

# Patients' and providers' satisfaction with shared medical appointments

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## Background

Shared medical appointments (SMAs) are comprehensive medical visits conducted with groups of patients. We have previously discussed the potential and assessed likely support for SMAs in Australia. In this paper, we report on patient and provider satisfaction, and some subjective outcomes.

## Objective

To measure patients' and providers' attitude and satisfaction with SMAs after attending at least two, and consider the most appropriate form of SMA suited to Australian conditions.

## Method

A total of 24 SMAs were conducted in eight medical centres in New South Wales, South Australia and Queensland. Satisfaction and subjective outcomes from these sessions were tested in a mixed method analysis after more than 200 attendances.

## Results

Satisfaction with SMAs was high among patients and providers. Almost all of the patients involved said they would continue using SMAs, if these were available. All providers wished to continue being involved as an alternative form of clinical management.

## Discussion

The results of this pilot study, and our previously reported studies, suggest that SMAs could be a valuable process tool in chronic disease management in Australia.

We have previously discussed the potential of shared medical appointments (SMAs) and their possible acceptability among patients and providers.<sup>1,2</sup> SMAs (also known as group visits) are '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 [general practitioner]'.<sup>3</sup> SMAs have been used effectively in the US and some European countries,<sup>4–6</sup> but concerns regarding Medicare funding have limited their use in Australia. Discussions with Medicare and an application to the Medical Services Advisory Committee (MSAC) for a special item number for SMAs has incited interest in their potential use and success in Australia.

A pilot study of patients' and providers' satisfaction with SMAs in urban, regional and rural primary care centres in Australia in the first half of 2014 was conducted with a grant from the HCF Research Foundation and the Royal Australian College of General Practitioners. Different variations of the SMA process and their suitability under varied circumstances were also tested. Our results help us to consider a potential future for SMAs as an adjunct form of clinical treatment for a range of chronic diseases in Australia.

## Method

### Groups, patients and providers

A total of 24 (three in each of eight centres) SMAs with eight GPs, two facilitators and a number of practice nurses were carried out in New South Wales, Queensland and South Australia in 2014. Centres included seven primary healthcare centres (four urban, two regional and one rural and remote) and one Aboriginal and Torres Strait Islander health centre. Five centres focused specifically on type 2 diabetes, and one ran a chronic pain group. One of the centres ran a weight-loss program for men ('GutBusters') and another group designed to look at chronic disease in general for Aboriginal and Torres Strait Islander men.

Group sizes ranged from 3–15 patients. Only two groups (Aboriginal and Torres Strait Islander men and GutBusters) were segregated by sex and/or ethnicity.

Consecutive groups (three) in each centre were spaced about 1 month apart. A variation of providers was tested, depending on the location and personnel available. This varied from one GP or one ‘facilitator’ only, to both being available, in addition to a practice nurse taking basic observations and a documenter who records medical records. Documenters included the facilitator, a medical student, a GP sitting in on the group, or a practice nurse. Facilitators are crucial to the SMA process as they control the timing and running of the session, organise the GPs and can contribute to the content of the discussion, depending on their experience. One of two facilitators from the research team (GE or JS) was used in all groups in this study. Eight GPs were used within the groups.

Ethics approval was provided by Southern Cross University Human Ethics Research Committee (approval number ECN 13-270).

**Procedure**

**The process**

Patients were invited by doctors, nurses and clinic staff to attend a trial of a new 90-minute appointment (SMA) in their clinic. On registration patients signed a consent form and confidentiality agreement, information was handed out, and permission sought in order to write limited medical records on a whiteboard or butcher’s paper during the meeting. A space was available so patients could record any topic they wanted to discuss with the doctor. A summary of program materials from the GutBusters men’s waist-loss program<sup>7</sup> was provided in one group, and a pre-set agenda covered by the facilitator. Each group was preceded by 20–30 minutes with the facilitator as individuals arrived, discussing the process and any health information that could be managed by the facilitator or group. The GP entered the room after introduction and

discussion by the facilitator. A computer with open patient records was accessible between the GP and facilitator. The GP was directed by the facilitator to the first patient where a typical consultation would begin. Others would listen in, observe and contribute, where appropriate, until the doctor was directed to the next patient. The facilitator controlled timing and discussion. The doctor left the room after a set time (based on the number of participants in the group with a maximum of 1 hour) and further discussions followed.

**Evaluation**

Mixed methods were used to assess:

- patients’ and providers’ satisfaction
- subjective outcomes
- operational procedures in the groups.

A non-contributing observer was used after session one in each centre to conduct an informal affinity/discussion group with patients. A questionnaire was used

after session three to quantify patient attitudes. De-briefs with providers were carried out after each session and a semi-formal interview was carried out with each GP after session three. Field note data were also collected at each session by at least one of the researchers to assist in triangulating findings.

**Results**

A total of 219 patient visits, averaging nine per group (range 3–15) were carried out over a 6-month testing period. Patients were aged 24–86 years, although they were mainly 40–70 years of age and represented a wide range of socioeconomic status. Approximately 5% of patients in the primary care centres identified as Aboriginal and/or Torres Strait Islander. A total of 64 patients attended three sessions, with 11 attending two sessions and five attending one. Sixty patients who had attended three group

**Table 1. Patient rating of SMA consultations**

	Rating
Now you have completed these SMAs:	
How do you rate this form of care for type 2 diabetes?	4.55*
How would you rate it for other forms of care (pain, asthma, etc)?	4.25*

*\*Mean Likert score, range: 1–5*

**Table 2. Patients’ rating on the potential use of SMAs**

	Rating
Would you continue to come to SMAs if these were available at your medical centre?	4.86*
Would you ever use an SMA instead of a standard medical appointment?	4.11*
Do you think SMAs would reduce the number of other visits you would need with your doctor alone?	3.81*
Do you think SMAs would reduce the number of other visits you would need with your doctor alone?	4.68*
Do you think people would pay a co-payment to come to an SMA?	1.42*
If yes, how much do you think most people would be prepared to pay?	\$4.24 <sup>†</sup>
How many ordinary visits to your doctor might you <b>not</b> need over 6 months as a result of attending an SMA (24% of patients did not answer this or responded ‘0’)	1.64 <sup>‡</sup>

*\*Mean Likert score, range: 1–5; <sup>†</sup>range: 0–\$15; <sup>‡</sup>range 0–5*

sessions completed questionnaires. All attendees were involved in affinity group assessments, which involved discussion with an impartial interviewer after each session.

## Questionnaire assessments

### Satisfaction

Patients who attended all three SMAs were asked to rate the appointments on a 5-point Likert scale, where 1 was considered poor and 5 great. The mean score ratings are in *Table 1*.

The potential use of SMAs was measured on a similar 5-point scale where 1 = definitely not and 5 = definitely. The mean score ratings to each question are shown in *Table 2*.

### Enjoyment

Participants were asked to rate how much they enjoyed each of a number of factors in regards to the SMAs they attended on a scale of 1 to 5, where 1 = did not enjoy at all and 5 = enjoyed very much. The mean score ratings to each question are shown in *Table 3*.

Participants were asked what they did not enjoy about the SMAs. They were given options of 'lack of confidentiality', 'lack of personal attention from the doctor', 'having other people in the room', 'difficulty in keeping people quiet', 'sessions too long', and 'nothing'. All of the respondents answered 'nothing'.

Participants were given a choice on their initial concerns, and were later asked

whether these were still of concern after participating in SMAs. Of those who completed this question, 58% (n = 44) said they initially 'did not understand the process'. However, all participants agreed this did not concern them after the process. Forty-five percent claimed they were initially concerned about confidentiality, but none were concerned after their experience. Another 25% claimed at the outset to not be 'a group-type person', while one participant noted that this was still of concern to him after attending SMAs.

### Diabetes behaviour

Participants from the diabetes group (n = 40) were asked 'Do you do any of the following more as a result of attending these shared medical appointments?'. Their responses are in *Table 4*.

### Affinity group assessments

Patients' satisfaction was overall positive with no negative complaints. Only 5 out of 80 patients (6.25%) in 219 visits failed to attend after their first visit without a reasonable excuse. One patient stated a lack of interest in returning because of the group format, and one who had been 'sent by his wife' to a GutBuster's program did not re-appear. When asked 'Did this feel like a consultation with your doctor?', generally all agreed. They also agreed that they would like to come back for further SMAs after their first session. Those who completed two or more sessions agreed they would like to have the option to attend an SMA on a 2–3-monthly basis.

The most common reasons given for enjoying the group setting was peer support, feeling 'you're not alone with your disease' and 'learning from others'. This was confirmed by the questionnaire assessments (*Table 3*).

*'It's good to hear other people's issues. It makes you realise you're not alone and you're not as bad off as you think' (patient, Queensland).*

*'I got so much out of this because I heard answers to questions that I always forget to ask the doctor' (patient, northern New South Wales).*

**Table 3. Patients' rating on the enjoyment of SMAs**

	Mean score*
Having more time for asking questions	4.84
Seeing the doctor more relaxed	4.64
Having the doctor's full attention	4.58
Getting support from other patients	4.77
Contribution of other health people	4.77
Hearing experiences of other patients	4.90
Getting information from others	4.97

\*Mean Likert score, range 1–5

**Table 4. Patients' subjective behaviour change as a result of SMAs**

Do you do any more of the following as a result of attending these SMAs?*	Much more		A little more		No more	
	n	%	n	%	n	%
Check my blood sugars	14	35	8	19	18	45
Am more careful with the food I eat	19	48*	9	22	12	30
Take my medication as required	16	40	4	10	20	50
Do regular physical activity	16	40	16	40	8	20
Follow my doctor's advice	18	48*	9	22	12	30
Follow my diabetes educator's advice	13	32	13	32	14	36
Take care of my own health	23	58*	5	13	12	29
Feel confident in managing my diabetes	19	48*	14	35	7	17

\*The numbers do not always add up to 100 because some participants did not answer some questions.

Concerns of the time involved in a consultation did not seem to be an issue. Most participants claimed to enjoy hearing others' issues, enjoy having more relaxed time with the doctor and to be interested in others' ailments, even if it was not appropriate to them.

*'Even when it was something that wasn't relevant to me, I was still interested and inevitably things were talked about that were exactly what I wanted to know or hadn't thought to ask'* (patient, western New South Wales).

*'Everyone respected what I had to say. No-one gave me heaps for what I had to say. I don't normally talk in groups ... but this was different'* (Aboriginal and/or Torres Strait Islander patient, northern New South Wales).

### Provider evaluation

*'One of the things I realised out of doing these SMAs is that we (providers) assume medical literacy. We think we adjust our language to meet the knowledge of the patients, but obviously we don't do it as well as we think – people in these groups still didn't know the difference between fat, carbohydrate and protein. I assumed they would. Some didn't understand the relationship between drinking 70 cans of coke a week and weight gain and poor sleep. I assumed they would. So I've been telling them things they have no hope of understanding! I've already changed that in my practice as a result of the SMAs'* (GP, New South Wales).

All eight clinicians involved expressed satisfaction with the SMA process, although some had reservations before the research program:

*'A great idea. Hugely motivational. Patients learn a lot from each other. It's difficult to explain the problems of diabetes to individual patients, but this is easy with other people in the room'* (GP, western New South Wales).

*'Very useful and a totally different approach to what we are used to. Quite natural after you start doing it'* (GP, Queensland).

All GPs agreed that SMAs should 'decrease health costs in the long term':  
*'... [it] leads to an increase in efficiency and helps us do health promotion/ education better'* (GP, northern New South Wales).

Most also agreed SMAs would decrease standard medical visits:

*'If done by the patient's own GP, they would definitely decrease other visits'* (GP, Sydney, New South Wales).

All agreed they 'would like to continue running SMAs in some form in their practice':

*'As a doctor, you're not lecturing at people, and hence the doctor becomes more acceptable to the patient'* (GP, Sydney, New South Wales).

The main advantages of SMAs over standard medical consultations mentioned here were:

- patients supporting each other
- the benefits of group dynamics
- not having to repeat yourself
- more relaxing than one-on-one visits.

Disadvantages were mainly attributable to organisational and administrative issues, but this was usually overcome after attending the first SMA. A second concern was getting a special Medicare Benefits Schedule (MBS) item number or agreement to use current item numbers with Medicare. However, all agreed after running groups that this should not be an issue. All involved regarded the facilitator as crucial to the process and were of the opinion that training for facilitators should be mandatory, with perhaps an accreditation system.

### Discussion

The findings reported here, and in previous work<sup>1,2,8</sup> and international experience,<sup>9</sup> have found that SMAs are acceptable to Australian patients and providers. They could have a significant role in chronic disease management in the healthcare system. Patients' and providers' satisfaction with SMAs after they experienced them (at least with self-selected patients who attended these groups) was almost unanimous. Patients most enjoyed:

- peer support, and hearing experiences and getting information from others
- the feeling of not being alone with your disease
- having more time to ask the doctor questions, and having questions they may not have thought to ask being asked by others
- interest in other peoples' ailments and how they dealt with these
- the relaxed atmosphere of the group approach to treatment.

Almost all patients wanted to continue with SMAs: some instead of, but most in addition to standard medical consultations. However, most agreed SMAs would reduce the number of standard consultations they would attend.

Provider satisfaction came from:

- less need for repetition of lifestyle advice
- apparent better uptake of advice when agreed by peers
- the opportunity to better educate patients
- the relaxed atmosphere and ability to focus on patients, not record keeping with the help of the facilitator.

The current study was not designed or powered to measure medical outcomes. However, changes detected in the short time frame in this study, as well as self-reported changes in behaviour (eg taking care of one's own health, following the doctor's advice more, changing diet and feeling more confident in managing one's own diabetes), suggest the process is worth considering in Australia.

The biggest barriers to the introduction of SMAs in Australia appear to be:

- the initial reservation of participating doctors (mainly based around billing concerns)
- organisational and administration issues
- the development of a business model that is in line with current MBS payment schedules.

Currently, payment methods are restricted by MBS reimbursement, and the confusion around item numbers and their validity for SMAs. An application for a unique item number has been made with the MSAC and a decision expected in 2015.

Consideration of operational procedures throughout the study suggest patient numbers in groups can range from a minimum of six (just economically viable using Medicare item numbers) to an optimum of 10–12 (administratively manageable, depending on the topic being considered). Our experience has found that complex problems such as chronic pain may require the minimum number for optimal outcomes. By contrast, a more homogeneous group for chronic diseases such as type 2 diabetes could extend to 12 patients.

Patients' and providers' interest is likely to expand the use of SMAs in Australia. There is agreement between patients and providers that SMAs should decrease standard medical consultations and provide a cost-saving dimension to the health system. These factors should be considered by health authorities. Reduction of just one extra annual visit for diabetes would yield an estimated cost saving of around \$100 million per annum. This is based on the calculation of \$50 per visit, per year, with 2 million Australians with diabetes and pre-diabetes. Discounted lifetime costs of diabetes have been estimated at over \$US126,000 per person.<sup>10</sup> As there are currently around 2 million Australians with diabetes or pre-diabetes,<sup>11</sup> this represents a significant saving to the system. The addition of other chronic disease savings would add a significant multiplier to this. However, it should be noted that a detailed cost-benefit analysis of SMAs in Australia has not been conducted and should be a high research priority.

The overwhelming satisfaction with the process of SMAs by Aboriginal and Torres Strait Islander men was of particular interest in this study. Group 'yarning' in a gender-specific environment is a common cultural practice in Aboriginal and Torres Strait Islander communities. This form of consultation appeared to be much more natural to Aboriginal and Torres Strait Islander men than a single medical consultation, which many described as 'scary'. The men in the Aboriginal and

Torres Strait Islander component of this trial claimed to enjoy the process and want to continue with SMAs. In several cases, this led to further individual consultations for identified problems that had not been considered previously. The attending GP found Aboriginal and Torres Strait Islander men to be much more open with the doctor in the group environment than in individual appointments.

Our experience suggests that the facilitator is likely to be the key to the success of SMAs in Australia. Facilitators may be allied health professionals external to a clinic. However, financial realities suggest the clinic's practice nurse or other allied health professionals may be the most appropriate person for this role. Our experience suggests that limited training is required to ensure practice nurses acting as facilitators adopt certain standards and keep accessible records for long-term evaluation of SMAs. The current MSAC application includes a proposal that facilitators be accredited in order for claims to be legitimised.

### Limitations

The current study was not designed to measure the hard outcomes of SMAs and further work is necessary to demonstrate this in the Australian context. However, accumulating findings from other countries suggest outcomes are generally as good as, if not better than, one-on-one clinical situation.<sup>12</sup> Group and patient numbers were also limited in the current work. However, the universality of findings suggest further groups would have contributed little more to the outcomes. Finally, by definition, patients (and to some extent doctors) involved in the current work were self-selected to the process. However, most patients had little information about SMAs, and therefore the extent to which this influenced their decision is questionable.

### Summary

While healthcare has traditionally been delivered in a one-on-one situation, there are no data to support the use of

this process over any other. There was overwhelming support for SMAs in general practice from the satisfaction of patients and providers. It would appear in discussion with various specialties that the process would be just as successful in areas such as rheumatology, oncology and gynecology. It is appropriate that the process is properly understood and promoted within the healthcare system as it appears the process may ultimately be available as an adjunct approach to chronic disease management.

### Recommendations

- Research – further research is required to measure outcomes and provide a cost-benefit analysis of SMAs under Australian conditions.
- MBS funding – an MBS item number and facilitator training program accreditation for running SMAs is proposed to ensure proper rollout.
- SMA training – although appropriate allied health professionals are suited to the role of facilitator, practice nurses within primary care clinics are ideally placed for this role.
- SMA materials – standard templates for SMAs including explanatory pamphlets/posters, confidentiality agreements, trainers workbooks etc, will be required for centres interested in running SMAs. Processes for assisting recruiting and promotion will also be required.
- Evaluation – ongoing and iterative evaluation could be established through an iCloud network of centres participating in SMAs.
- Increased awareness – awareness of the advantages and processes of SMAs needs to be increased among patients and providers.
- Specific SMA groups – experience with different groups suggest specific topics (eg diabetes, chronic pain, quitting smoking, obesity management and cardiac rehabilitation) may be ideally suited for SMAs.
- Specialist use – medical specialties (eg dermatology, rheumatology, respiratory physiology, oncology, cardiac rehabilitation, etc) are ideally suited to

the SMA process and could lead to cost savings in these areas.

- Aboriginal and Torres Strait Islander peoples' health – on the basis of the findings in this study it seems appropriate to further test SMAs with Aboriginal and Torres Strait Islander groups (men and women), with a view to accredit Aboriginal health workers as SMA facilitators.

## Key points

- We have previously discussed the potential for SMAs as a means of better chronic diseases management in primary care in Australia.
- We found high patient and provider satisfaction after participating in a pilot study of SMAs in this mixed methods trial.
- The structure of an appropriate SMA in Australia may be different from that of other countries, with the facilitator being the key to a successful SMA.
- There are no real disadvantages to SMAs seen by patients after attending. Providers see organisational problems as an issue, but something that can be easily overcome.
- SMAs may be particularly suited to the delivery of Aboriginal healthcare.

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