

SHARED MEDICAL APPOINTMENTS

A Proven Health Care Delivery Model

The Harvard Vanguard/Atrius Health & ProMed
Experiences with this Novel Approach to
Improving Health Care Delivery

{How You Can Successfully Implement Group Visits into Your Practice}

Jointly sponsored by the Massachusetts Medical Society &
Harvard Vanguard Medical Associates, an affiliate of Atrius Health

Speakers: *Ed Millermaier, MD*, Chief Medical and Operating Officer, Borgess Health
Zeev Neuwirth, MD, Chief of Clinical Effectiveness & Innovation
Ed Noffsinger, PhD, VP of SMAs and Group-Based Disease Management
Deb Prescott, Program Manager of SMA Department

November 6, 2009



Speakers



Edward Millermaier, MD, is the chief medical and operating officer in the Ambulatory Care Division at Borgess Health in Kalamazoo, Michigan.



Zeev E. Neuwirth, MD, SM, is the chief of clinical effectiveness and innovation at Harvard Vanguard Medical Associates, an affiliate of Atrius Health.



Edward B. Noffsinger, PhD, is the vice president of shared medical appointments and group-based disease management at Harvard Vanguard Medical Associates, an affiliate of Atrius Health.



Debra Prescott is the director and program manager of shared medical appointments at Harvard Vanguard Medical Associates, an affiliate of Atrius Health.



Edward Noffsinger, PhD



Considered a pioneer in the area of group medical visits, Dr. Noffsinger is the originator of the drop-in group medical appointment (DIGMA) and the physicals shared medical appointment (PSMA) models. He is a nationally and internationally recognized expert in the area of group visits and an advisor to medical groups and health care organizations around the country and the world. Dr. Noffsinger and his team at Harvard Vanguard Medical Associates, an affiliate of Atrius Health will have launched over 30 DIGMAs and PSMAs in his first two years there. He previously worked at the Kaiser Permanente Medical Centers in Santa Clara and San Jose and was the director of clinical access improvement at the Palo Alto Medical Foundation. His work in the area of group visits has been featured in numerous medical journals, and he is widely published in the field. Dr. Noffsinger has given well over a thousand invited presentations in the private, public, and government health care sectors — both nationally and internationally.



Let's go to the Video



WHAT PROBLEMS DO SMAs ADDRESS?

- ✓ Access
- ✓ Productivity (shortage of physicians)
- ✓ “Job Do-ability” (for clinicians & staff)
- ✓ Reduced Repetition of Same Information
- ✓ Variability in Quality (Performance Measures)
- ✓ Cost Effectiveness of Medical Care
- ✓ Immunity to No-Shows & Late Cancels
- ✓ Patient and Physician Satisfaction

OTHER ADVANTAGES

- ✓ Patient Experience
- ✓ Chronic Disease & Practice Management
- ✓ Reflective Practice of Medicine (time to think)
- ✓ Teaching Opportunities
- ✓ Growth of your Practice (f'n of Access & Pt demand)
- ✓ Benefits to Pts, MDs, Healthcare Org's., Insurers, & Corporate Purchasers

COOPERATIVE HEALTH CARE CLINIC (CHCC) MODEL

- Originated 1991 by Dr. J. Scott (Kaiser, Colorado)
- High Utilizing, Multi-Morbid Geriatric Pts
- Same 15-20 Pts (+SPs) Attend Monthly (Pts own MD)
- MD, Nurse, Program Coordinator, & Speakers
- 1st Part: Group Segment (of Structured Monthly 90' Session)
 - Structured group segment is largely educational, with some care
 - Warm-up; Educational presentation; Working break; Q&A; & Planning for the next session segments
 - Possible billing issues for patients not needing medical care
- 2nd Part: 60' of Individual Care Follows (for ~6 Pts)
 - Medical care delivered individual to ~1/3rd of Pts needing it
 - No efficiency gain here as it's the same old one-on-one office visit
- Specialty CHCC Retains Same Format
 - Follows same group of patients over time
 - Meets irregularly according to best practices
- Strengths, Weaknesses, & Research



WORK SMARTER, NOT HARDER!

↑ Quality ↑ Access ↑ Outcomes ↓ Cost

- **Leverage Existing Resources**
 - ↑ Productivity (200-300%, or more)
 - Better manage practices & chronic illnesses
 - ↑ Job Do-ability
- **↑ Patient & Physician Satisfaction**
 - ↑ Quality & outcomes (Pt Ed, health maintenance, injections, etc.)
 - ↑ Time, support, compliance, Pt Ed
 - ↑ Pt-MD relationships
- **Have Fun & Make Money!** (A Group Room Can Create 2.5 FTEs)
- ***ALL AT THE SAME TIME!!!***



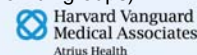
WHAT IS A SHARED MEDICAL APPOINTMENT (SMA)?

- Typically a 90-minute appointment (starts & ends on time)
- Clinician conducts serial individual visits in group setting
- For Follow-Up visits (DIGMA) & Physical Exams (PSMA)
- Used in all areas of primary care (plus medical & surgical specialties)
- Homogenous, Mixed & Heterogeneous Subtypes
- Integrates other Pts help & support into each Pt's experience
- As much care as appropriate is delivered in the highly efficient group setting (where all can listen, learn, interact, and help one other)
- Leverage provider's time via multidisciplinary team effort:
 - 'Behaviorist' (facilitator)
 - Documenter
 - Nurse/LPN &/or MA
 - Care Coordinator



WHAT IS REQUIRED FOR DIGMAs & Physicals SMAs

- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ <u>Administrative Support</u> ▪ <u>MD & Staff Buy-In</u> ▪ <u>Facilities Requirements</u> <ul style="list-style-type: none"> ▪ DIGMA <ul style="list-style-type: none"> ▪ Group room for ~ 25 ▪ 1 Nearby equipped exam room ▪ Physicals SMA <ul style="list-style-type: none"> ▪ Smaller group room for ~ 12-15 ▪ ~4 Equipped exam rooms ▪ <u>Thorough Training</u> ▪ <u>Quality Promotional Materials</u> | <ul style="list-style-type: none"> ▪ <u>Staffing</u> <ul style="list-style-type: none"> ▪ Provider ▪ Behaviorist ▪ 1-2 Nurses ▪ Documenter ▪ Care Coordinator ▪ <u>In Larger Systems:</u> <ul style="list-style-type: none"> ▪ Champion
(Needed to rapidly expand program) ▪ Program Coordinator
(Assist champion, monitor census, etc) ▪ Dedicated Scheduler
(Very important for full groups) |
|--|---|



PROMOTE SMAs EFFECTIVELY

- Send Announcement Letter to Pts at Start of SMA
- Framed Wall Posters in MD's Lobby & Exam Rooms
- Program Description Fliers
- Carefully Design Patient Packet
- Have Pts Invited by:
 - Scheduler
 - Receptionist (invitations)
 - Nurse/MA (fliers)
- MD Must Personally Invite All Appropriate Pts During Office Visits (most important step, but should only take 30-60 seconds)

ADDRESS CONFIDENTIALITY

- Cover in All Promotional Materials
- All Attendees Sign Confidentiality Release
 - Drafted by attorneys
 - Made Pt friendly by administration
 - Behaviorist fully covers at SMA's start
 - "Your care will be discussed in group"
 - "Don't identify others after group is over"
 - But take home & share what is useful
- No Problems to Date

PATIENTS FOR DIGMAs

Include Most Pts:

- Routine f/u CARE
- Relatively Stable Chronically Ill
- Some New Patient Intakes
- F/U's: Medications, Labs, Referrals
- Difficult & Problematic Pts
 - Extensive info/psychosocial issues
 - Non-compliant & psychosomatic Pts
 - High and/or low utilizers alike
 - Pts needing ↑ time/peer support
 - "Worried well", anxious & depressed
- Pts Willing to Attend (**voluntary**)

Exclude Some:

- Pts Not Speaking the Language
- Too Demented or Hearing Impaired to benefit
- Serious Infectious Illnesses
- Medical Emergencies
- Complex Medical Procedures
- Pts Provider Wants Excluded
- Pts Refusing to Attend

WHY PATIENTS LIKE DIGMAs & Physicals SMAS

- Prompt Access & More Time (90 min. with own MD)
- ↑ Pt Education & Psychosocial Needs
- Max-Packed Visits (1-stop healthcare shopping)
- Help from Other Pts & Behaviorist
- Appropriate Privacy Is Maintained
- Closer Follow-Up Care
- An Additional Healthcare Choice

WHY PHYSICIANS LIKE SMAs

- Improved Access & Productivity
- Better Management of Large Practices
 - More time & relaxed pace
 - Learn more about patients
 - Optimize appointment mix
 - Refer patient phone calls
 - “Oasis” in hectic pace of traditional office visits
- Opportunity to Do Something New & Different
- ↑ Patient Education (more teaching)
- ↓ Repetition
- They are fun!

DIGMA CHARACTERISTICS

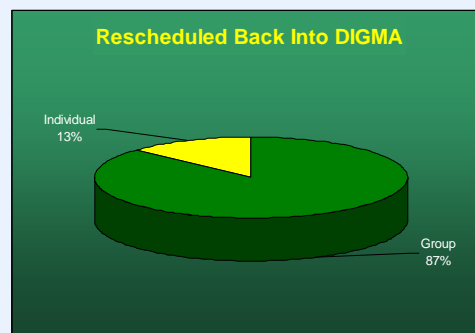
- Typically 90-min. Weekly Sessions—daily OK
 - Heterogeneous, Homogeneous, & Mixed Subtypes
- Open to Most of MD’s Practice (typically f/u visits)
- Different Pts Attend Sessions (only w/medical need)
- Medical Care from Start to Finish—no “class”
- Used in FFS & Capitated Systems
 - Series of 1 MD-1 Pt encounters with observers
- Most Care & Exams Delivered in Group
- Private Discussions & Exams as Needed
- Behaviorist & Often a Documenter
- Expanded Nurse & Behaviorist Roles

FLOW OF A TYPICAL DIGMA

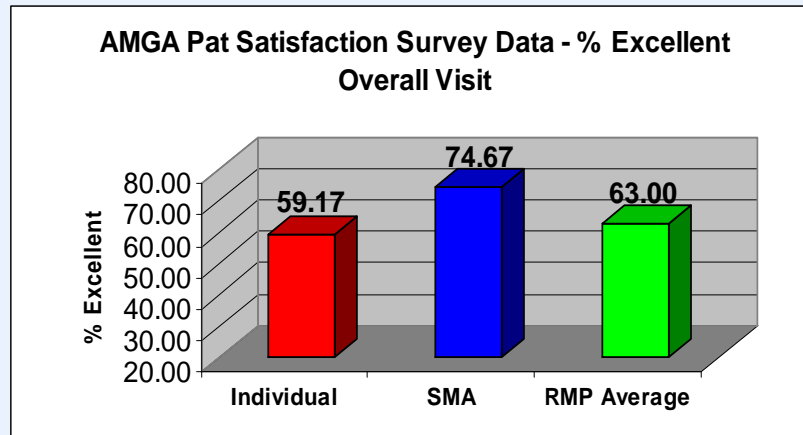
- 10-16 Different Pts Register
- Most by App't. (some drop-in)
- Pts Often Get Patient Packet
- Sign Confidentiality Release
- Nurse(s) Starts Vitals Early
- Behaviorist Arrives Early
 - Warms up group
 - Writes down Pts' issues
- Pts Sit in Circle (with SPs)
- MD Sits Next to Behaviorist
- Starts with Behaviorist's Intro.
- Start with Pts Leaving Early
- History & Medical Decision Making
- Exams As Needed (mostly in group)
- Chart After Each Pt (must support bill)
- MD Delivers Care to Rest (1 at a time)
- Last 5-10' for Private Exams/Talks
- Start & End on Time
- MD Leaves Promptly when SMA ends
- Behaviorist Stays Late (not MD)

PATIENT SATISFACTION (Cleveland Clinic)

- **87%** of patients rescheduled into a future DIGMA
- This excludes Physicals SMAs—which are not rescheduled



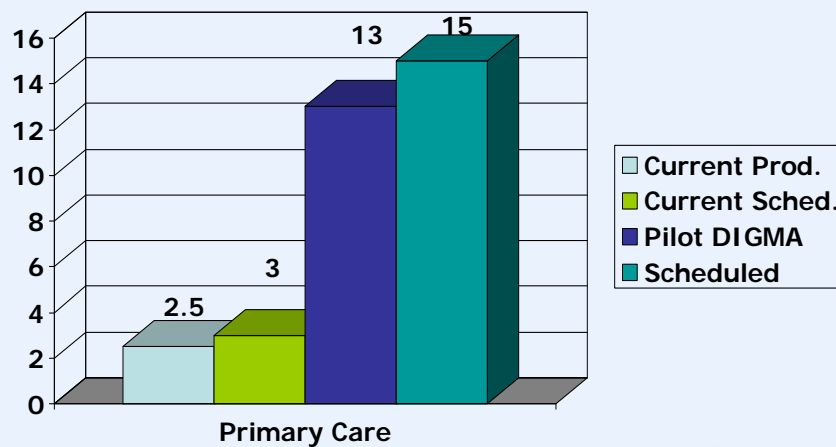
PATIENT SATISFACTION IS GREATER WITH SMAs (Cleveland Clinic)



VA PILOT

Primary Care Heterogeneous DIGMA Feb. '04

(↑ MD Productivity = 520%) (Patient Satisfaction = 4.58/5.0)



INCREASED MD PRODUCTIVITY

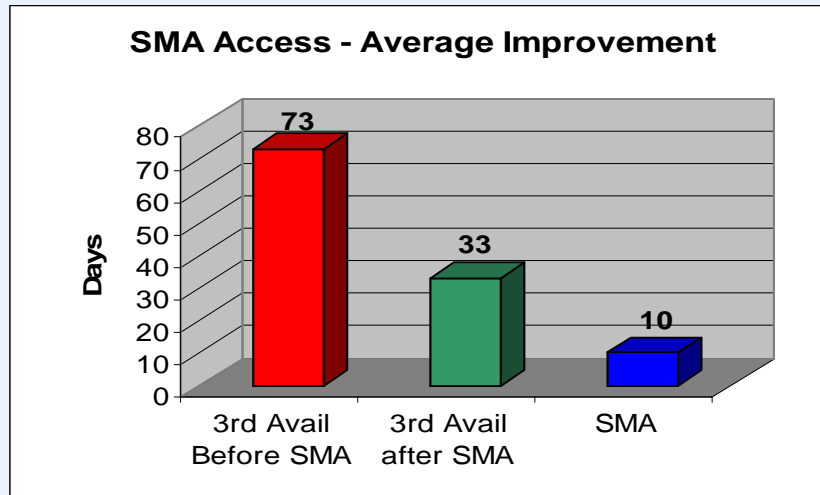
Pilot Study at Sutter Medical Foundation (Pt Sat. = 4.7/5)

Type of DIGMA	Week #1 12/6/99	Week #2 12/13/99	Week #3 1/3/00	Week #4 1/10/00	Week #5 1/17/00	Week #6 2/7/00		
	# Pts/Wk	# Pts/Wk	# Pts/Wk	# Pts/Wk	# Pts/Wk	# Pts/Wk	Avg. # Pts /Wk	% Increase in MD Product.
Dr. A - Internal Med. Initial # Pts / 90' = 4.5 Min. Census = <u>13.5</u>	12	12	14	16	5	25	14.0	311.1%
Dr. B - Rheumatology Initial # Pts / 90' = 2.9 Min. Census = <u>8.7</u>	5	6	9	8	7	17	8.7	300.0%
Dr. C - Family Practice Initial # Pts / 90' = 4.2 Min. Census = <u>12.6</u>	8	Cancel (Ill)	7	11	8	14	9.6	228.6%
Dr. D - Family Practice Initial # Pts / 60' = 4.7 Min. Census = <u>9.4</u>	10	13	6	6	13	9	9.5	202.1%
Total	35 / 4	31 / 3	36 / 4	41 / 4	33 / 4	65 / 4	41.8	256.4%

3 PILOT MDs PROMPTLY IMPROVED ACCESS

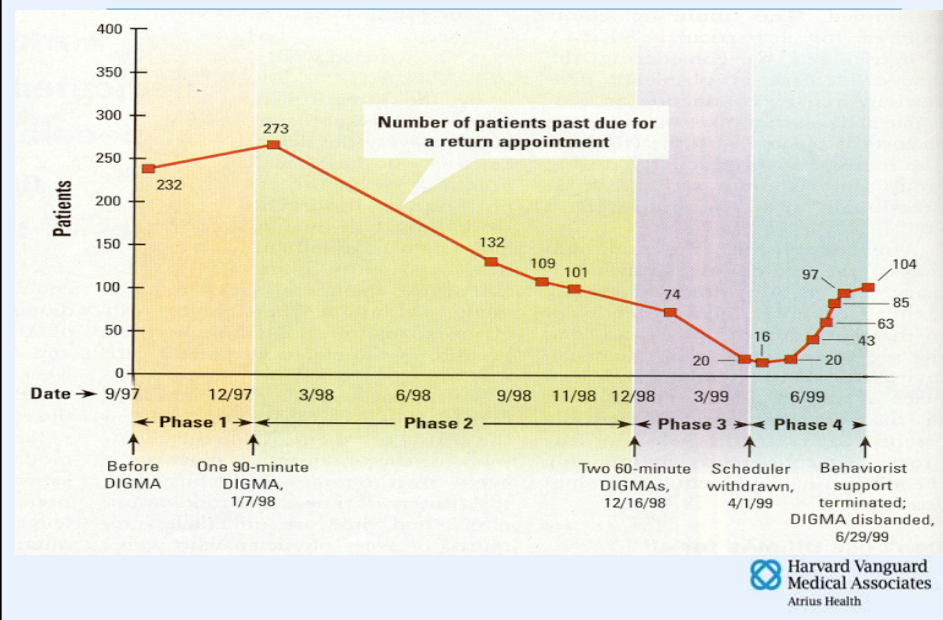
Pilot Physician	Number of Days Until 2 nd Available Return		
	Aug. 4, 2000 (8 Weeks prior to launch)	Sept. 28, 2000 (1 Day after launch)	% Decrease in Wait List
Dr. A – Internal Med/Endo	35	16	54.3%
Dr. B – Family Practice	39	14	64.1%
Dr. C – Podiatry	103	68	34.0%
Avg. # Days Wait for 2nd Available Return App't.	59.0	32.7	44.6%

CLEVELAND CLINIC: SMA ACCESS DATA



Harvard Vanguard
Medical Associates
Atrius Health

DIGMAs WORK BUT REQUIRE SUPPORT



Harvard Vanguard
Medical Associates
Atrius Health

BEFORE DIGMAs, THE NEUROLOGY DEP'T WAS HOPELESSLY BACKLOGGED

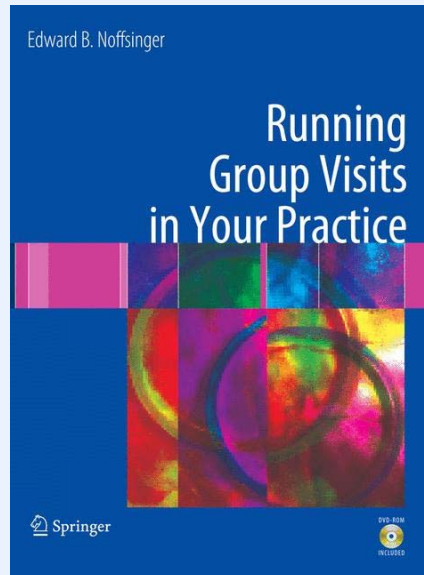
- **DIGMA Designs Employed** (all 3 launched at once)
 - 2 Mixed
 - 1 Heterogeneous
- **At Start of Study**
 - Severe access problems (No appt's. for 3 months)
 - Lacked resources to hire another neurologist
 - Low MD morale
 - Many Pt complaints, phone calls, & "work-ins"
- **1 Month after Launch**
 - 43.5% ↓ in wait list
 - 67% ↓ in Pts past due appointment
- **2 Months after Launch**
 - Pts past due completely caught up

ACCESS PROBLEMS SOLVED!

(Results After 1 Year)

- | | |
|---------------------------------|--------------------------------|
| ■ 650% ↑ in f/u productivity | ■ ↑ Pt-MD relationships |
| ■ 26% ↑ in f/u appt's. | ■ ↓ Pt phone calls |
| ■ Equivalent to ↑ .7 FTE | ■ ↓ Pt complaints re. access |
| ■ Elimination of backlogs | ■ ↓ Need to force book Pts |
| ■ ↑ Availability indiv. app'ts. | ■ 3 DIGMAs = heterogeneous |
| ■ ↑ Pt & MD satisfaction | ■ ↑ Ability to follow Pts |
| ■ All Pts scheduled 2mo ahead | ■ ↓ Referrals back to PC |
| ■ 46 openings next 2 months | ■ Avg. # DIGMA visits/yr = 2.0 |

NEW BOOK: "Running Group Visits In Your Practice"



Now Available through:
WWW.Springer.com or
WWW.Amazon.com

 Harvard Vanguard
Medical Associates
Atrius Health

HVMA/Atrius Health

- Multi-Specialty Non-profit Ambulatory Care Practice
- 750 physicians
- 6000 employees
- 30 practice sites in Eastern Massachusetts
- 700,000 patients
- Over 2.3 million visits per year
- Highest quality metrics in MA



 Harvard Vanguard
Medical Associates
Atrius Health

Shared Medical Appointments at HVMA

- 32 SMAs created in 2008 & 2009
- 10 Specialties
 - (IM, FP, Peds, ObGyn, Cardio, Endo, Neurology, Dermatology, Nephrology, Physiatry)
- Six Sites
- Over 5,000 patient visits in SMAs/PSMAs to Date

PERFECT STORM in Health Care

- Shortage of physicians (esp. PCP's)
- Job is not doable
- Increasing demand for care
- Access will continue to worsen

ASK YOURSELF THIS QUESTION

- **What is your healthcare organization doing differently to improve:**
 - access, quality, & chronic disease treatment?
 - the cost effectiveness of care?
 - patients' care experience?
 - providers' ability to manage busy practices
 - 'job doability' for clinicians and staff?

Some of the Innovative Solutions at HVMA

- EMR with email portal (MyHealth, After Visit Summary)
- Patient Centered Medical Home
- Home Tele-monitoring
- Comparative Effectiveness
- Lean Methodologies
- Leadership Academy
- Shared Medical Appointments

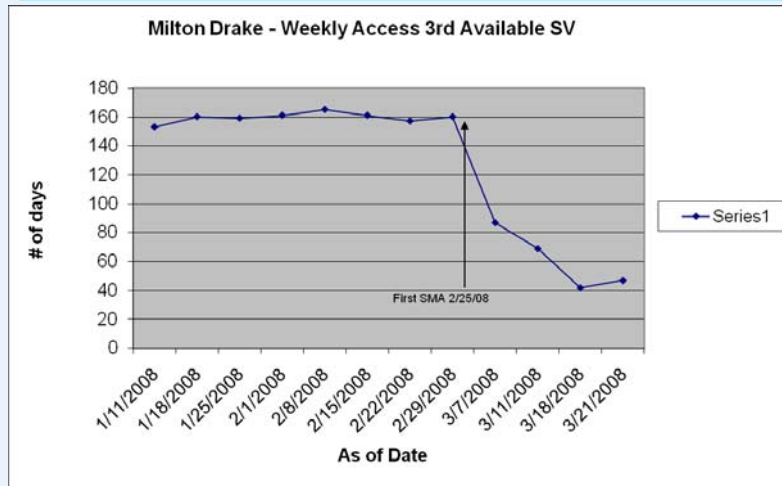
Benefits of Shared Medical Appointments

- Patient
 - Access to PCP & specialists
 - More time with physician & more relaxed pace
 - Greater patient education & disease self-management
 - Support & learning from other patients (including community resources)
 - Max-packed visits, 1-stop healthcare, & greater satisfaction
- Provider
 - Documenter & team support (visit efficiency/job doability/pract. mgm't)
 - Can focus on patients & practice of medicine (less repetition)
 - Able to see patients w/ more frequency & provide higher quality care
 - Enhanced revenue (panel size, encounters, immunity to no-shows)
- Staff
 - 'Team medicine'
 - Closer to patient care
 - Learning experience

Organizational Benefits

- Quality of Care
 - Access
 - Patient Satisfaction
 - Standardized team protocol for screening & preventive measures
 - Enhanced health education (questions & concerns addressed)
 - Behavior change due to "peer to peer" interactions & support
 - "Mind" as well as "Body" needs addressed
- More Effective Ambulatory Medicine Teaching Forum
- Financial
 - Increased revenue
 - leveraging of existing resources
 - increased productivity (encounters)
 - increased downstream ancillaries (pharmacy, lab, radiology)
 - P4P (quality & efficiency)
 - Decreased unnecessary costs
 - decreased urgent care & ED visits
 - decreased use of external specialists & external ancillaries

Shared Medical Appointments – Access

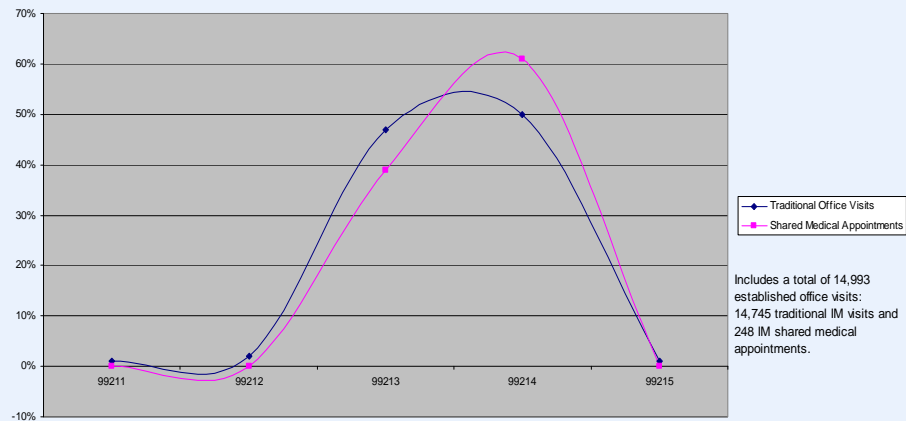


HVMA - Shared Medical Appointments (SMA) Productivity

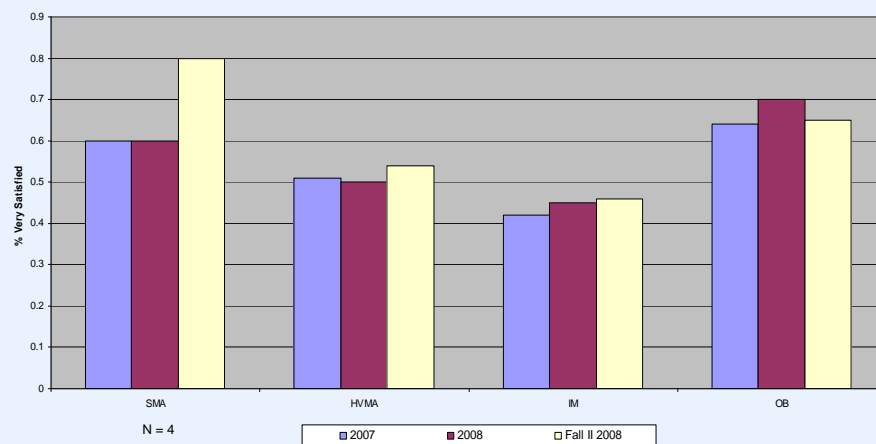
Provider	Type	Specialty	Overall % Increase in Weekly Productivity/Adj for FTE
Dr. A	SMA	IM	16%
Dr. B	PSMA	IM	24%
Dr. B	SMA	IM	15%
Dr. C	PSMA	IM	13%
Dr. C	SMA	IM	12%
NP A	SMA	Peds	17%
Dr. A	PSMA	OB/Gyn	20%
Dr. B	PSMA	OB/Gyn	25%
NP A	PSMA	V-Service/OB/Gyn	29%
NP B	PSMA	V-Service/OB/Gyn	26%

Coding for Shared Medical Appointments

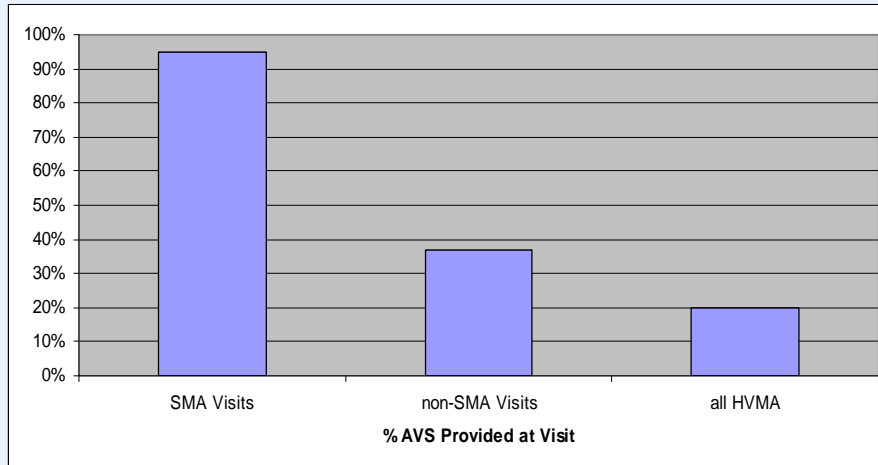
Chelmsford IM - Coding Profile
for Established Office Visits



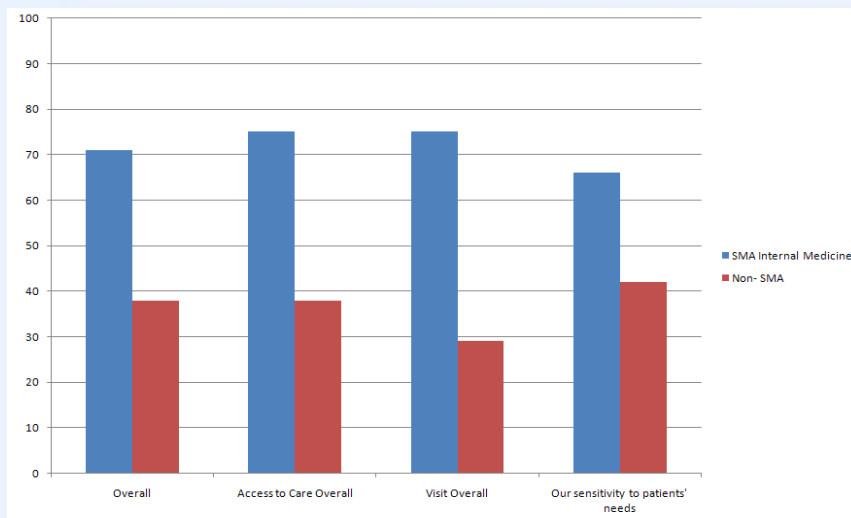
AMGA MD Satisfaction: Quality of Care Dimension



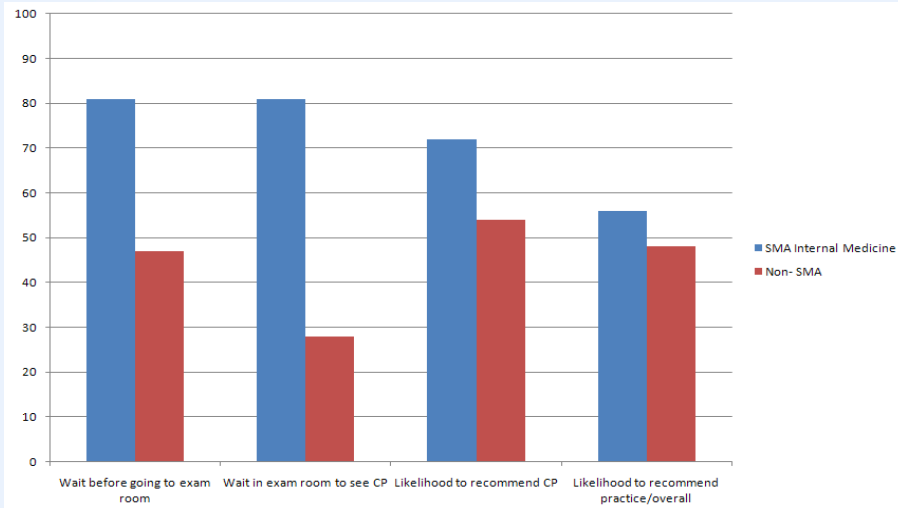
Comparison of Provider Use of 'After Visit Summary' Marker or Surrogate for Quality



SMA Outperforms on Key Measures of Patient Experience Scores



SMA Outperforms on Key Measures of Patient Experience Scores



Introducing

Ed Millermaier, MD

Implementation Protocol

- Develop infrastructure of your program
- Determine how and what you are going to measure
- Involve Coding and Billing Staff in the development
- Include someone from IT in your initial planning
- Develop standard templates for promotional materials

Implementation Protocol

- Meet with department to introduce concept (videos...)
- Meet with clinician to design/adapt DIGMA or PSMA
- Train Behaviorist, Documentor, & Clinician
- Develop marketing and invitation protocols to fill SMAs
- Train nursing and scheduling staffs
- Work with manager/team on workflow & EMR issues
- Conduct 'mock' session with staff as patients
- Conduct 1st session & debrief (track metrics thereafter)

COMPONENTS OF A PSMA

- **Patient Packet Segment**
 - Send Patient Packet to Pts (when app't is scheduled)
 - Patients complete/return questionnaire & lab tests
 - Entered into chart note (and group room wall chart)
- **Physical Exam Segment**
 - Provided privately in 4 exam rooms
 - Documentation support shadows MD
- **Interactive Group Segment**
 - Basically a small DIGMA
 - In group room
 - Documentation support like DIGMA

TYPICAL PHYSICALS SMA

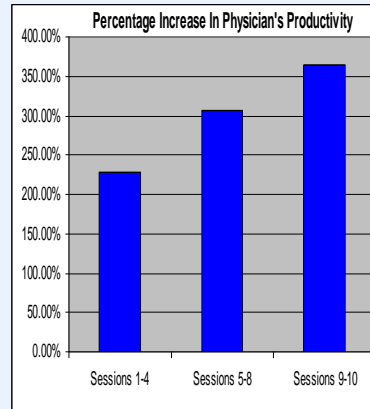
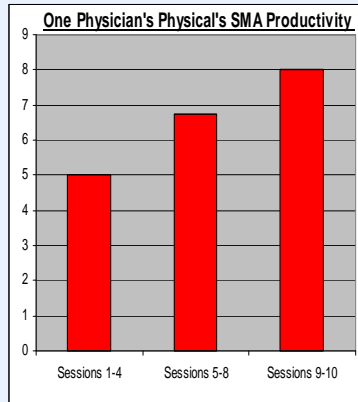
- Model Design
- Held Each Week for 90'
- Mixed Subtype (by age/sex)
- Private Exams 1st, then Grp.
- Behaviorist runs group while exams are done
- ↑ Nurse & Behaviorist Roles
- MD's Own Pts Scheduled
 - Also from other MDs' wait lists
 - Or pre-screened new Pts

Flow Of Physicals SMA

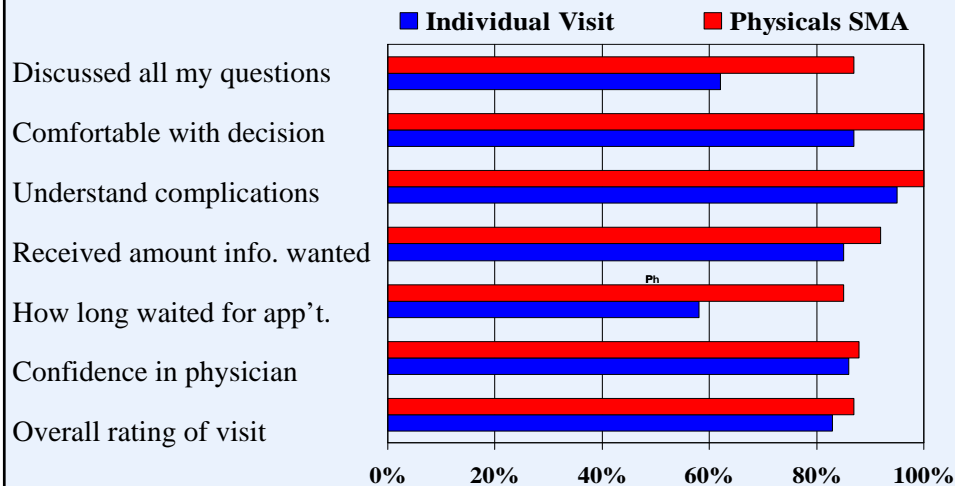
- Send Pt Packet 2 Wks. Ahead
- Pts Return Questionnaire/Tests
- 6-9 Same-Sex Pts Register
 - 300% ↑ MD productivity
- Exams at Start (min. talk)
 - Use ~4 Exam Rooms & 2 nurses
 - While behaviorist runs group
- Followed by Group (2nd half)
 - Basically a small DIGMA
- Documentation Support
- Care Coordinator Role
- Minor Procedures at End
- Start and End on Time

1 MD's ↑ PRODUCTIVITY Through Physicals SMAs

(Pre-SMA productivity = 2.2 individual physicals / 90 min.)



PATIENT SATISFACTION RESULTS (Individual versus Physicals SMA Visits—Plastic Surgery)



MEDICAL SPECIALTIES TO DATE

(Have Launched Over 450 DIGMA & PSMA MDs—20,000 Pt Visits)

- Internal Medicine
- Family Practice
- Allergy
- Cardiology
- Dermatology
- Endocrinology
- General Surgery
- Gynecology
- Nephrology
- Nurse Practitioners
- Obstetrics
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopedics
- Pediatrics
- Physiatry
- Plastic Surgery
- Podiatry
- Psychiatry
- Pulmonology
- Rheumatology
- Sports Medicine
- Travel Medicine
- Urgent Care
- Urology
- Weight Management
- Women's Health



CHRONIC ILLNESS POPULATION MANAGEMENT PARADIGM THAT MAKES FULL USE OF GROUP VISITS (Kansas City VA)

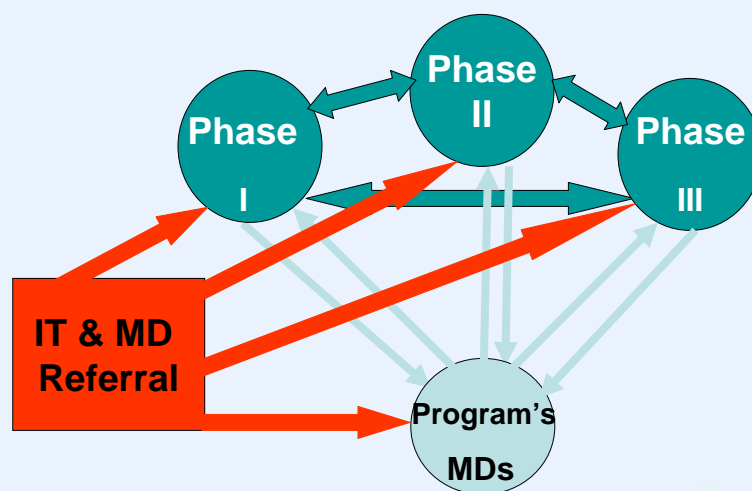
- Because of access problems being experienced in their diabetes program, the Kansas City VA was the first healthcare organization to bring me out to apply my new chronic illness population management paradigm that makes full use of group visits—a comprehensive model that works equally well for all types of chronic illnesses.



MAJOR COMPONENTS OF PARADIGM

- Referrals from IT & providers throughout system
- 3-Phase disease management program
 - Phase 1 entry point is typically an educational class
 - If more than 1 session, referrals accepted into each session
 - Phase 2 is the follow-up component (largely group programs)
 - Phase 3 is “individual case management” (use SMAs when possible)
- All providers within the program must:
 - Shift to primarily providing DIGMAs and PSMAs
 - Run enough SMAs to accept routine referrals within 1 week
 - Offer same-day access for urgent visits
- Every component can refer to any other in 1 week

FULL USE OF SMAs IN THIS CHRONIC DISEASE MANAGEMENT PROGRAM



GETTING PAID

DIGMAs & PSMAs = The Efficient Delivery of One-On-One Quality Care to Pts in a Supportive Group Setting that Addresses Each Pt's Unique Medical Needs Individually"

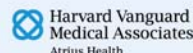
- **Voluntary Practice Management Tool**
- **Run as a Series of 1MD-1Pt Encounters with Observers**
- **Addresses Each Pt's Unique Medical Needs Individually**
- **Complete Exams & F/Us (medical care from start to finish)**
- **DIGMAs & PSMAs are Typically Billed by:**
 - Level of Care Delivered & Documented
 - Documentation must support bill
 - Do not bill for counseling time or behaviorist's time
 - No current E&M codes (Are they needed for DIGMAs & PSMAs?)
 - Not fully resolved—adjust to any future changes in rules
- **Used in Almost All Primary & Specialty Care Settings**
 - Fee-For-Service & Capitated
 - Profit & Not-for-Profit
 - VHA & DoD (USAF, Army, Navy)
 - Public Sector (public hospitals, community health centers, etc.)
- **1 Insure Recently Incentivized DIGMAs & PSMAs**



Financial Analysis— Assumptions

(Based on 1 benefit alone—i.e., ↑ MD Productivity)

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ MDs: <ul style="list-style-type: none"> ▪ Avg. 300% ↑ productivity/SMA ▪ 36 hrs/wk clinic time—unchanged ▪ Run one 90' DIGMA or PSMA /wk ▪ <u>Avg. cost = \$200K /yr</u> ▪ Behaviorists : <ul style="list-style-type: none"> ▪ Cost \$80K /yr ▪ <u>Full-time = 18 DIGMAs/yr</u> ▪ Wall Posters & Promotion: <ul style="list-style-type: none"> ▪ <u>Cost \$1K per DIGMA or PSMA</u> ▪ Schedulers: <ul style="list-style-type: none"> ▪ Cost \$50K /yr ▪ <u>Full-time = 18 DIGMAs & PSMAs</u> | <ul style="list-style-type: none"> ▪ Champion & Prog. Coord: <ul style="list-style-type: none"> ▪ Champion Costs \$120K /yr ▪ Program Coord. Costs \$80K/yr ▪ <u>Launch 18 DIGMAs & PSMAs /yr</u> ▪ Nurse(s) = \$ Savings <ul style="list-style-type: none"> ▪ Time is also leveraged ▪ Documenter = No Cost ▪ Assumptions: <ul style="list-style-type: none"> ▪ SMAs launched at uniform rate ▪ Personnel hired as needed ▪ Team only paid for SMAs held ▪ Group rooms are available ▪ There is no DIGMA turnover ▪ <u>Total saving =1.5 x MD salary</u> |
|--|--|



FINANCIAL BENEFITS (of Well-Run DIGMAs & PSMAs)

		1 st Yr 18 DIGMAs	2 nd Yr 36 DIGMAs	3 rd Yr 54 DIGMAs	4 th Yr 72 DIGMAs	5 th Yr 90 DIGMAs	6 th Yr 108 DIGMAs	7 th Yr 126 DIGMAs
EXPE NSES (x \$1,000)	Champ/PG	200	200	200	200	200	200	200
	Behaviorist	40	120	200	280	360	440	520
	Scheduler	25	75	125	175	225	275	325
	Marketing	18	18	18	18	18	18	18
	Total	283	413	543	673	803	933	1063
SAVI NGS (x \$1,000)	FTEs Saved	0.75	2.25	3.75	5.25	6.75	8.25	9.75
	MD Salary	150	450	750	1050	1350	1650	1950
	Total (x1.5)	225	675	1125	1575	2025	2475	2925
Total Net Savings		-58K	262K	582K	902K	1222K	1542K	1862K
Total Net DIGMA Savings Over 7 Years = \$6,314,000								

DIGMAs & PHYSICALS SMAs SUPPORT ADVANCED CLINIC ACCESS

- Help Work Down Backlog without Extra Hours in Clinic
- Supply Enhancement
- Demand Reduction
- Match Supply to Demand
- “Max-Pack” Visits (1-stop healthcare experience)
- Tool for Managing “Good Backlog”
- ↑ Value (continuity & the doctor-patient relationship)

However, You Must Consider Ultimate Census Challenges
(Also, DIGMAs & PSMAs create extra appointment types)

SMAs CAN ALSO SUPPORT THE PATIENT CENTERED MEDICAL HOME

- DIGMAs & PSMAs Add Capacity & Reduce Pt Demand
- DIGMAs & PSMAs Can Provide the “Economic Engine” to Support the Entire PCMH Infrastructure
- DIGMAs & PSMAs Dramatically Leverage Existing Resources (can create extra MD FTEs our or existing staff)
- This Allows Extra Time to Conduct Added Duties
- DIGMAs & PSMAs Make PCMH Easier to Achieve
- Payment Issues Can Be Resolved through SMAs
- Multidisciplinary Team-Based Approach to Care
- SMAs Are a Great Tool for Team-Building



Other Possible Sources of Financial Benefit

- Max-packed visit and “1-stop” health care
- ↑ Practice and chronic illness management
- P4P
- Many Pts will prefer highly efficient SMAs to costly IVs
- Increased continuity & decreased OU
- Valuable positive PR often received from mass media
- Reduced malpractice risk?
- High Pt and MD satisfaction can ↓ turnover
- Competitive advantage of a new service liked by many Pts
- Better address psychosocial needs that drive many office visits
- Compliance and appropriate utilization of services can be ↑
- Immunity to “no shows” and “late cancels”
- Comprehensive chart note optimizes billing
- Insurers might incentivize group visits



SMA OPERATIONAL CHALLENGES

“SMAs Must Be Properly Designed, Supported, Promoted, & Run”

- A Major Paradigm Shift that Involves Much Change
- SMAs Exacerbate All Pre-existing System's Problems
- SMA Model Is Highly “Counter-Intuitive”
- “Beginner's Mistakes” Are thus Easily Made
- SMAs Are a Highly “Standardized Process”
- MDs Often want to Change the Initial Design
- There Is a Tendency to Get Excited & Launch Prematurely
- Require Admin. Support, Budget, Personnel, & Facilities Requirements
- Needs a SMA Champion & Program Coordinator (in large systems)
- Behaviorists, Documenters, & Care Coordinators Sometimes Not Available
- There Are Always Competing Resource Demands
- Require Effective Training, Promotion, & Buy-In
- Maintaining “Census” is critical to success—Requires Ongoing Tracking
- Full Groups Best Achieved with Busy, Backlogged Providers
- Scheduling Is Often Seen as “Extra Work”
- Must Achieve Predetermined Launch Rate



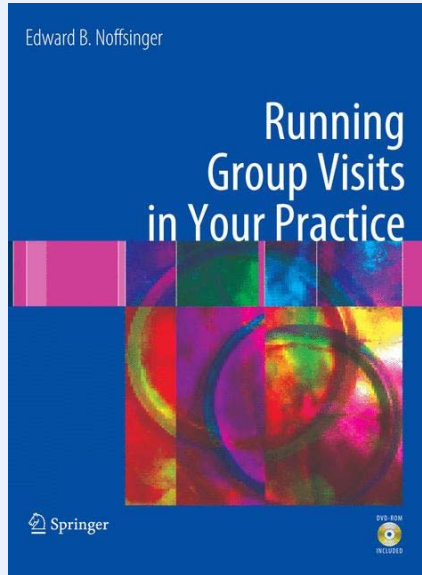
LESSONS LEARNED IN PRACTICE

“All Programs Must Be Carefully Designed, Supported, Promoted, & Run”


- | | |
|--|---|
| <ul style="list-style-type: none"> ▪ Make SMAs Standardized Work ▪ Best Possible SMA Champion ▪ First Get Admin. Support ▪ Select MDs w/Access Problems ▪ MD & Team Must Stay <i>On Model</i> ▪ Use Skilled & Trained Team <ul style="list-style-type: none"> ▪ Best possible champion & PC ▪ ↑ Nurse/behaviorist's roles ▪ Try to get documenter ▪ Use a dedicated scheduler ▪ Engage MD's operational staff ▪ Train MD's support staff ▪ MD Delegates to Team | <ul style="list-style-type: none"> ▪ Clinician & support staff agree to: <ul style="list-style-type: none"> ▪ Invite patients ▪ Fill all group sessions ▪ Always Maintain Census <ul style="list-style-type: none"> ▪ Periodically track & monitor ▪ Promote program effectively ▪ Use quality marketing materials ▪ Use well designed Pt Packet ▪ Foster Group Interaction ▪ Have Pts Stay All Session ▪ Start & Finish on Time ▪ Solve Any System Problems ▪ Ongoing SMA Evaluation ▪ Study Book & Articles |
|--|---|



NEW BOOK: "Running Group Visits In Your Practice"



Now Available through:
WWW.Springer.com or
WWW.Amazon.com

 **Harvard Vanguard
Medical Associates**
Atrius Health