provider support and pharmacists. These team members interact with patients one on one. Titration of medications is completed, if needed. Ideally, this only takes between 5 and 10 minutes for each patient. Consultations are placed as needed with a written treatment plan and list of medications for the patient upon check-out. If seen in individual rooms for treatment plan, patients may or may not rejoin the group after their individual session. As needed, the provider seeks input from other team members by asking another member in for a quick consultation or requesting and relaying information back to patient.

**Content Expert (Or Disease Specific Expert):** The expert can be a nurse, pharmacist, physician, or nutritionist.

It is critical that at least one team member is an expert on the specifics of management of the identified disease/condition.
Documenter: Such a person who is accustomed to the terminology and with records open can relieve some of the burden of recording from the providers and indeed may also generate prescriptions/letters/questionnaires from a database.

3.1.4 Session and Format Parameters

In Figure 2 there is summarized a recommended approach for implementing SMAs, but some parameters will be a function of local contextual factors. The visit itself begins with the group format where introductions and information sharing occurs, followed by more open group discussion which also has an educational component. The group discussion facilitates peer support, one of the keys to success in disease management. Arranging chairs in a circular format creates a sharing environment. It is important for the team members to be seen as equal members in the group with the patients and family members, therefore, the group discussion where all team members are sitting rather than standing is recommended. It is important to stay focused within the SMA visit and to adhere to specified time frames. The other component of the visit is the clinical component (examination if needed and management) where medication titration is done and other issues related to the condition are addressed in a one-on-one format with a Clinician. Patients may or may not ‘rejoin’ the group after their individual session whether this is in the Group, off to the side or in a separate room. Generally rejoining the group should be encouraged.

Preparations prior to SMA session

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Tasks</th>
<th>Main team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 weeks prior</td>
<td>Send letters of invitation to first ten patients (signed by Clinician)</td>
<td>Recorder/Admin</td>
</tr>
<tr>
<td>2 days prior</td>
<td>Make reminder phone calls/texts</td>
<td>Recorder/Admin</td>
</tr>
<tr>
<td></td>
<td>Print out list attenders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attach lab/test results</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepare hand-outs</td>
<td></td>
</tr>
</tbody>
</table>

Preparations on the day (e.g. 9am start)

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Tasks</th>
<th>Main team member</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30am Set up room</td>
<td>Enough chairs placed in discussion format Hand-outs/questionnaires in place with pencils</td>
<td>Admin/Nurse</td>
</tr>
<tr>
<td>8.45am Patients start arriving</td>
<td>Reception with a smile. Pass to nurse for initial screening, basic info in place, ensure lab data available.</td>
<td>Nurse</td>
</tr>
<tr>
<td>9.00am Group session begins</td>
<td>Welcome &amp; privacy reminder. Introductions – patients share names, how long with condition, how treated to date.</td>
<td>Facilitator invites patients and charts on white board</td>
</tr>
<tr>
<td>9.10-9.30</td>
<td>Socratic discussion of issues. Referral to printed records and ask patients their values and targets. Questions to engage patients but no lecturing.</td>
<td>Facilitator and patients</td>
</tr>
</tbody>
</table>
**3.1.5 Other considerations**

A table for the group is useful for patients to review their health related information and take notes, but is not critical.

**3.2 Early implementation**

A number of things need to happen early in implementation and include: identifying and contacting patients and their respective family members (or caregivers), mapping out the process during the group session prior to the session itself and identifying the most appropriate guidelines in directing clinical care delivered in the SMA. Potential patients should be screened for other issues or conditions that would suggest SMAs might not be appropriate.

The following exclusions to participation in diabetes SMAs may apply: an inability to speak English, a diagnosis of dementia or other cognitive impairment, and any behavioural problem which interferes with group participation and discussion.

The letter of invitation is sent about two weeks prior to the SMA session the patient is invited to attend. A reminder phone call is made one or two days prior to the session. Both the letter of invitation and the reminder phone call clarify that significant others are also invited to attend. Initially the team should be involved in identifying and contacting potential patients, but once the process is established, these steps may be handled by one individual on the team (e.g. PN or nurse practitioner) who has access to the register but this could be handled by others who have clerical positions if trained). Prior to the SMA session, a review of the patient’s record is conducted. Specifically, data is gathered to assess the need for lab tests or investigations prior to the visit and if the patient has been appropriately triaged to the SMA.

Then during the SMA session, patients are checked in at the site of the group visit, not at the Reception. This permits basic measurements to be obtained. The patients may be given copies of most recent lab tests or investigations. Additional educational material may be provided.

The SMAs begin with ground rules, information and reminders about confidentiality. Subsequent to the confidentiality reminder, one must realize that the session introduction is very important to help set the tone. Sessions begin with introductions of everyone present by going around the room and providing a brief introduction of the clinician and the patients including how long s/he has had the condition. This also helps the team who may not be familiar with all of the patients at the session. Introductions can also be altered to help steer the process of information-sharing beyond the basic information. It is important to remember to be flexible as the issues the patients want to discuss need to surface and be part of the process.

Typically the group discussion begins with asking an open-ended question to encourage patient participation. The facilitator and other team members ensure that relevant educational topics are discussed and that goals are established during the discussion. The topics, and the approach to discussing the topics, are designed to evoke better self-management skills and to empower and prepare patients to manage their health condition and health care. Patients may receive educational materials that include target goals.
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An important goal is to get the patients to share and problem-solve with and for each other. The facilitator’s role is to keep patients engaged with the group activity to the extent that this is possible. After sufficient discussion (i.e. the topics have been shared and discussed in a patient-driven format), individualized planning begins by taking patients out or to one side individually if necessary for the one-on-one session. The other patients remain in the group session and the facilitator continues to facilitate relevant discussions. Patients are welcome to return after their one-on-one session to continue to participate in discussion. Typically one may start one-on-one sessions with patients who have attended several previous SMAs or have time constraints and/or other commitments (e.g., need to get back to work).

It is useful to have a debriefing huddle immediately after SMA session. During the debriefing huddle the health care team discusses the individual and group encounter portion of the patient visit. Additional collaboration happens that may lead to further recommendations for follow up care and/or charting in the medical record. Opinions and consensus occurs during these sessions. In addition, this provides an opportunity for assessing the overall process and goals as well of spread of inter-professional expertise. You may find the debriefing component decreases over time, but it is important to continue debriefing if only for a few minutes. This time may provide an opportunity for Inter-professional cross-training and professional development as new evidence-based healthcare practices emerge. This is especially true if trainees of different disciplines are included in this clinical venue. Unintended consequences may arise that may be addressed in the team debriefing session.

3.3 Keys to sustaining SMAs

Sustaining successes for a group is the result of a continuous quality improvement process, staying alert to unintended consequences and developing supportive tools to track and measure outcomes. Demonstrating value added to clinical care with improved outcomes must be a part of early and ongoing assessment strategies. Improved outcomes may be intermediate outcomes such as decreased hospital or practice visits or patient satisfaction with SMAs. It is important to find some measure of improved care to demonstrate value within local systems of care.

3.3.1 Developing supportive tools and environment

Six key ingredients or elements have been identified that are associated with successful implementation of SMAs, including improvement of quality of care as evidenced by significant improvement in patient clinical outcomes, high SMA patient and provider satisfaction, and decreased waiting times for patients. The core keys to success are:

1) Multi-professional team development (including continuity of team)
2) Motivational interviewing
3) Nurturing peer support
4) Teaching and encouraging self-management
5) A register for identifying and tracking patients
6) Continuous Quality Improvement / evaluation

The keys to success are discussed below and it is important to recognize that they function together to ensure success. Thus, for example, having a highly dynamic group with peer support but without motivational interviewing strategies to focus on what patients’ desire as goals is problematic – both are necessary to make improvements in outcomes.

Multi-Professional Team Development (Including Continuity of Team): The more consistent the team members, the more quickly a team can adapt the implementation strategies to their local
environment. Deference to expertise, not rank, is an important consideration in fostering teamness; that is the sense of mutual interdependence and supportiveness. Additionally focus on successes, which allows for high provider team satisfaction.

Continuity of team need not mean that only the same three people do the session each and every time. What it does mean is that there is continuity in that all team members who rotate or take turns are seen as part of the team and involved with training, updates, debriefing and continuous quality improvement. It may be helpful to send summaries of the debriefing session to the team member(s) who aren’t scheduled for that session, or decide to have a monthly Team Continuity Meeting with all team members to reinforce the common goals and objectives.

**Motivational Interviewing: Setting the Tone for Patient-Centred Group Encounters:**
Healthcare providers and group facilitators help promote behaviour change in individuals through use of innovative approaches to communication such as motivational interviewing (MI). This approach is particularly useful when patient motivation and adherence are barriers to treatment effectiveness. Given that motivation is often a significant obstacle to behaviour change, MI has been used to address many health problems related to lifestyle as well as in the prevention and treatment of many chronic conditions. Although there are many strategies that can be used in the application of this method, MI is not a technique so much as a style for provider-patient communication. MI has been described as a patient-centred counselling style used for eliciting behaviour change by helping patients to explore and resolve ambivalence. It has been further described it as “a way of being with people, that is also directive in seeking to move the person toward change by selectively evoking and strengthening the patient’s own reasons for change”. The tenets of Motivational Interviewing acknowledge (a) most people move through a series of steps prior to changing behaviour, (b) effective change is self-directed, (c) confrontation and negative messages are ineffective, (d) knowledge alone is insufficient for behaviour change, and (e) patient ambivalence about change must be addressed before successful behaviour change can be accomplished.

To use this method, the practitioner and the patient work together to address the patient’s healthcare needs, emphasizing a collaborative approach. In MI, the practitioner selectively elicits and reinforces positive self-statements, consequently directing the patient to move in the direction of behaviour change. However, the patient, not the practitioner, argues for change. To promote positive behaviour change, providers must learn to utilize several principles in communicating with patients and these include rolling with resistance, expressing empathy, avoiding arguments, developing discrepancy and supporting self-efficacy (READS). Ambivalence regarding change is considered part of the process. Thus, the central goal in MI is to recognize the discrepancy between the patient’s stated goals and his/her present behaviour. Eliciting reasons for change from the patient is more powerful than giving the patient prescribed reasons why change is necessary.

**Nurturing Peer Support:** Peer support is considered an essential component of SMAs and provides an opportunity for participants to share similar life experiences and challenges, offer support and activate one another toward positive behaviour change. Among patients dealing with the same condition, sharing experiences with others adjusting to similar medical and/or behavioural regimens has been found to be an effective means of gaining mastery over self-management skills and improving disease outcomes. Assimilating new knowledge and appraisals through mutual exchange of experiences may occur more effectively when presented by peers with whom the patient identifies and shares common experiences. Group interaction appears to provide emotional support while lessening feelings of isolation and stigmatism that are associated with the condition. Peer support also provides an additional social support network that many individuals lack when trying to meet
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the demands of their condition. Patients are actively involved in decision-making and problem solving in relation to issues raised by others within the group. Moreover, the act of assisting another person can promote a real sense of contribution and certainly increase group cohesiveness. Promoting peer support in shared medical appointments requires the group facilitator to attend to both the content of what is being said and the process of the group (e.g., who is talking, for how long, which patients are disengaged, etc.). Often new facilitators interact with patients by either lecturing or engaging in a question/answer session. This interaction sets the norms for the group and will inhibit patients from engaging in discussion with one another. Promoting peer support begins with the initial interaction and can be fostered by the facilitator.

In general, the facilitator’s job is to find ways to keep the patients talking with one another. Questions/interaction should be aimed at facilitating and promoting peer interaction. Sometimes you have to work harder to get patients interacting, but avoid falling into a lecturing style: ask questions, ask for stories, engage patients you know, rephrase question with another example, and don’t feel like you have to fill the silence with information.

**Teaching and Encouraging Self-management:** The focus of self-management education within a SMA includes an emphasis on self-efficacy. Patients are encouraged to set a goal to help attain one of any relevant values or other health care measures (such as tobacco cessation or weight loss).

**Register for Identifying and Tracking Patients:** The register is any form of record that identifies actively managed patients. If there is no current disease specific register then a generated list of patients fitting the determined population will work.

**Continuous Quality Improvement/Evaluation:** Measuring the outcomes of the work the team is doing for and with patients is critical. Not only do administrative staff and clinic directors want to see successful improvements in patient measures, but this is critical for the clinical team as well. Recognize that measures can be patient satisfaction, care co-ordination, patient functional status, or number of A+E visits. Choosing measures at the onset is important to show value to clinical leadership for sustained resources. As mentioned earlier, a key component of success is continuous quality improvement. It is impossible to evaluate progress and make adjustments without measuring aspects of the care provided.

### 3.3.2 Identifying and addressing challenges

Although success will be achieved, several challenges may need to be met and overcome. The following are several challenges which could be encountered as SMAs are initiated and sustained.

**Managing Misinformation and Urban Legends:** Occasionally patients will want to discuss home remedies for their condition as if the remedy is scientifically based. This can almost have an infectious effect among group members. They often want to know more about the “cures.” One way to defuse any type of misinformation is to gently interrupt the discussion, recognize that there are many home remedies that people have tried over centuries, that science is investigating some of these complementary and alternative treatments, but for our discussions we have to stay with what science recommends now, but also realize that other treatment modalities (some based on home remedies) may be included in our treatment options in the future after they have been verified by sound science.

**Administrative Hurdles:** From an administrative standpoint, pressure to serve patients in a traditional clinic setting may present barriers to changing formats and to allowing staff the initial time needed for developing and adjusting to changes. Emphasis on the long term gains and benefits
(increase in patient numbers over time, improved access, cost savings when intermediate outcome measures improve, and high patient satisfaction) must be recognized by administrators in order to persevere through the initial adjustment period. The champions are often critical for getting and maintaining administrative support.

**Growing Pains:** Is important for the team to recognize there is an investment in developing the process for each local setting, with a return, but this must happen over a period of time with those intimately committed and involved helping to refine the process. In a local setting, it is prudent to meet and continue to meet after each shared medical appointment for 10 to 20 minutes to collaborate on patients as well as refine the process and flow (debriefing). Collaboration may mean various health professionals help in ways that are not specific to his/her disciplines. For example, a health psychologist will enter no-show notes at the end of the session and a nutritionist will help download information when needed. Flexibility and persistence are necessary and will pay off in the end.

**Roles and Cross-Training:** The multi/inter-professional nature of SMAs may be uncomfortable until enough cross-training has occurred. The cross-training is critical because it enables more flexible roles to emerge. Being flexible and cross-training help guarantee sustainability, otherwise if you lose one person, the structure of the SMA is lost.

**Clinic Capacity:** Clinic capacity depends upon space and available staff. Initially, it is often reasonable to invite fewer patients. This permits the team time to assess acuity, establish flow, and adjust the process of care delivery. The experience with patients failing to keep this type of appointment ranges from 20% to 50%. Efforts to reduce the DNA rate have included: reminder phone calls, calling patients who DNA and scheduling letters. Some sites have also reported use of patient attendance contracts. Invitations sent by clinicians have a 90% attendance rate. Adequate patients in clinic can be achieved additionally by overbooking the clinic. If you take this approach, overbook by no more than 40% of the total number of patients desired. Although it makes for a busy clinic if overbooked patients come to clinic, they can usually be accommodated more easily with multiple providers than with one provider. Teamwork is maximized and some patients may opt to be seen and not participate in the group session component due to time constraints.

The group discussion usually occurs in a large group room with individual (intimate) examinations occurring in smaller exam rooms. Two to four small exam rooms may be needed to keep the overall clinic time at 90 to 100 minutes. However, it is important to remember that ‘traditional’ exam rooms are not usually necessary. It is possible to work quite comfortably if you have access to only one traditional exam room and several private or semi-private spaces. Recall that the focus in the individual patient (one-on-one) session is on condition-relevant issues; the goal is not to conduct a complete exam.

**4. Conclusions and caveats**

The patient-centred care in an SMA reinforces the concept that each patient is an individual, with unique life experiences, values, religious and cultural influences and psychological strengths and weaknesses that are taken into account in treatment and discharge planning. Informed and activated patients understand the vital role they play in managing their condition. SMAs provide an opportunity for clinicians to see and learn things that don’t happen during a one-on-one session, providing more insights for helping patients manage their condition 365 days a year. This type of
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appointment allows patients to see differing perspectives in problem-solving and productive interactions with other patients and healthcare professionals at one medical appointment.

Ideally, at the end of each session, a team debriefing occurs where patient issues and clinic processes are reviewed. The SMA promotes collaboration and effectively multi-professional care while integrating patients’ perspectives.

While implementing a new shared medical appointment, it is prudent to recognize that there will undoubtedly be challenges, but if you are persistent and adhere to the essential phases, core ingredients, and key elements for success, it will be worth the effort for you and your patients.