Personalized Health Planning in a Shared Medical Appointment

An Implementation Manual for Delivering Personalized, Proactive, Patient-Centered Care in a Group Setting

Caroline Meade
Connor Drake, MPA
Sharon Hull, MD, MPH
Ralph Snyderman, MD

Duke Center for Research on Personalized Health Care

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Acknowledgements

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Preface

Ralph Snyderman, MD
Chancellor Emeritus, Duke University
James B. Duke Professor of Medicine, Duke University
Director, Duke Center for Research on Personalized Health Care

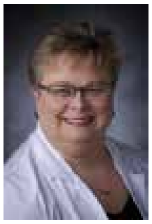
I had the privilege of serving as Duke University's Chancellor for Health Affairs from 1989 to 2004 and of overseeing the development of the Duke University Health System and serving as its first President and CEO from 1998 – 2004. During that time, I saw that our health care delivery system was focused on treating clinical events associated with late-stage chronic disease. Care was reactive to established disease, sporadic, and physician-directed. It was generally ineffective in preventing chronic diseases and not designed to treat them coherently when they occurred. The full range of needs for patients to navigate difficult clinical challenges was largely neglected. Care was focused on the disease, not the individual.

I became increasingly convinced that to improve care, patients needed a more holistic approach to their care, as well as a far greater opportunity to participate as a member of their care team. Their engagement was key to successful outcomes, particularly for the management of chronic disease. These concepts led to a focus on integrative approaches to care, combining the best therapeutics with patient-centricity and attention to the individual's broader needs to facilitate best outcomes.

By the turn of the 21st century, I also appreciated that genomics, proteomics, metabolomics, bioinformatics, etc., would soon provide medicine with transformational new capabilities – disease risk prediction and the ability to focus on prevention and chronic disease mitigation. It was clear that the evolution of health and disease was dependent on an individual's genetic make-up modified by a broad range of environmental exposure over time. Thus, new opportunities for prevention existed. Nonetheless, medical practice was almost exclusively focused on clinical events that occurred long after the underlying disease began to develop.

I reasoned that with new technical capabilities and understanding of patients' needs, we could transform health care to comport with the dynamic nature of health and disease development. By 2003, my colleagues and I proposed a radical new approach to care: one that is proactive, personalized, and driven by a partnership between the provider and an engaged patient. This approach combines the best of integrative care with predictive, precise medical care. We call this Personalized Health Care and at its core is a flexible clinical workflow called Personalized Health Planning. What is described herein is an approach to care that merges the needs and desires of the patient with proactive, personalized, state-of-the-art care enabled by a personal health plan. The following manual describes the adaptation of Personalized Health Planning to Shared Medical Appointments. We believe this approach will be transformational in delivering more cost-effective health care.

Preface (Cont.)



Sharon Hull, MD, MPH
Professor
Department of Community and Family Medicine
Duke University School of Medicine

As a family physician and a preventive medicine physician, it has been my privilege to serve as a member of the faculty in Duke University School of Medicine's Department of Community and Family Medicine since 2013. During that time, our clinic built on the work of many others to offer shared medical appointments (SMAs), or group visits, to our type 2 diabetes patients. SMAs are not a new concept, but the way we sought to implement them was. The typical expectation of SMAs is that patients with a similar condition (typically a chronic disease or pregnancy) are invited to obtain medical care in a group of 6-10 people, in a visit that lasts 90-120 minutes. Private history and physical exams are provided, but the visits also include extensive education and group discussion.

So, what was different for our program? We were invited by Dr. Ralph Snyderman and his team at the Duke Center for Research on Personalized Health Care to combine our SMA concept with his team's concept of Personalized Health Planning (PHP), designed to maximize patient engagement in goal-setting and tailor a treatment plan to address the patient's concerns.

The pairing of SMAs with PHP creates an experience that is greater than the sum of its parts. From the patient perspective, it meets the need of participants to have more extensive and more meaningful time with a provider. In our experience, this approach also results in improved clinical outcomes and patient satisfaction.

From the provider perspective, this combined PHP SMA model builds off the strengths of the concept of a Patient-Centered Medical Home. It lends itself to improved access and patient engagement, as well as systematized population health management in patients with chronic disease. Perhaps as important as any other provider-centric measure, though, is the potential for decreasing the burden on primary care providers by leveraging the power of an integrated team approach and allowing for a more satisfying way to practice medicine. As a thirty-year primary care provider, I can personally share that my clinic time with PHP SMA groups was rewarding in a way I had not experienced since my earliest days in the profession.

Introduction

This manual is a guide for the implementation of Personalized Health Planning in a Shared Medical Appointment for individuals with type 2 diabetes. The Personalized Health Planning Shared Medical Appointment provides personalized, proactive, patient-centered care within a group setting. It enables a practice to deliver personalized care, diabetes education, group support, and help patients meet their goals, all while making cost-effective use of existing resources.

Personalized Health Planning (PHP) tailors health care to the needs, values and preferences of the individual patient. It facilitates the use of the best available technologies for proactive, predictive medicine while recognizing the value of engaging patients in their care. Its clinical workflow allows for creation of a personal health plan for each patient in which shared patient-provider goals are outlined to address the patient's proximate and long-term health risks. The PHP model is flexible and adaptable to many clinical needs and settings. In the program described here, PHP is adapted for use within a **Shared Medical Appointment (SMA)** for individuals with type 2 diabetes. SMAs are conducted in 90- to 120-minute group visits, wherein 6-10 patients meet together with a small clinical team and provider. The synergy between PHP and the SMA provides the value of personalized, proactive, patient-centered care with the added benefits of more clinical time, comprehensive educational content, and social support. PHP emphasizes the importance of patient engagement in their care by providing a framework to facilitate goal-setting and care coordination within the SMA. **The Personalized Health Planning Shared Medical Appointment (PHP SMA)** is suitable for clinics or providers with the resources to provide SMAs and an interest in improving care for individuals with type 2 diabetes.

This manual provides assistance for clinics to offer the PHP SMA to their patients and includes:

- Suggestions for initiating practice change
- A detailed guide to PHP within the SMA
- An implementation checklist
- Information about recruiting, referring, and retaining patients
- Staffing requirements and care team competencies
- Templates for calculating the cost of the PHP SMA to a practice
- Suggestions for data collection to inform quality improvement

After reading the manual, you should be prepared to bring the PHP SMA to your practice.

Background

The basic premise behind the PHP SMA is to improve the delivery of chronic disease care, specifically for the care of type 2 diabetes, which affects an estimated 9.3% of the U.S. population and accounts for an estimated $245 billion in direct and indirect costs.[1]

This premise aligns with the Institute for Healthcare Improvement's Triple Aim, which highlights 3 major areas for improvement in health care:

1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing the per capita cost of care.[2]

Primary care is tasked with prevention, patient education, and treatment of chronic diseases, including type 2 diabetes. The trend towards value based care and a greater focus on quality will require clinicians and leadership to innovate, particularly in finding novel ways to prevent and manage chronic disease.

The PHP SMA is an innovation that is especially applicable for patients with type 2 diabetes, as effective therapy requires appropriate therapeutics as well as a patient who is committed to lifestyle modifications over time. The PHP SMA is based on established frameworks and evidence-based interventions for improving chronic care delivery.

Applying the Chronic Care Model to Diabetes Care

The Chronic Care Model (CCM) is a framework that outlines major elements required to improve chronic disease care.[3,4] A goal of the PHP SMA is to provide a clinical structure to deliver care that enables successful management of chronic diseases, in particular type 2 diabetes. The American Diabetes Association emphasizes the importance of aligning diabetes care with these 6 CCM core elements:

- *Delivery system design*: Moving from a reactive to a proactive care delivery system where visits are coordinated through a team-based approach.
- *Health self-management support*: Enabling and empowering patients to manage their own health and health care decision making.
- *Decision support*: Basing care on evidence-based guidelines.
- *Clinical information systems*: Using registries that provide patient specific and population based support to the care team.
- *Community resources and policies*: Identifying or developing resources to support healthy lifestyles.
- *Health systems*: Creating a quality-oriented culture.[5]

PHP is a clinical work flow that is suited to deliver the components of the CCM and the core elements noted above. As such, the PHP SMA is a strategy for primary care practices seeking to deliver high quality and comprehensive diabetes care.

Comprehensive Diabetes Care

The PHP SMA addresses the importance of acknowledging the multiplicity of needs that patients have in dealing effectively with their care. Diabetes care requires a comprehensive approach that often involves changing the behavior of the patient. To effect constructive change, it is important for the patient to have the opportunity to learn about the interplay between their health and their mind, body, social environment, and physical environment. The concept of considering the patient's physical, social, and emotional wellbeing has been embraced by care delivery systems around the country, including the Veterans Health Administration (VHA).[6] The Wheel of Health (below), developed by Duke Integrative Medicine[7], depicts how physical, social, and emotional wellbeing contribute to an individual's whole health. Type 2 diabetes is a complex and multifactorial disease, and the PHP SMA combines the best medical technologies with a holistic perspective of health to enable the best outcomes for patients.

Personalized Health Care

Personalized Health Care (PHC) is an established framework for the reorganization of care called for in the CCM. The goal of PHC is to reorient care towards proactivity, prevention, personalization, and patient-centeredness, as opposed to the traditional reactionary, disease-focused approach.[8] With rising health care costs, due in part to the high costs associated with treating late-stage chronic disease that develops over time, a change in our current model of care is necessary. Health care must move from its current reactive and disease-centric system to one that is proactive and focused on wellness, disease prevention, and the precise treatment of disease.[9] With the boom in predictive and precision technologies, targeted therapies, and the growing evidence of benefits from effective patient engagement strategies, this shift is now possible.

PHC proposes that through proactive care, disease risk (especially chronic disease) can be identified early and disease can be prevented or mitigated through therapeutic or lifestyle interventions. If disease does develop, it can be treated precisely and in a coordinated, patient-centered manner.

PHC is achieved by assessing the patient's current health status, health risks, and therapeutic needs using the best available clinical capabilities and health risk assessment tools.[8] Therapeutics and wellness plans to improve health and prevent disease are developed. Shared patient and provider goals and the means to achieve them are established in personal health plans. PHC combines this proactive clinical approach with strategies that enhance its impact by increasing patient engagement.[9] For more information on the personalized health care framework, visit http://dukepersonalizedhealth.org/

> *** Note:**
> *The goal of Personalized Health Care is to reorient care towards proactivity and patient-centeredness as opposed to the traditional reactionary, disease-focused approach*

Shared Medical Appointments and Diabetes Care

The Shared Medical Appointment (SMA) is a group appointment for individuals who share a common chronic disease. It can be useful for providing care to a population of individuals with type 2 diabetes because it gives providers the opportunity to offer diabetes management and education to multiple patients at once in the context of a billable clinical visit. The evidence base for the effectiveness of SMAs for type 2 diabetes is outlined in the Program Overview section. For this program, the SMA provides the foundation for implementing PHP and adding personalization to the SMA experience.

The PHP SMA and Patient Engagement

Clinical models for diabetes care that embrace the transformational potential of an activated patient are critical to improving health and wellbeing. Patient activation is a term used to describe an individual's knowledge, skills, and ability to manage his or her own healthcare.[10]

Higher patient activation is related to a lower probability of health-related outcomes such as obesity, smoking, and emergency department visits.[11] Patient engagement, a more general term, "combines patient activation with interventions designed to increase activation and promote positive patient behavior."[12]

The PHP SMA is one such intervention as it engages patients by providing the following resources and opportunities:

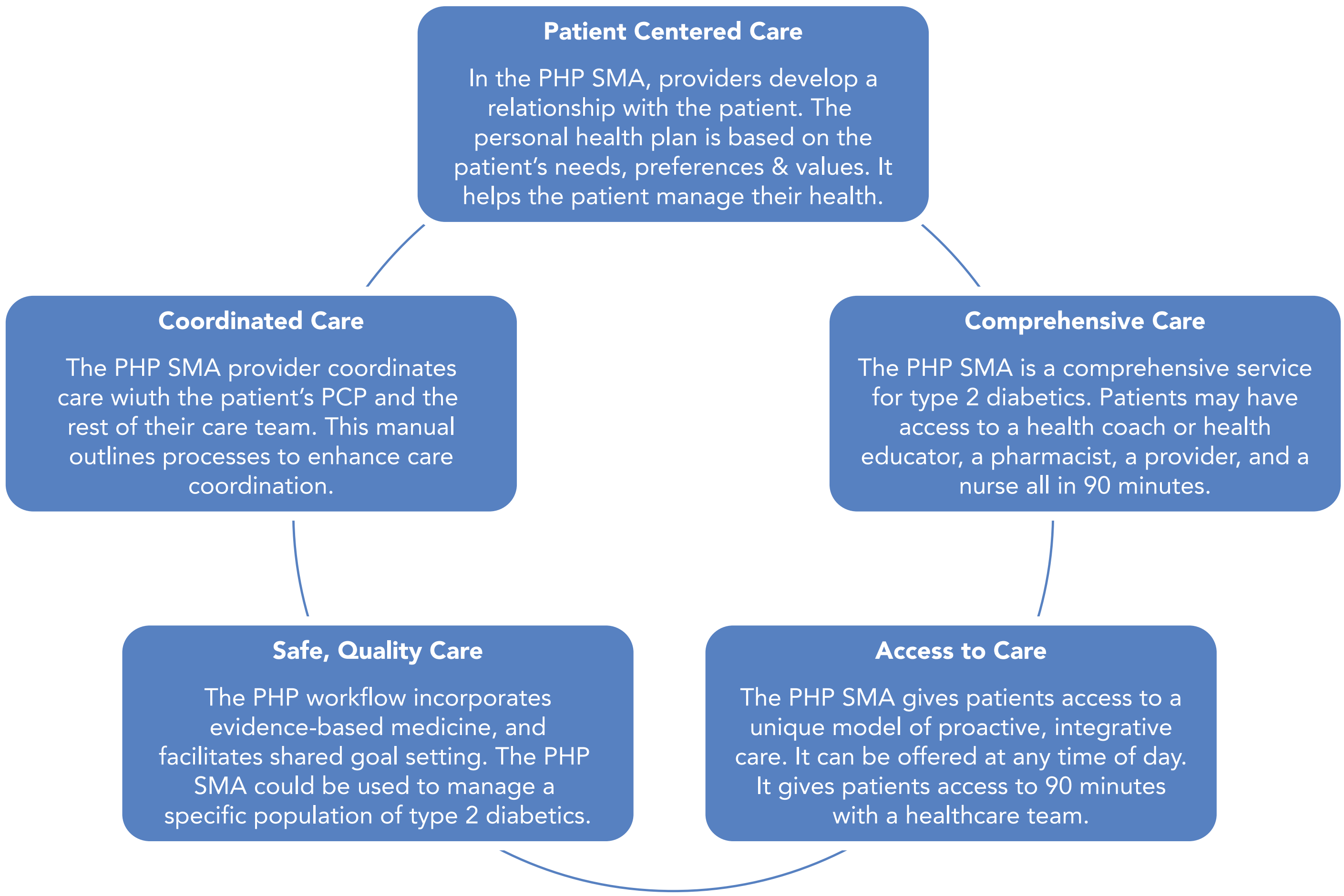
- *Health self-management tools and education*: A person with a chronic disease is responsible for its day-to-day management. Health outcomes are often more related to these decisions than they are to the health services and care the individual receives in a clinical setting. Health self-management tasks include problem solving, decision making, resource utilization, forming a patient/provider relationship, and taking action.[13] The PHP SMA program focuses on enabling the skills, knowledge, and abilities for patients to become capable and empowered self-managers of their health.

- *Shared decision making*: Shared decision making has been called "the crux of patient centered care."[14] The goal of shared decision making is to incorporate patient preferences into health care decisions. Instead of a paternalistic power dynamic wherein "the provider knows best," shared decision making is based on shared expertise. The patient is an expert of his or her own life, values, and preferences, while the provider is an expert in medicine. Personalized health planning culminates in shared goal-setting between patient and provider. It is a participatory approach, designed to take into account the patient's needs and preferences.

- *Peer support*: Self-management of a chronic disease like type 2 diabetes presents challenges that can be exacerbated by a lack of peer or social support. Peer support comes from an individual who "has knowledge from their own experience with a condition."[15] Key aspects of peer support include assistance in daily management (diet, physical activity, medication adherence), social and emotional support (in the form of listening and encouragement), linkages to clinical or community resources, and ongoing support.[16] The SMA gives patients a group of peers with type 2 diabetes to interact with over time. The PHP SMA program encourages group discussion, particularly when it comes to support in overcoming challenges and celebrating progress.

The PHP SMA and the Patient Centered Medical Home

A structure designed to provide comprehensive diabetes care is the Patient Centered Medical Home (PCMH), which helps clinics provide coordinated, safe, accessible, comprehensive, and patient-centered care.[17] PHP is designed to provide a clinical workflow for the PCMH, as it offers a structure for fulfilling the goals of this approach In PCHMs that serve large populations of individuals with chronic disease, particularly individuals with type 2 diabetes, the PHP SMA is a vehicle for delivering efficient, effective, and high quality care. Aspects of the PHP SMA align well with each of the five tenets of the PCMH: Patient Centered Care, Comprehensive Care, Access to Care, Safe Quality Care, and Coordinated Care. The figure below describes how the PHP SMA facilitates the type of care described by each tenet.



The new tools and capabilities for care coordination and population health management that a PCMH puts into place will align well with the PHP SMA. It is an opportunity for a practice to add a patient-centered, team-based approach that emphasizes care coordination. It gives patients with type 2 diabetes access to comprehensive care focused on their needs and whole health.

Program Overview

The Personalized Health Planning Shared Medical Appointment (PHP SMA) was developed by adapting Personalized Health Planning (PHP), a clinical workflow for personalized, proactive care, for delivery via a Shared Medical Appointment (SMA). In this section, we describe the two main pieces of this evidence-based program and how they combine to form the PHP SMA.

Personalized Health Planning

Personalized Health Planning (PHP) is the clinical workflow used in this program. It is based on a framework for the organization of care delivery called Personalized Health Care[8] which was introduced in the Background section.

PHP has been utilized to provide personalized, proactive, patient-centered care for a variety of patient populations in several health care settings, including veterans[18], Medicare advantage patients in primary care[19], multi-morbid homebound patients[20], and patients with cardiovascular risk factors.[21] A systematic review of 19 "personalized care planning" studies using a collaborative process to improve chronic condition management through self-management information, education, lifestyle modification, showed better diabetes management, better blood pressure reduction for patients with hypertension, and improvements in self-management capabilities when compared to a control group.[22]

The 5 key steps to the PHP clinical workflow are:

1. The patient completes a comprehensive self-assessment with supervision to engage them in identifying what they want their health for.

2. The provider conducts a comprehensive health evaluation and health risk-assessment with conventional and best available predictive technologies. The provider determines the most important health risks and creates a therapeutic plan to mitigate them.

3. Patient and provider set shared goals to address the patient's clinical needs and their goals for their health.

4. Shared health goals are documented in the personal health plan which is created to detail plans to achieve goals and track clinical metrics and progress toward the goal. A printed copy is given to the patient and an electronic version is stored in the health record.

5. The personal health plan sets dates for future follow-up and is updated in the electrtonic health record to coordinate care around achieving goals.

The Personal Health Planning Process

- Patient Responsibility
- Provider Responsibility
- Shared Responsibility

1. **Health Self-Assessment**
   Patient defines his/her needs, preferences, and goals for whole health

2. **Health Risk Assessment**
   Provider conducts clinical evaluation and health risk assessment, creates therapeutic plan

3. **Shared Goals**
   Goals address clinical needs in the context of what matters to the patient

4. **Personalized Health Plan**
   Signed by patient and provider, this living document details therapeutic plan and tracks clinical goal progress

5. **Follow Up/Coordinate Care**
   Goals are tracked in EMR, health plan is updated, care is coordinated over time

The Implementation Section of this manual describes the PHP process in more detail, providing step-by-step directions for executing PHP in the SMA setting.

The Shared Medical Appointment (SMA)

The SMA brings together patients who share a certain chronic illness for longer visits led by a clinical team. SMAs are different from group diabetes education because a medical provider is present, meaning that each patient's SMA visit is billable.[23] A meta-analysis of 17 studies that compared diabetes SMAs with usual care or enhanced usual care shows an association between participation in a diabetes SMA and a reduction in A1C levels (mean -0.55 percentage points) and lower systolic blood pressure (mean -5.22).[24]

The care team for an SMA can consist of a physician, physician's assistant (PA) or a nurse practictioner (NP) as the lead health care provider and a health coach or group facilitator, with ancillary team members that may include pharmacists, residents, nurses, nutritionists, or social workers in complementary clinical support or health educator roles.

> **Note:**
> *While a traditional individual appointment with a primary care provider is short, typically lasting 15 to 30 minutes, SMAs are 90 to 120 minutes long and occur in a group setting of 6-10 patients. Some SMAs have an open door policy, wherein patients can 'drop-in'. Others, like the PHP SMA described in this manual, are closed groups with a cohort that completes the program together.*

The SMA provides the time and space for a patient-centered health care experience, including an individual physical exam, group discussion of successes and challenges, and tailored diabetes education. It is also an ideal venue for carrying out the components of the PHP approach. The added time and social support allow for opportunities to engage patients in their care, create personal health plans, and track and support progress.

Personalized Health Planning + Shared Medical Appointment: the PHP SMA in Practice

While PHP can be used in many clinical settings, the benefits of the SMA complement the PHP approach. PHP provides the clinical workflow for proactive, patient-centered care, and the SMA provides the time and space in which to implement the clinical workflow.

Personalized Health Planning + Shared Medical Appointment = PHP SMA

- Patient Engagment
- Health Risk Assessment
- Shared Decision Making
- Health Goals
- Personal Health Plan

- Peer Support
- Accountability
- Education
- Time

There are a total of eight 90-minute sessions that occur over the course of 4-12 months. Frequency of sessions are selected by each clinic or facility and will differ depending on provider bandwidth, clinic capacity, and the patient population. During every PHP SMA session, patients have a short physical exam with their provider. Once the physical exam is completed, the patient returns to the group diabetes session/education.

In the first two sessions of the PHP SMA, the patient is introduced to the PHP process and the personal health plan is created. Steps 1-4 of the 5-step PHP process are completed in these first two sessions.

Quotes from PHP SMA Patients and Care Team

In the following quotes, patients and care team members express the value and synergy of offering PHP in the SMA setting.

> "The participants are the same so you do get to know each other… [the PHP SMA] gives you like people to speak to… this is a group of people who understand what we're going through." – *PHP SMA participant*
>
> "I think that's the beauty of adding PHP into the group setting. PHP couldn't be done in a 15-minute appointment very easily. It can be in the group setting."
> - *PHP SMA provider*
>
> "I think group discussion is important, but I think patients saw more value when the group discussion was complemented by a health plan that had been tailored to their needs, their values, what's important to them, and their preferences."- *Health Coach*

The PHP SMA in Operation

While PHP can be used in a variety of clinical settings, this section will explain the specifics of how it fits into the SMA structure. This section outlines the course of the PHP SMA and the components of each session.

The 5 main steps of Personalized Health Planning (outlined on pages 12-13) are detailed below.

Step 1: Patient Engagement Using the Whole Health Self-Assessment

Conducting the whole health self-assessment is an integral part of the personalized health planning process. The full health self-assessment document is located in the accompanying participant notebook and may be useful to consult as you read this section.

This is an opportunity to re-orient the patient to their role in their care. A health coach or certified diabetes educator (CDE) is well-qualified to guide the patient through the self-assessment, but a nurse or other provider with training in motivational interviewing and the transtheoretical model[25] for health behavior change could also fill this role. This is also an opportunity to assess the patient's level of engagement in their care. Is the patient motivated to make change? Do they understand their disease and how to manage it? Do they feel like an active member of their health care team? The health coach or CDE can assess patient engagement by reviewing the patient's answers to the whole health self-assessment.

The whole health self-assessment is based on the Wheel of Health[7], which depicts all of the areas of one's life that influence their health. It emphasizes the concept of whole health and can initiate a conversation about how the various areas of one's health are connected.

After orienting the patient to the Wheel of Health, their role in their care, and the concept of whole health, the health self-assessment asks the patient to begin considering what good health means to them.

What do you need or want your health for?
In other words, what is most important to you about your health? What makes it Important to you? How would you like to feel and look? What activities would you like to be able to do? What would good health be like for you? Use the 'Wheel of Health' on the cover page to assist you in thinking about areas of your life or activities that are important to you that you need your health for.

Examples: I would like to have the energy and stamina to play with my grandchildren; I need my health to provide for my loved ones; I would like to lose weight to fit in to a certain article of clothing.

____
____
____

Next, it walks the patient through an assessment of their current and desired states. For each area on the Wheel of Health (ex: Physical Environment, Nutrition, etc.), the patient is asked to think through where they are now and where they would like to be. This exercise allows the patient to consider their personal and health-related goals.

By the end of the self-assessment, the patient will be primed to set health goals with their provider during PHP SMA session 2.

<table>
<tr><td colspan="2">Nutrition: You can improve your health through the food you eat by providing your body with healthy, balanced meals with plenty of fruits and vegetables each and every day. Also, drinking enough water and limiting sodas, sweetened drinks, and alcohol can help with weight loss and improve energy levels.</td></tr>
<tr><td>1 = My diet is very poor 10 = I eat healthy meals
Where are you? Please rate yourself
1 2 3 4 5 6 7 8 9 10</td><td>1 = My diet is very poor 10 = I have a healthy diet
Realisitically, what level do you see yourself improving to?
1 2 3 4 5 6 7 8 9 10</td></tr>
<tr><td>How did you decide on this number?</td><td>What would you be willing to do to get to a higher level? What changes could you make to help you get there?</td></tr>
</table>

Step 2: Provider's Therapeutic Plan

The PHP SMA is an opportunity for the provider to focus on creating a care plan centered on the patient's diabetes. With the primary care provider remaining in the picture to handle all other health concerns, the PHP SMA provider must conduct the patient's physical exam and chart review and use that information to identifying the patient's short term and long term health risks that can be addressed over the course of the PHP SMA.

While the provider's therapeutic plan should center on managing or limiting the progression of the patient's diabetes, it should also align with the tenets of the Wheel of Health in recognizing that other health risks, such as hypertension or chronic stress, may be most important to address in order to get the patient's diabetes back on track.

The provider will complete a thorough risk assessment for diabetes and its complications.

At the onset of the PHP SMA process, the provider will need to thoroughly review each patient's chart for specific information. Through the patient's chart, the patient's medical history, and a physical exam, the provider will review the following:

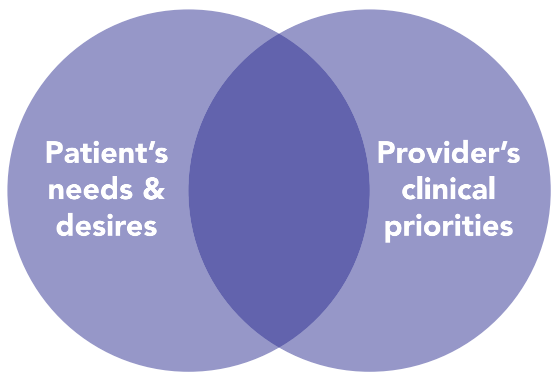
- Co-morbid conditions, such as known cardiovascular disease, hypertension, peripheral vascular disease, depression, anxiety and others.
- End-organ diseases (other than cardiovascular) specifically related to diabetes, including retinopathy, nephropathy, and neuropathy.
- Current medications and allergies, with particular attention to classes of diabetes medications that have been tried or are currently in use.
- Patient's goals for addressing their diabetes, if indicated in the chart.

This review, along with a thorough physical examination and use of PHP tools described here to assess the patient's primary goals and their readiness to change behaviors, will allow for development of a robust plan for managing diabetes as a partnership between the provider and the patient.

> **Note:**
> *The care coordination form from the patient's primary care provider (PCP) can be useful in developing this therapeutic plan.*

Step 3: Setting Shared Goals

Setting shared goals with the patient is fundamental to the health planning process. Using the completed whole health self-assessment, the provider bridges the patient's priorities with their therapeutic goals for the patient. Below is a useful guide for initiating shared goal setting.



1. Start the conversation by asking the patient about their whole health self-assessment:
   "What are some important things you need and want your health for?"
   "What are some areas you have identified where you'd like to improve?"

2. Summarize what you heard from the patient:
   "So it sounds like you want your health for _____ and are interested in ______. Is that correct?"

3. Include your clinical perspective:
   "Let me share with you what I've learned about your health from your physical exam and looking at your chart."

4. Relate your clinical perspective to what is important to the patient:
   "Based on _____, you are at risk for _____. This could affect your ability to do ______."

5. Engage the patient in connecting their goals to your clinical assessment:
   "When you think about what is important to you and what I've shared with you about your health risks, are there any changes you'd like to make?

6. Help the patient create a Specific, Measurable, Action-Oriented, Realistic, Timed (SMART) goal.
   "Great, I'm excited that you're interested in making changes in _____. Let's talk about some specific actions you can take between now and our next session."

7. Once SMART goal(s) are created, fill out the personal health plan.
   "I'm glad you have chosen a goal. How would you like to track your progress? We will follow-up next session to see how you are doing with this goal."
   "Now, let's both sign the personal health plan. I am committed to helping you achieve this goal"

Foundational skills like motivational interviewing, shared decision-making, and SMART goal setting are part of the training a health coach and provider should have before implementing PHP. See the appendix for additional training resources.

Step 4: The Personal Health Plan

Shared goals are put into in the personal health plan which is revisited at each SMA session and documented in the electronic health record. The personal health plan serves as an agreement between patient and provider about the patient's health risks, the shared goals they set together, and action steps for making progress on those goals. Relevant metrics for tracking progress that align with the shared goals should be established.

My Personal Health Plan

Dates:

I, ______________________________ **and** ______________________________

(name of patient) (name of clinician)

Have spoken about my health risks and created the following plan for improving my health:

Step 5: Coordinating Care and Revisiting the Personal Health Plan

The curriculum includes time during each PHP SMA session to check in with patients about their progress on the goals and action steps outlined in the personal health plan. This is time for group discussion, or individual conversations with patients depending on how they are feeling about their progress. If a patient is not making progress on a goal, it may be time to it may be time to think about setting smaller action steps. If a patient has met a goal, it is time to celebrate that achievement with the group and set a new goal. Progress is documented in the patient's chart for other providers to see. At the end of all sessions, a Progress Note from the PHP SMA provider for the patient's PCP closes the loop. The Progress Note (found in the Appendix) highlights the patient's progress and ensures that the patient's PCP can continue to work with the patient on personalized health planning.

Sessions

An overview of how the 5 PHP steps fit into the 8 SMA sessions is included below:

Session 1

1. The health coach leads the patient through a whole health self-assessment of their needs, values and preferences for care.
2. After conducting the physical exam, the provider assesses the patient's current health status and health risks using the best information available to them. The provider identifies risk-mitigation and therapeutic priorities for the patient.

Session 2

3. Patient and provider set shared health goals, based on the patient's whole health self-assessment and the provider's therapeutic goals.
4. The shared goals are incorporated into a personal health plan, which both patient and provider sign. The personal health plan identifies metrics for tracking the patient's progress and is documented in the electronic health record.

Sessions 3-8

5. Throughout the course of the SMA sessions, the provider coordinates care with the rest of the patient's care team. The personal health plan is revisited at each SMA session.

The group setting provided by the SMA complements the personalized health planning process. It gives patients a sense of camaraderie and accountability as they seek to achieve their goals, it gives them a support system when they hit bumps in the road, and it gives them a cheering section when they make progress. Many patients do not have this type of supportive environment for goal achievement outside of the SMA setting.

Example Case

Note: name and case details are hypothetical

The patient (Michael)

- 40-year-old male
- Diagnosed with type 2 diabetes 3 months ago
- Lost 50 pounds 4 years ago
- Has regained some of the weight
- Recently unemployed

Michael feels overwhelmed with all of the lifestyle changes he is supposed to make on top of losing his job which has been stressful. Michael agrees with his PCP that this personalized health planning shared medical appointment could be helpful. He tells his PCP he'll try it.

Michael's PCP refers him to the PHP SMA. The scheduler calls Michael the next day, adds Michael to a group that works with his schedule, and notes that he would like reminders via his patient portal. Two days before the first PHP SMA session, Michael gets a reminder notice in his patient portal. On Thursday afternoon, he arrives at the classroom for his first PHP SMA visit.

Prior to the first PHP SMA visit, the provider leading Michael's PHP SMA cohort reviews care coordination forms from patients' PCPs. Michael's form indicates the following:

- Most recent hemoglobin A1c score is 7.0%
- No end organ diseases related to uncontrolled diabetes
- History of obesity

Michael's PCP identified his top 3 Health Risks as: 1) glucose control (short-term), 2) obesity (long-term) and 3) cardiovascular disease. The provider notes that no diabetes goals have been documented in Michael's chart.

Michael enters the classroom and is greeted by a nurse or medical assistant. He fills out forms, and learns to take his own weight and blood pressure. His blood pressure is high and his BMI is 29.5. After he finishes intake, another patient is meeting with the provider, so Michael goes to the circle of chairs in the middle of the room. The health coach introduces herself and gives Michael his participant notebook. He starts reading about the health self-assessment. Another patient comes and sits down and introduces herself. They chat a bit about why they're there.

Now it is Michael's turn to have his physical exam. He meets the provider, who tells him what she learned from his care coordination form. She checks his feet, and does a brief physical exam. The provider tells him that she is looking forward to creating a personal health plan with him for his diabetes in the next session.

After his physical exam, Michael goes back to the center of the room. He talks to a pharmacy student about the fact that he is taking metformin, but that he isn't liking the side effects. Once everyone has arrived, the provider and the health coach welcome everyone. They describe this program, each patient introduces his or herself, and the group sets guidelines for confidentiality and productive conversation. The health coach describes mindfulness, one of many tools that Michael learns he will receive during the PHP SMA. They do a mindfulness practice as a group, and Michael feels focused and centered-there is nowhere else he needs to be during this time. The health coach asks each of them to think about what they really want their health for and to write it down in their whole health self-assessment. They will have more time to think about this between now and the next session.

Michael leaves the first session feeling excited about the PHP SMA. On his drive home, he starts to think about the areas of his health he'd like to improve, and why they are important to him.

Michael returns to the second session two weeks later and is excited to see many familiar faces. He takes his own weight and blood pressure, and talks to a pharmacy student about his medications while other patients arrive. Like last session, the provider and health coach welcome the group, and the health coach leads everyone in another mindfulness exercise. She reminds them about their CD of mindfulness recordings, and Michael makes a note to try to use them at home when he gets stressed about searching for a job. The provider tells everyone that this session is all about setting goals based on each person's specific needs and preferences for health. A few people share those priorities. Michael wants to be healthier so that he can take any type of job, even those that require physical activity. Next, the health coach and provider go around the room and work with each person to set a shared health goal. When it is Michael's turn, the provider tells him what his health risks are. Michael feels like he'd like to begin exercising more, and the provider and health coach describe how exercise can help decrease his weight and his risk for cardiovascular disease. He and his provider set a shared SMART goal: Michael will walk twice around the block 4 days a week after lunch before he sits down to search for a job. His health coach even suggests that he could try mindful walking to reduce stress.

Once everyone has set a goal, each person shares his or her goal with the group. Michael feels supported by the people in his group, and he looks forward to sharing his progress with them next time.

Over the course of the next 6 sessions, Michael continues to work towards his goals. As he achieves them, the group celebrates his progress and he works with his PHP SMA care team to set new goals. He learns about all of the areas of his health, and begins to recognize how his stress and weight gain are interrelated and all contribute to the health risks his provider identified. At the end of the 8 sessions, Michael feels like he has a toolkit of valuable information to help him manage his health. He understands his disease and has tips and information about managing his disease from his provider, his health coach, and his groupmates. He has seen success in setting and achieving goals and feels empowered to continue doing so. Finally, he knows that even though the group is over, his groupmates will continue to be a support system he can lean on.

Quotes from PHP SMA Patients and Care Team

The group environment of the shared medical appointment can be powerful for supporting goal progress. This is best illustrated by quotes from PHP SMA patients and providers.

> “Again it was accountability because it wasn’t just like your doctor you’re accountable to…but it was to each other that we were accountable. And I think in some ways being accountable to each other meant a little bit more than being accountable to professionals.” – *PHP SMA participant*
>
> “I think the patients all have different stories and the patients, we encourage each other and it’s motivating to me and inspiring to hear the achievements of other patients.” – *PHP SMA participant*
>
> “What we’ve done is we’ve created a productive and healthy social support system” – *Health Coach*

In addition, the health coach discusses the value of the PHP process:

> “I think it really helps us achieve the goals we set …We put it into a health plan, we sign it, we’re buying in, there’s buy-in there from the patient, they take it home with them, we document it in the EMR and we track progress over time and we work towards it together with the understanding that it might not be a linear process, we might take one step forward or a step back and then two steps forward, but that we’re there to work with them to achieve this goal.” – *Health Coach*
>
> “This isn’t a provider telling a patient what they need to do, this is a provider and patient collaboratively building a health plan together.” – *Health Coach*

The Curriculum

To guide the educational content and discussion in each session, a full curriculum is available. Please visit our website to request the curriculum. It includes scripts for each session, educational content (including worksheets and handouts), and a participant notebook for the patient.

The curriculum was developed in the spring of 2015 and refined over the course of 14 months based on feedback from patient focus groups, notes taken by the provider and health coach throughout PHP SMA sessions, and interviews with the PHP SMA care team.

Each PHP SMA session script includes the following three main components:

- An introductory mindfulness practice (optional)
- Educational content for a 15 to 20-minute lesson and discussion
- Structure for group discussion about goal progress and personal health plan refinement

PHP SMA session scripts highlight which care team member (provider or health coach) should lead each portion of the session. The scripts guide conversation in each session, though the PHP SMA care team should recognize that the priority is addressing patient questions and allowing time for discussion. As group facilitators know, things in a group do not always go as planned, and this is okay!

What makes the PHP SMA unique is its focus on creation of a personal health plan with shared goals. The curriculum is designed to facilitate time for patients to check in about their goal progress with their provider and the group in each session. They can use this time to set new goals for continued progress if necessary. This time for discussion of goal progress is an integral aspect of the PHP SMA.

Educational Content

Educational content for the PHP SMA is based on the concept of whole health, emphasizing that health is physical, social, and emotional. Educational topics include: Goal-Setting, Diet & Nutrition, What is Diabetes?, Stress and the Mind Body Connection, Movement, Exercise & Rest, Medications, and Personal Relationships & the Health Care Team.

The Participant Notebook

Throughout the curriculum, the script references worksheets and handouts in the participant notebook. It holds the patient's health self-assessment, their personal health plan, handouts and worksheets. Some of these will be reviewed during the PHP SMA sessions, while others are for the patient to explore on their own.

Community Liaison & Engagement

Throughout your PHP SMA, situations may arise where a patient is in need of a resource not offered by your clinic or organization. In these cases, referral to community resources may be appropriate. In order to connect patients with community resources, knowledge of what is available in your community is necessary.

In other cases, your community may be offering resources that are complementary to the PHP SMA. For example, your local public health department could have diabetes classes or peer-led diabetes groups. If this is the case, it could give your PHP SMA patients additional resources to take advantage of or become involved in both during and after completing their eight PHP SMA sessions.

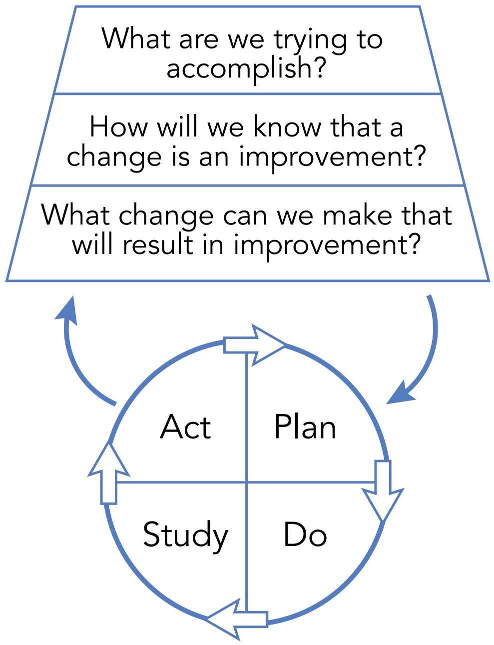
As health care systems transition towards population health, partnerships with community public health departments will become increasingly common. The Practical Playbook, developed by the de Beaumont Foundation and the Duke Department of Community and Family Medicine, is a foundational guide to building a successful primary care-public health partnership.

Evaluation

Any clinic implementing PHP SMAs should evaluate the new approach as quality improvement for practice redesign. Regardless of what strategies you use to implement the PHP SMA, it will be an iterative process of determining what works, what doesn't work, and what changes can be made to improve the program at your clinic. Think of it as a Plan-Do-Study-Act (PDSA) cycle for continual improvement. Did you meet the goals your clinic set for the PHP SMA?

The Duke Center for Research on Personalized Health Care would like to learn more about this approach. If interested in evaluating the PHP SMA as clinical research or quality improvement, please contact us at personalized-health@duke.edu. We can provide guidance and expertise related to delivering this approach as clinical research or quality improvement, specific scales and measures for evaluation, and guides for conducting focus groups.

Model for Improvement



Some areas for evaluation of the PHP SMA are: attendance and attrition, financial feasibility (see appendix), clinical and psychometric outcomes, and patient satisfaction.

Attendance and Attrition:

Tracking attendance is not only important for determining financial feasibility but also for identifying areas for improvement. A simple chart in Microsoft Excel can track attendance. Attendance data can be shared with the PHP SMA provider, the patient's PCP, and clinic leadership.

Clinical Metrics for Evaluation:

Tracking clinical metrics will tell you if measurable clinical improvement is occurring. Some clinical metrics that may be worthwhile to track over time are: hemoglobin A1C levels, low density lipoprotein levels, body mass index, and blood pressure.

Psychometric Measures for Evaluation:

Patient-reported outcomes are also highly relevant to track. Increases in self-reported measures of engagement and self-efficacy could be an indication that patients have gained the skills and resources necessary to manage their health. Patient activation, health literacy, and self-efficacy are potential areas for evaluation.

Patient Satisfaction:

Soliciting patient feedback is a way to engage patients in quality improvement efforts at your clinic. It may even be an opportunity to identify patient champions for community engagement.

Patient Focus Groups:

Focus groups are a strategy for soliciting more in-depth feedback from patients. Focus groups were used to refine the program described in this manual and can also be used to refine your delivery of the PHP SMA. If you are interested in conducting focus groups and would like additional resources, please contact us. We can offer a focus group guide, including questions to ask focus group participants.

Bringing the PHP SMA to Your Practice

Minimum Resources Required

The strength of the PHP SMA is that it can be adapted to a number of different clinical settings. While this manual presents opportunities to incorporate a wide variety of staff and resources into the PHP SMA, the program can also be delivered in settings with basic clinical staff.

In order to implement the PHP SMA, minimum resources required are:
- A primary care provider
- A group facilitator (could be a nurse, certified diabetes educator, volunteer, etc.)
- A nurse or medical assistant to conduct check-in
- A conference room or classroom that can accommodate a group
- A population of patients with type 2 diabetes who require additional support

Defining the Patient Population(s)

Choosing a patient population of focus is an early step to consider. This program is generally of benefit to patients with type 2 diabetes who need extra support for health self-management.

For our purposes, type 2 diabetes can be broken down into 3 stages: early, mid, and late disease. For specific clinical criteria for early (pre-diabetes and early diabetes) and late (out-of-control diabetes) stages, see the "Setting Eligibility Criteria" section (page 38).

The first time this intervention was implemented, the patient population was mid-to-late stage diabetics. Many had had diabetes for years, and almost all were out of control, with hemoglobin A1c measurements greater than 7.0%. While this approach is suited for keeping out of control diabetics from developing serious diabetic complications, it may also be effective for early stage pre-diabetes or recently diagnosed diabetes. When conducting focus groups with mid-late stage PHP SMA participants, nearly all expressed that they wish they had access to the groups earlier, and that they lacked this type of support when they were first diagnosed.

If interested in offering the PHP SMA for pre-diabetes, please contact the authors at personalized-health@duke.edu. We hypothesize that individuals with early stage diabetes may be more motivated to make lifestyle change, resulting in better outcomes.

Making Practice Change

If your practice is not already offering group-based models of care, implementing PHP SMAs will require resources along with support for innovation and organizational change. Making change in a primary care setting is a challenge, especially when services are in high demand and established clinical workflows guide everyday clinical care. Here are a few guidelines to remember as you consider implementing PHP SMAs in your clinic:

1. **Develop a case statement**
   a. Why is the PHP SMA a worthwhile program to implement at your clinic?
   b. Arm your case statement with data. What segment of your patient population could this help the most?
   c. Put your case statement in the context of current movements in care redesign (population health, the Patient-Centered Medical Home requirements, personalizing care).

2. **Engage clinic leadership and staff early in the process**
   a. The more people buying into the practice change, the better. Identify key stakeholders early on.
   b. Clinic leadership and staff support is important.

3. **Much of the work will revolve around process management**
   a. Work within the constraints of your current clinical workflow.
   b. Develop "ideal" processes for recruitment, documentation, etc. (some are proposed in this manual) and be prepared to refine them over time.

4. **Approach this as a Plan-Do-Study-Act cycle for quality improvement**
   a. Again, it's all about the data. How will you track improvement?

5. **Take your time in the planning phase**
   a. It takes time to build a case and garner support, but you can't move forward without them.
   b. Strategic planning is like health planning. Be proactive, foresee potential problems, and plan to mitigate them.

6. **The PHP SMA is a flexible approach**
   a. Be creative! Every clinical facility will have different constraints or facilitators of the PHP SMA intervention. If something suggested in this manual doesn't work for your clinic, innovate around it.
   b. Create a list of "must-haves" for the program and identify aspects of the program you could compromise on.

Our implementation checklist (see Appendix) can help guide you through the processes of obtaining leadership approval and getting your PHP SMA up-and-running. The rest of the sections in this manual are designed to help you address the following questions:

- What key stakeholders need to be engaged?
- How will you define your desired patient population?
- Where will PHP SMA sessions be held?
- How far apart will PHP SMA sessions be?
- How many PHP SMA groups will be offered at one time?
- Who will play key and ancillary PHP SMA care team roles?
- How can the PHP SMA be implemented so that it is feasible from a cost perspective?
- How does one document PHP SMA visits?

Common FAQs for PHP SMA Implementation

Q: My practice is understaffed and running a multitude of other programs. Is this feasible in such a setting?
A: *Yes, it is feasible. First, if implemented successfully, the PHP SMA can increase provider productivity by allowing one provider to bill for the same, if not more, patients as they would in 90 to 120 minutes of 1:1 clinical encounters. Second, the PHP SMA can decrease strain on staff who may be burnt out from their daily schedule. Providers may jump on the opportunity to break up their week with leading PHP SMA group.*

Q: How do I pitch this to the providers in my clinic?
A: *Pitch it as a resource for providers to offload the diabetes care for their challenging individuals with out-control- type 2 diabetes to the PHP SMA provider. This will allow them to focus on the patient's other needs. Also emphasize the personal health plan which will guide the patient's PHP SMA care and allow for documentation of SMART health goals, and the follow-up note to ensure care coordination. Finally, mention that it can increase clinic efficiency by allowing PHP SMA providers to bill for each patient at the same rate as they would for one-on-one appointments.*

Q: What are the "must-haves" for the PHP SMA?
A: *We believe that must-haves for the PHP SMA are:*
- *A "closed" group cohort where the same patients attend each session. Social support for goal progress is not as strong in "open groups" that allow drop-ins.*
- *Use of the PHP process to create a personal health plan with shared goals for the patient. Without this, one simply has an SMA with patient education.*
- *Specific time set aside each session for discussion of the personal health plan and goal progress. This adds consistency to each session and ensures that patients receive support for health self-management and goal achievement.*

Q: Do I have to run multiple PHP SMA cohorts at once?
A: *Absolutely not. In fact, piloting the program with one group cohort at your facility can give you opportunities to personalize it to your clinic's needs, refine recruitment or session workflow, and assess feasibility.*

Initial Considerations

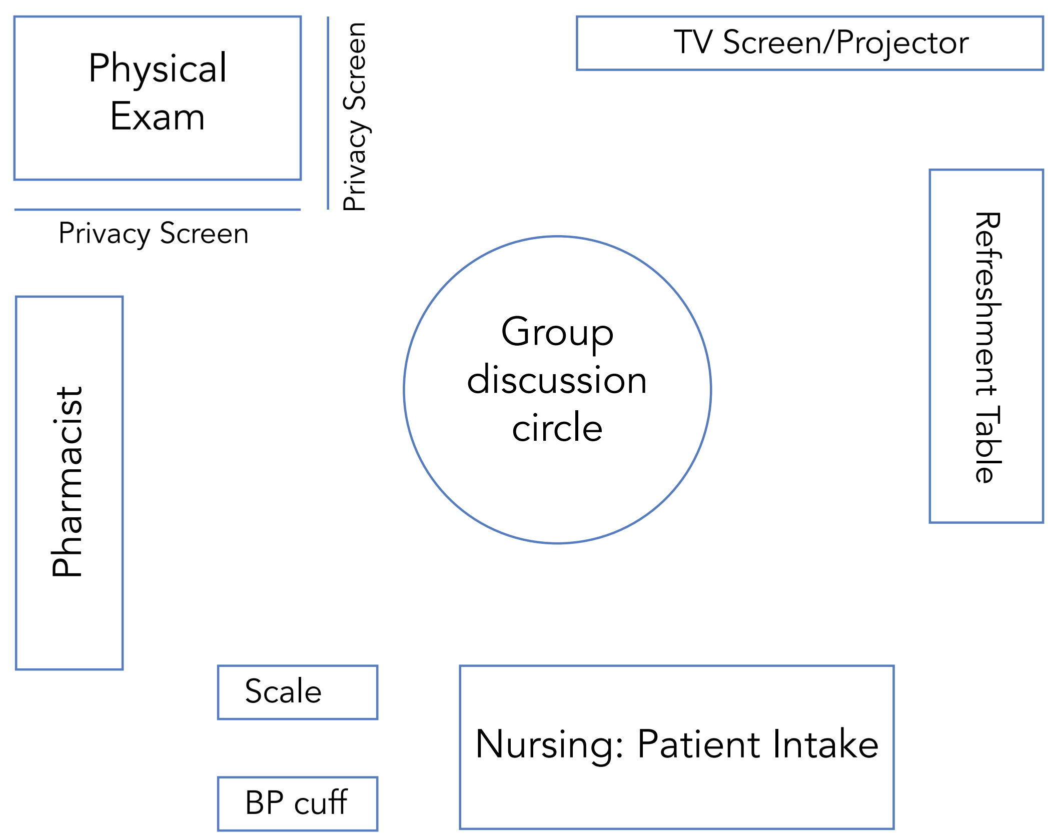
Space

Considering where you will hold PHP SMA sessions early-on will allow for early booking of the space and scheduling of sessions around space availability.

Some facilities may have a designated classroom for group education, while others may not. In general, as long as a room can accommodate 8-12 people with an area to hold private physical exams, the space should work for the PHP SMA. For physical exams, utilizing a privacy barrier or curtain can allow you to conduct all PHP SMA activities in one room.

There are various stations each patient will make their way through during the PHP SMA. Below is an example of an ideal PHP SMA classroom set-up.

Classroom Set-Up



Scheduling of Sessions

The 8 PHP SMA sessions can be offered at varying amounts of time apart. For example, sessions could be one month apart, 2 weeks, or even 1 week apart. They can also be offered at varying days and times. This decision will depend on your patient population and availability of the PHP SMA care team. Also consider:

- Sessions 1 and 2 of the PHP SMA curriculum focus on setting goals and creating the personal health plan. It may be helpful to schedule these sessions closer together than other sessions.
- Generally, according to the literature, closed-cohort SMAs typically do not last longer than 1 year or shorter than 2 months.[24]
- Sticking to the same day and time for each session so that patients can easily work it into their schedule.
- An older patient population will have more availability during the day.
- PCMHs can receive benefits from offering expanded clinical hours. Evening PHP SMA sessions could achieve this.

An ideal scheduling of sessions might be all sessions scheduled at 6pm on Wednesday evenings. Sessions 1 and 2 are offered 1 week apart. After session 2, sessions are two weeks apart for a total program length of ~3 months.

Staffing Requirements

The PHP SMA leverages a multi-disciplinary care team to deliver care in each group session. In fact, with a group of 6-10 patients, more than one professional is necessary. There are key members of the team and ancillary team members. Basic staffing needs are:

Provider champion:
Finding a provider champion is key. This could be the provider who will lead the PHP SMA sessions, or someone in your practice devoted to facilitating quality improvement. The provider champion will work with clinic leadership to get approval and will shepherd the program through implementation and evaluation.

Key members:

1. A **primary care provider** (PCP) who can conduct a physical exam and bill for the visit. In most cases, this can be an MD, NP, or a PA. It can also be the provider champion.

2. A **health coach** to facilitate the groups and support patients in health behavior change. This can be a CDE, an individual with formal health coach certification, or a peer facilitator who has training in health behavior change, motivational interviewing, and group facilitation.

3. A **nurse or medical assistant (MA)** to assist patients with check-in (taking vitals, completing forms). These individuals are a part of group discussion or leave after vitals are logged, depending on clinic capacity.

4. The **scheduler** plays an important role in recruiting and scheduling patients to PHP SMA groups.

Ancillary team members (not required but encouraged):

1. A **pharmacist or pharmacy students** can either run the medications session, be there as a resource for medication therapy and discussion, serve as a floater during each session, or serve as a referral resource.
2. **Medical residents and other trainees**. The PHP SMA can be a useful teaching tool for residents. In addition to the learning opportunity, some learners can assume tasks within their scope that may benefit the workflow and reduce the resource needs from other staff members.
3. **Social worker and nutritionist** can attend sessions or serve as referral resources.

Clearly defining roles for the PHP SMA in your clinic prior to starting the program is important for organizational and financial purposes. Each PHP SMA session, including charting time, will take up about ½ of a clinic day for the providers involved.

Care Team Competencies

Each team member plays a unique role in the PHP SMA, and the key members' roles are further defined by core competencies and characteristics necessary for conducting successful appointments. Additional resources for training in the core competencies can be found in the Appendix.

Primary Care Provider: The provider should be an MD, PA, or NP with a background in diabetes care. The provider reviews the patient's medical history, conducts a physical exam at each session, identifies short and long-term risks and develops therapeutic goals for the patient. These therapeutic goals for the patient are synergized with the patient's goals in order to create shared goals. He or she recognizes the balance between patient needs and therapeutic goals, creatively connecting the patient's needs and desires for their health to their health risks. The provider will work with the health coach to review patient goal progress and ensure that it is aligned with the therapeutic plan and entered into the medical record. The provider is an active participant in the education and discussion portion of each session.
Core competencies:

- Clinical evaluation
- Shared decision-making and motivational interviewing skills
- Interpersonal skills for relationship building
- Ability to contribute in a group
- Ability to de-escalate potential conflicts

Health Coach: The health coach can be a certified diabetes educator (CDE), nurse, nutritionist, or a trained peer facilitator. The health coach/CDE is responsible for leading the education and mindfulness portions of each session in addition to moderating group discussion. The health coach introduces the concept of whole health and helps patients complete their health self-assessments. Additionally, the health coach should keep track of patient goals and patient goal progress at each group session, and work with the provider to revise or create new shared goals as needed.
Core competencies:
- Group facilitation skills
- Motivational interviewing
- Mindfulness training
- Comfort dealing with differing personality types and educating groups of individuals
- Strong interpersonal skills for building relationships
- Ability to navigate unexpected questions that may arise during the sessions

Nurse or Medical Assistant: The nurse/MA is responsible for making sure the proper medical equipment is in the room before each session and conducting patient intake at the beginning of each session. The nurse/MA should be knowledgeable about general diabetes self-management strategies. The nurse/MA is also an active participant in the group discussions.
Core competencies:
- Organization skills to facilitate intake of multiple patients at one time
- Strong interpersonal skills
- An ability to contribute constructively to group discussions on diabetes care

Scheduler: The scheduler is responsible for recruiting patients, managing patient appointments, and preparing the materials needed for each session. This is an essential behind-the-scenes role that ensures the SMAs will run smoothly.
Core competencies:
- An understanding of personalized health planning, shared medical appointments, and the ability to communicate this to potential patients and team members
- Ability to plan ahead, organize lists of patients
- Strong communication skills to relay information with the other team members

Cost

Considering the financial feasibility of implementing this program will help you define must-meet parameters before you start. There is no billing code for Shared Medical Appointment - each session is billed like any other one-on-one primary care visit. If each PHP SMA session is full, the PHP SMA provider can potentially bill for more one-on-one encounters in 90 minutes than they would normally be able to. However, higher no show rates for SMAs than for traditional appointments can affect provider productivity levels. Reviewing costs can help you design your PHP SMA to meet your clinic's financial needs. A cost analysis can determine how many patients you need at each PHP SMA session to meet necessary productivity levels.

For a more in-depth financial feasibility analysis, see our Cost Feasibility Analysis Worksheet in the Appendix. This worksheet allows for a rough cost comparison of the SMA to a traditional one-on-one encounter and identification of key variables to focus on in building your PHP SMA.

Note:

Planning ahead for variables such as no-show rates or knowing the average reimbursement rate of the population you've chosen (e.g. are many of your type 2 diabetics on Medicare or Medicaid?) will allow you to personalize your recruitment process to your clinic's specific financial needs.

Documentation

Proper documentation of the personal health plan in the electronic health record is critical; it enables care coordination with the patient's primary care provider and facilitates patient-centered care. A template for documentation should include the following:

- Brief summary of education provided in each session or session topic
- List of patient's short and long term health risks and most current lab results
- Space to record patient's priorities and major outcomes from their self-assessment
- List of shared health goal that patient and provider are working toward
- Space to list clinical metrics for tracking progress and defining success

Outline of Each Session

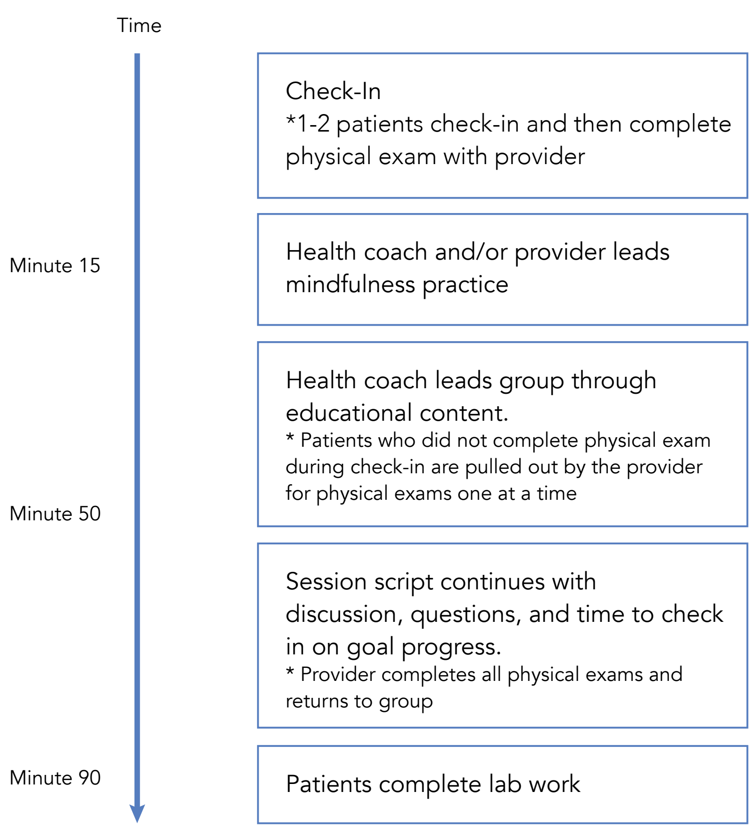
Completing all of the required clinical and educational tasks for 6-8 patients in 90-120 minutes can present challenges. Some patients arrive late, some early. Patients will need lab work done at different intervals; patients will be taking different medications; and, there is a flurry of activity at the beginning of each session/during in-take. This section provides organization and preparation tips to overcome these logistical challenges.

Process Mapping

Depending on your PHP SMA care team, the workflow during a session might vary. In general patients must get through the following in a 90-minute session:

- Intake forms and vitals taken
- Physical exam with provider
- Group diabetes education
- Group discussion of personal health plan and goal progress
- Lab work

This section presents a potential workflow for each session, assuming your clinic has a provider, a nurse, and someone to take on the health coach role. Remember that depending on your facility's needs and resources, this workflow may look different. To develop a workflow, we suggest listing all tasks and activities that you would like to be carried out during each session.



1. Patients arrive and complete intake: blood pressure, height, weight, clinic-specific forms. Those who arrive early go directly to a one-on-one physical exam with the provider.
2. After intake, all patients, health coach, and provider sit in circle in middle of room.
3. The health coach opens session with mindfulness practice.
4. Provider continues to pull patients one by one for individual physical exams. Physical exams should take 5-7 minutes per patient.
   The exam includes:
   a. Review history
   b. Determine if patient is tolerating medication and/or seeing any side effects
   c. Listen to heart and lungs, check abdomen, check feet (if foot exam identifies an issue, do a monofilament test).
5. While provider runs physical exams, the health coach leads the session using the PHP SMA curriculum.
6. After physical exams for all patients have been completed, the provider joins the group to participate in the discussion and to answer clinical questions.
7. At the end of the session, patients needing lab work are sent to the lab.

> * **Note:**
> *If a patient arrives presenting symptoms of a glycemic emergency, attending provider will immediately divert from normal workflow to attend to the emergency as appropriate.*

If you have a pharmacist or nutritionist attending the PHP SMA sessions, there are a number of ways to utilize this individual's time. Depending on the needs of your clinic, one of the following may work better for you than others:

- The specialist is a floater. They are part of the conversation and can address individual specific needs when necessary.
- The specialist has their own station, just like the provider's station for physical exams. If your PHP SMA group is smaller or if your patients all have identified problems with medication adherence, this option may be best for you.
- The specialist leads the group to discuss the topic (diet or medications) for a short amount of time (5-10 minutes) each session.
- The PHP SMA provider refers patients to meet with the specialist outside of the PHP SMA session time.

Recruitment & Referral

The flow-chart on the following page outlines the recruitment and referral process for PHP SMAs. Note that the major tasks for recruitment and referral leading up to a patient's enrollment in the group include:

- Defining and releasing eligibility criteria to the entire practice
- Identifying patients via 3 unique pathways
- Contacting the PCP for approval and referral to SMAs

Setting Eligibility Criteria

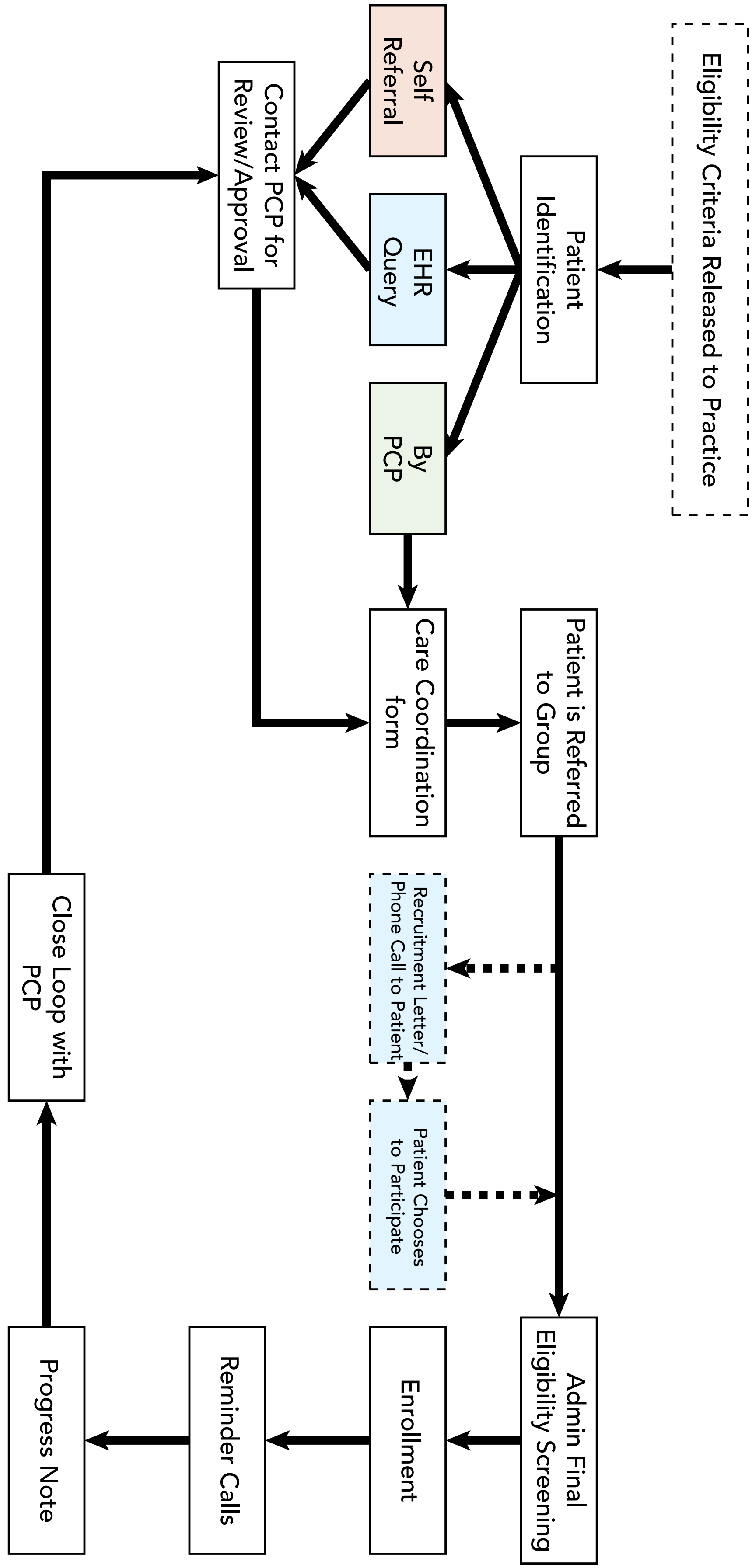
After you have chosen your general patient population of interest (diabetes in this example), you can define parameters for inclusion and exclusion criteria. This step will help providers in your practice identify patients for referral to the SMA more easily.

Example inclusion and exclusion criteria (note that these criteria can and should be modified to fit the goals and needs of your target population):

Prediabetes:
Patient's most recent HbA1c score must be between 5.7% and 6.4% and taken in the last 6 months. Patient should know that they have prediabetes.

Early Diabetes:
Patient's most recent HbA1c score must be between 6.5% and 7.5% and taken in the last 8 months. Patient should have been diagnosed with type 2 diabetes within the last 2 years. Patient should have no amputations or other serious complications from type 2 diabetes (kidney failure, blindness, etc.). Poor management of type 2 diabetes is the patient's most pressing health risk

Out-of-Control Diabetes:
Patient's most recent HbA1c score must be between 7.5% and 14% and taken in the last 8 months. Patient should have a diagnosis of type 2 diabetes. Patient should have no amputations or other serious complications from type 2 diabetes (kidney failure, blindness, etc.). Poor management of type 2 diabetes is the patient's most pressing health risk.


Eligibility Criteria Released to Practice
Patient Identification
Self Referral
EHR Query
By PCP
Contact PCP for Review/Approval
Care Coordination form
Patient is Referred to Group
Recruitment Letter/ Phone Call to Patient
Patient Chooses to Participate
Admin Final Eligibility Screening
Enrollment
Reminder Calls
Progress Note
Close Loop with PCP

Releasing Eligibility Criteria to the Practice

Your entire practice should be aware that PHP SMAs are going to be occurring and should know which patients will be eligible. This will ensure that providers identify the right patients to refer to the SMAs.

Patient Identification

If your practice has an Electronic Health Record (EHR) system, the easiest way to find eligible patients is to **run a query for patients meeting your eligibility criteria**. Eligible patients can also be identified via **self-referral** and **PCP referral**. Determine how you want to advertise for your groups and how you want to identify eligible patients.

There are 3 pathways by which a patient could be identified for the group. They are:

1. **Self-referral**. The patient sees a flier in the clinic and decides he/she is interested in the PHP SMA. Patient contacts the scheduler, who checks that they match eligibility criteria and their PCP is notified when they are added to the SMA. For examples of fliers, see the Appendix

2. Direct **PCP referral**. PCP meets with a patient who could benefit from the PHP SMA. PCP describes the PHP SMA to the patient, patient expresses interest, and PCP submits a referral to the scheduler. Scheduler confirms eligibility and enrolls patient in a PHP SMA group.

3. **EHR Query**. PCPs are sent a list of their eligible patients to review and mark patients who they believe are inappropriate for the PHP SMA. Not being marked as inappropriate constitutes an initial referral to the PHP SMA from the PCP. All patients identified by the PCP as appropriate are sent a letter from their PCP describing the PHP SMA. This can be done via regular mailing or electronic mailing if your practice has a patient portal. It lets the patient know that if they are interested, they should contact the scheduler. For many patients, feeling like this is a program their PCP recommends increases their motivation to try it out. Example recruitment letters can be found in the Appendix.

Contact PCP for Review/Approval

Ensure that however you decide to identify patients, the PCP is involved in the referral process and notified when their patient is enrolled in the PHP SMA. While patients may be eligible based on their clinical metrics, behavioral concerns could keep a patient from thriving in a group setting. A patient should not be added to the SMA without a referral from their PCP.

Care Coordination

In the Appendix of this manual, a Care Coordination Form is provided to serve as a template for the referring provider. The form asks the referring provider to highlight the patient's main health risks and highlight specific reasons for why the PHP SMA is an ideal management strategy for the patient. The form should be completed by the PCP or a designee (such as a nurse or an appropriate trainee) and sent to the provider leading the PHP SMA prior to the patient's official enrollment in the group. This will help the PHP SMA provider create a therapeutic plan and ensure care coordination.

Enrollment

Once the recruitment starts, the scheduler will have an ongoing list of patients who have been identified and approved by their provider. The scheduler calls the recruited patients to schedule them into a PHP SMA group. Depending on how many groups your practice wants to run, there may be multiple days of the week and times for the patient to choose from. The scheduler should keep an enrollment log so that you know which patient is in each group.

> **Note:**
> *Be sure to remind patients that the PHP SMA sessions are recurring, so they should pick a group that will meet on a day and at a time that will work for them long-term. Make sure that the patient has their calendar in front of them when you are discussing dates.*

Reminder Calls

Once a patient is enrolled in the group, a reminder call or patient portal email is the most effective way to get them to the groups. Try to have the scheduler place reminder calls one to two days prior to the PHP SMA session.

Progress Note

The progress note closes the communication loop between the PCP and the PHP SMA provider. After the final PHP SMA session, the PHP SMA provider will send the PCP a note documenting the patient's progress over the course of the PHP SMA sessions. For an example Progress Note, see the Appendix.

Quotes from PHP SMA Patients and Care Team

Here, PHP SMA patients highlight their views on defining the patient population of focus for this program, and the value of pulling together a well-rounded care team.

> "As we learned, once you're diagnosed with diabetes it's too late to cure it. Whereas if you're pre-diabetic, if you learn about it and what's going on, you might be able to keep yourself off of medications and other stuff for a good long time." – *PHP SMA patient*
>
> "I would almost say change the emphasis of the whole program towards prediabetes." – *PHP SMA patient*
>
> "I think it was good to have [the health coach] there because diabetes isn't just… medical. It encompasses everything. And so having a well-rounded team which includes the medical as well as the coaching I think ties it all together and makes it all cohesive." – *PHP SMA participant*

PHP SMA IMPLEMENTATION CHECKLIST

Provider Champion:_______________

Complete?	Task	Notes
	Before Leadership Approval	
☐	Identify key stakeholders to engage	May include: • Chief of staff • Director of population health • Director of quality improvement • Manager of patient billing • Clinic scheduler • Patient advisory panel • Patient educators, nutritionist, pharmacist
☐	Define patient population and eligibility criteria	Chosen criteria:
☐	Identify classroom space	PHP SMA sessions will be held:
☐	Determine length & frequency of PHP SMA program	8 sessions. Each will be ______ minutes long, offered ______weeks (or) _____months apart.
☐	Determine how many groups to run	One group to pilot? Multiple groups concurrently?
☐	Identify care team *Remember to consider students (residents, pharmacy students, medical students) as potential team members	Key Team Members: PHP SMA Provider: ______________________ Health Coach:__________________________ Nurse or MA: ___________________________ Ancillary Team Members: _______________________________________ _______________________________________ _______________________________________
☐	Complete cost feasibility analysis	With your patient population and billing structure, how many patients need to be in each group to cover costs? What resources are available to incentivize attendance?
☐	Present case to leadership for approval	Collate parameters from above. Present plan. Presentation/meeting date: ____/____/____

Complete?	Task	Notes
After Leadership Approval		
☐	Make any necessary changes to plan	Changes made: • • •
☐	Release information about PHP SMA to practice	Can be done via email, meeting, memo, etc. Key for success of recruitment process
☐	Train PHP SMA provider team	Training will be conducted by: _______________ Meeting / Distributing Readings / Practice Run-Through
☐	Develop EMR note template	
☐	Set start date	Start Date: ____/____/____
☐	Book space	
☐	Personalize recruitment plan to your clinic	Updates made to recruitment protocol:
☐	Meet with staff to review recruitment plan	Meeting scheduled for: ____/____/____
☐	Ensure that clinic providers understand recruitment plan	Communication via: email / meeting presentation / memo Provider referrals occur via: _______________
☐	Start recruitment	Depending on recruitment plan: ☐ Post flyers ☐ Distribute care coordination form to providers ☐ Begin taking provider referrals ☐ Conduct EHR query for eligible patients ☐ Send letters ☐ Field phone calls from patients ☐ Conduct phone calls to patients
Once Group(s) are Filled		
☐	Print patient and provider materials	Participant notebooks, provider manual, curriculum, clinic-specific forms
☐	Conduct patient reminder calls	

MODELING FINANCIAL FEASIBILITY

This model will ultimately help you to determine how to most efficiently build your PHP SMA, avoiding wasted time and energy. It will help you think through key questions related to financial feasibility. For example, is it worth it for an MD, whose time is more expensive, to run this session, or will a PA be sufficient? Does the provider need to stay the whole time or can a certified diabetes educator run the session after the individual Evaluation & Managements (E&M)? This model will help highlight these often-overlooked details, which can cost your practice money if neglected. It will help you consider the factors that go into creating revenue, weighing them against the costs of the SMA. Most importantly, this model will help you understand what you need to at least break even with your current traditional individual-appointment-based practice, thus not losing money by venturing into this new model of care.

SMA vs. Traditional Appointment

In this financial feasibility model, we assume that you are already running your practice efficiently through traditional appointments and are seeing enough patients to make money. We define "Traditional Appointments" (TAs) as one patient seeing one provider for diabetes-related care. The goal when transitioning to SMAs is to at least break even when comparing this care delivery model with your current practices. There are added benefits to the SMA such as improved patient outcomes and reduction in provider burnout. That being said, there is potential to improve profit if enough patients attend PHP SMA sessions. Quality of care should be prioritized over most other metrics.

The model can be found in the accompanying excel document. There is a blank model for you to fill out, and an example financial analysis model, completely filled out already. The numbers used to fill it out are based on North Carolina averages-this does not represent any one clinic's numbers.

Information needed to fill out the model:

1. Types of Insurance your practice accepts
   a. Reimbursement rate per Relative Value Unit (RVU)
   b. Percent of type II diabetes patients with each insurance type
      i. Note: this can be an average for your practice to start, but can be refined for specificity as you enroll patients in the SMA
2. Scheduling data for SMAs and TAs
   a. # scheduled per SMA
   b. no show rates for SMAs and TAs
      i. No show rates for SMAs have been shown to be higher ~30-50%
3. Space
   a. SMA
      i. Hours used per session
      ii. Square feet of room
      iii. Cost per square foot of room
   b. TA
      i. Total time spent in room per patient

ii. Square feet of room
iii. Cost per square foot of room
4. Cost of any materials for SMA (that differ from TAs)
5. Cost of any incentives for SMA

Provider Data

1. Main Provider
   a. Salary
   b. Total time spent per total SMA (including prep and chart)
   c. Number of TA patients you can see in 1 hour
   d. Number of TA patients you can prep and chart for in 1 hour
   e. Weeks worked per year
2. Medical assistant or Nurse
   a. Hourly wage
   b. Hours worked per SMA and TA
3. Scheduler
   a. Hourly wage
   b. Hours worked per SMA or TA
4. Certified Diabetes Educator
   a. Hourly wage
   b. Hours per SMA
5. Pharmacist
   a. Salary
   b. Time spent per SMA

First, you will fill out the model with the data collected above. Once you see the difference between SMA and TA with your current numbers, see what changes you can make to produce more desirable numbers. Every clinic or practice will have different goals and parameters to meet.

In our experience, what made the most difference was number of *patients scheduled and attendance rate*. **Adjust cell C4** to see how this affects the percent difference of profit. Additionally, look carefully at how different providers are spending their time. As a general rule of thumb, for every task the cheapest provider that is qualified to do it should be the one to do it. Once providers have completed all their tasks, they should leave the session to work on other work.

We have found that medical assistants are sufficient to complete the tasks required during the setup and intake portions of SMAs. Nurses tend to cost twice as much per hour. Once the medical assistant completes his/her tasks, providers should utilize him/her in other parts of the practice such as helping another provider with TAs.

Certified Diabetes Educators (CDEs) are the recommended providers for physically running the education portion of the session. A CDE's hourly wage is comparable to a nurse's. Medicare, Medicaid, and private insurance can be billed for the CDE's time. A 1 hour CDE session is equivalent to 0.5 RVU's. Therefore, the CDE's reimbursement covers for his/her own time and more. Non-certified health coaches and nurses cannot bill Medicare and Medicaid for Diabetes Self-Management Education (DSME) sessions (CPT Code: G0109). Most private insurers do not require a certified CDE to bill code G0109, but in our experience, the majority of patients that enrolled in the SMAs had Medicaid or Medicare. Additionally, the use of a CDE allows for the main provider to step out of the SMA and conduct other business nearby since the CDE has the expertise to answer medical questions.

At this time, there is no CPT code for shared medical appointments. You should get in writing the policies for every type of private insurance you accept. Medicare and Medicaid stated in a letter to the American Academy of Family Physicians "...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." Additional guidance can be found here.

Filling out the Financial Feasibility Excel Spreadsheet

Shared Medical Appointment

1. Revenue
    a. Box 1: automatically calculates weighted avg reimbursement rate per Relative Value Units (RVUs) or C2
    b. Input types of insurance in column I (ex: Medicaid, Blue Cross Blue Shield, Cigna, etc.)
        i. These can be patient population averages (ex: top 5 most common insurance types for type 2 diabetics in the practice) or actual insurance types for patients enrolled the SMAs
    c. Input reimbursement rate per RVU for each insurance type in column J
    d. Input percent of patients in column K
    e. C4: input the average number of patients scheduled per Shared Medical Appointment session
        i. This is the number you will tweak at the end to determine how many people must attend each session in order for it to break even with traditional appointments
    f. C5: input average no show rate for shared medical appointments
        i. Typically higher than traditional appointments (30-50%)
    g. C11: shows total reimbursement amount for Evaluation and Management (E&M) level 4 billing (CPT Code: 99214)
    h. C12: shows total reimbursement amount for Diabetes Self-Management Education (DSME) billing (CPT Code: G0109)
    i. C14: shows total reimbursement per SMA
2. Cost
    a. Medical Provider
        i. C16: input percent per week spent on SMA
            1. For example: 4 hours in 40 hour week = 4/40 = .1

2. This time includes prep, session, and charting. Count every minute that goes towards one SMA
ii. C17: input salary per year
iii. C18: input 1/weeks working per year
b. Medical Assistant (MA)
i. C20: input hours MA works per session
ii. C21: input MA wage per hour
c. Scheduler
i. C23: input scheduler wage per hour
ii. C24: input hours scheduler works per session
d. Certified diabetes educator (CDE)
i. C26: input CDE average hourly rate
ii. C27: input CDE hours worked per session
e. Meeting Room
i. C29: input percent of week used
ii. C30: input 1/# weeks the building or room is open
1. This is to determine how much the room costs per week
2. For example, although you pay for the room on Christmas when you pay for a whole year, you likely can't use it then. Therefore the cost of the room is shifted to the remaining days of the year to make up
iii. C31: input square feet of the room
iv. C32: input cost per square foot
f. C34: input cost of other materials
g. C35: input cost of incentives (ex: food)
h. Pharmacist
i. C36: input pharmacist yearly salary
ii. C37: input 1/weeks worked per year
iii. C38: input percent of week spent on SMA
i. C41: shows total cost per SMA
3. C43: shows Reimbursement-Cost (Profit) for SMA

Traditional Appoinments

1. Reimbursement
a. Box 2: populates the average time per traditional appointment (TA) patient automatically into Box 3
i. The goal of this box is determine how long it takes the main provider to prep, see, and chart per patient in a traditional setting
1. If you already know this number (in minutes) input it into cell I21 and skip ii, iii , and iv below
ii. I14: input # TA (actual visit) in 1 hour
1. How many patients you can physically see in one hour
2. If you finish charting while seeing patients, skip iii
iii. K14: input # TA patients charted in 1 hour
1. Assuming you don't finish charting during visits, in one hour, how many charts can you finish
iv. M14: input # TA patients prepped for in 1 hour

b. Box 3: populates the average TA patients scheduled in the equivalent amount of time as a SMA
    i. For example, if you can see 10 patients in the 90-minute long SMA and it takes you two additional hours to chart those encounters, how many patients could you see and chart in a traditional setting in 3.5 hours?
    ii. I19: input total hours for SMA for main provider (prep/session/chart)
        1. Based on main provider because
            a. they are the only reimbursable provider for both SMAs and TAs
            b. they are the only required provider for both SMAs and TAs
c. F5: input the average no show rate for TAs
d. F14: shows total reimbursement for equivalent number of TAs

2. Cost
    a. Medical Provider
        i. F16: input percent per week spent on the equivalent number of TAs
            1. For example: 4 hours in 40 hour week = 4/40 = .1
        ii. F17: input salary per year
        iii. F18: input 1/weeks working per year
    b. Nurse
        i. F20: input avg hourly salary
        ii. F21: input hours used for total patients in equivalent time
    c. Rooms
        i. F23: number of equivalent TA patients per SMA automatically populated here
        ii. F24: input total time per patient in room for TA (MA/nurse + provider)
        iii. F25: input 1/weeks worked per year
        iv. F26: input total square footage of rooms
        v. F27: input cost per square foot
    d. F41: shows total cost per equivalent TAs
3. F43: shows Reimbursement-Cost (Profit) for equivalent number of TAs

Difference between SMA and equivalent Traditional Appointments

1. C45: shows the gross difference in SMAs and TAs
    a. SMA-TAs
2. C46: shows percent difference of SMA to TA per TA
    a. (SMA-TA)/TA

RECRUITMENT LETTER EXAMPLE

Date
Name
Address

Dear (patient name),

I am writing to tell you about an opportunity at [insert clinic name] that you might be interested in. In the next few months, we will be offering Personalized Health Planning Shared Medical Appointments (PHP SMAs) to help patients like you with type II diabetes. As your primary care provider, I believe that this program can help you manage your diabetes and reach your health goals.

PHP SMAs are 90-minute long sessions between you, 7-9 other patients, and a provider. The group meets once a month for 8 months. Several studies have shown that shared medical appointments can help people with type II diabetes in a safe and supportive environment. During the PHP SMAs, you will have a short physical exam with a doctor, followed by time to learn about diabetes management in a group. Patients have noted that they really enjoy the supportive group environment and extra time with a doctor during PHP SMA sessions.

"The participants are the same so you do get to know each other, and I would recommend being involved in … a group like this because it gives you like people to speak to… this is a group of people who understand what we're going through."
–PHP SMA participant

During these PHP SMAs, you will have access to a physician or physician assistant, nurses, a health coach, and other people like you with type II diabetes to learn how to gain better control of your diabetes. Your PHP SMA care team will work with you to create a personal health plan, tailored to your preferences and needs. The group will give you support as you work to reach your goals. You can keep seeing me, your regular doctor, for all of your needs outside of your diabetes. I believe this is an opportunity for us to provide you even better care and support.

If PHP SMAs are something you are interested in participating in or learning more about, please call [insert scheduler contact information] for more information. We will be glad to discuss any questions you may have.

If we do not hear from you, a staff member may call you in a few weeks to remind you and see if you are interested in Shared Medical Appointments.

Taking part in this opportunity is completely voluntary and whatever you decide to do will not affect your medical care in any way.

Best regards,

(PCP signature)

RECRUITMENT CALL SCRIPT

Hello [*insert patient name*]. My name is [*insert caller name*] and I am calling from [*insert clinic name*]. I am calling today about an opportunity that has come available at our clinic for individuals with type 2 diabetes. You may have gotten a letter about this in the mail.

Is now a good time to talk?
> **If yes**, continue with script.
> **If no**, note day/time to call back _______

Great. The opportunity is a group medical appointment program for individuals with type 2 diabetes. I am calling because your primary care provider, [*insert PCP name*], thinks that this might be a good opportunity for you.

The program involves attending 8 group visits at our clinic. Each visit will be [*insert length in minutes*] and they occur [*insert frequency*]. In each visit, you will meet with a provider, a health coach, [*insert other ancillary team members available*] and [*insert number*] other patients with type 2 diabetes. Each visit includes a private 5-10 minute physical exam with the provider, group education about how to manage type 2 diabetes (diet/nutrition, exercise, the mind-body connection, etc.), creation of health goals and a personal health plan, individual and group time with a health coach, and an opportunity to discuss challenges with diabetes management in a group.

In this group, we focus on your whole health. We want to provide you with an environment in which you can set personalized health goals with your provider and have the support you need to achieve them. This is about discovering your needs and preferences for your health, and setting goals around what you want your health for.

Again, I want to emphasize that we are calling because your provider thinks that this could be a good opportunity for you. Do you have any questions? Are group visits something you are interested in?

> **If yes**, begin trying to schedule the patient to an upcoming group. Encourage patient to have their calendar in front of them.

> **If no:** Are there any other questions or concerns about this program that I can address?
> **If no:** Okay, thank you so much for your time. If you change your mind, please give us a call at [insert number]

Frequently Asked Questions:

Will the provider for the group appointment be my primary care provider?
[Depends on the patient, but generally no]. You can continue seeing your PCP for all health-care needs outside of your diabetes.

Will there be a copay? How much will this cost me?
[Depends on clinic structure, but generally yes]. Yes, each group visit is a clinical visit, so you will have the same copay you normally would for a visit with your PCP, BUT you have the added benefits of a health coach, more time with your provider, educational information and materials, and the support of other individuals with type 2 diabetes to discuss your challenges and success with.

How do I know that my information will be kept confidential?
At the first group session, we tell patients that what is said in the room must stay in the room. We spend time reviewing group guidelines, and patients can suggest their own guidelines in addition to the ones we provide. Confidentiality is one of those guidelines.

PHP SMA CARE COORDINATION FORM

MRN:

Does patient meet eligibility criteria? (Checklist of criteria here) Example:

- ☐ HbA1c score between x and y
- ☐ Diagnosed with T2D in _____ year
- ☐ No amputations or major T2D complications (vision loss, renal failure)

Key Patient Information

Most Recent HbA1C Score: ______ Date of Initial DM Diagnosis: ___/___/_____

Other Key Recent Lab Results: ____

End organ diseases related to uncontrolled diabetes:

- ☐ History of amputations
- ☐ Diabetic nephropathy or proteinuria
- ☐ Diabetic retinopathy

Comorbid conditions that may increase cardiovascular risk/impact diabetes care:

- ☐ History of documented coronary artery disease
- ☐ History of stroke/cerebrovascular accident
- ☐ History of peripheral vascular disease
- ☐ History of obesity
- ☐ History of hyperlipidemia
- ☐ Current tobacco use
- ☐ History of depression and/or anxiety
- ☐ Chronic pain

Current diabetes medications:
Oral agents:
Injectable (insulin or other) therapy:

On ACE Inhibitor or ARB?
On Statin?
On ASA?
Treated for Depression?

Patient's Top 3 Health Risks (may specify proximate vs. long term):

1.
2.
3.

Any behavioral concerns in referring patient to a group-based appointment?

- ☐ No
- ☐ Yes ____

Have you discussed Shared Medical Appointments with this patient?

- ☐ Yes
- ☐ No

Patient goals for diabetes care:

____

____

____

Other key patient information relevant to SMA care:

____

____

____

Signed: ____________________________________

Print: ______________________________________

Date: _______________

PHP SMA PROGRESS NOTE

MRN:

Number of PHP SMA Sessions Attended: ____/8

Clinical Metrics: please list the patient's relevant clinical metrics at start & end of the PHP SMA

HbA1c	pre:	post:
BMI	pre:	post:
____	pre:	post:
____	pre:	post:

Standard Progress Note in SOAP (Subjective, Objective, Assessment and Plan) or other relevant format.

Major Diabetes Medication Changes: (ex: patient started insulin)

____

____

Patient noted he/she wants his/her health for:

____

____

Brief Summary of Patient's Progress:

____

____

Patient's current goals:

Goal 1: ____

Goal 2 (optional): ____

Goal 3 (optional): ____

PROVIDER TRAINING RESOURCES

Shared Decision Making

- This article outlines a three-step model for shared decision making between patients and providers.
- This fact sheet provides a quick summary on shared decision making as well as tools to help your organization get started.
- This website contains a variety of resources on shared decision making.

Motivational Interviewing

- This article gives motivational interviewing strategies and techniques along with the rationale behind them
- This book describes what motivational interviewing is, the core skills needed, and how this technique can specifically be applied in healthcare settings

Group Facilitation

- Chapters 1-4 of this toolkit touch upon the role of a facilitator, how to manage group dynamics, ideation and consensus, and how to run effective meetings

Mindfulness Training

- This article focuses on mindfulness and specifically the role it plays in diabetes and eating
- This fact sheet gives mindful eating techniques

Engaging in Group Discussion

- Pages 16-18 of this module discuss how meeting participants can effectively contribute and listen at meetings

MINDFULNESS IN THE PHP SMA

The PHP SMA curriculum has been designed with a mindfulness practice at the beginning of each session. Mindfulness is the cultivation of non-judgmental awareness through the practice of a meditation practice. It has become popularized as a secular therapeutic technique to improve mental, emotional, and physical health and wellbeing. Large population-based research indicates that a mindfulness practice can facilitate to a positive state of mind and minimize perceived stress, anxiety, and depression.[26]

In the PHP SMA, mindfulness is introduced as a way to bring focus, calm and intention to each meeting for both the provider team and the patient. It is described to patients in a non-threatening way as a self-care tool, and patients are encouraged to practice at home through a CD of guided mindfulness practices that is provided by the program. These guided mindfulness practices can be found on our website. Each meditation can be led by a member of the care team or through the use of an audio recording

> "I found at the beginning of the class [mindfulness] helped me get in the mode" – *PHP SMA participant*
>
> "To me, it's a tool in the toolkit. It's a valuable tool…to deal with stressful eating, stressful situations, and the role of stress for diabetes is huge. And once they understand that, mindfulness becomes a touchstone they can reach back and use." – *PHP SMA provider*
>
> "We would start with the intake and once everyone was together we'd do our mindfulness practice and it was almost a signal that we were ready to focus on healing and self-improvement." – *Health Coach*

The curriculum also connects mindfulness to some of the areas of the wheel of health, including Diet & Nutrition and Stress and the Mind Body Connection.

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