Shared Visits Boost Diabetes Education, Revenue

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LAS VEGAS – Shared medical appointments can be a financially viable way to implement effective diabetes education to a large number of patients in primary care settings, the experience of one practice in south Texas demonstrated.

The premise of the shared medical appointment (SMA), first described in 1974 as a model for well-child consultations, is to provide the educational part of a medical appointment once with a large group of patients rather than repeating the same material over and over again on a one-on-one basis.

"Shared medical appointments are a health care delivery model that provide an opportunity to manage chronic illness, and improve quality and patient self-efficacy and self-management," said certified diabetes educator Iris Sanchez, DNP, of the Weslaco (Tex.) Medical Clinic.

Weslaco is just to the north of the Mexico border. As such, the population is nearly 100% Hispanic and the diabetes rates are high: In the town's county of Hidalgo, 13.3% of the population has diabetes, compared with 10.3% for the state of Texas and 8.3% for the entire United States. Patients often travel long distances to get to the clinic for medical visits. Based on evidence from a large body of literature, shared medical appointments were seen as a potential way for the clinic to maximize efficiency of delivery of diabetes education while also delivering quality medical care, said Dr. Sanchez, whose report was published online earlier this year (The Diabetes Educator 2011 March 31 [doi:10.1177/0145721711401667).

The program was developed within the context of the chronic care model, a proposed framework for organizing care for patients with chronic conditions that incorporates the elements of community resources and policies, health systems, self-management support, delivery systems design, decision support, and clinical information systems (Milbank Q. 1996;74:511-44).

The clinic employs one physician and two nurse practitioners. The team invited to speak to the group about self-management included a dietician, podiatrist, exercise physiologist, social worker, and others. Flyers were posted in exam rooms and in the lobby to advertise the "Diabetes Days," and ads were placed in the local newspaper in English and Spanish.

The shared medical appointment, including the educational component plus the medical visit, lasted a total of 90 minutes. Patients were called out during the group education session to see the physician or nurse practitioner for their medical visits, and would then return to the room. To maintain confidentiality, individual cases were not discussed during the educational sessions, Dr. Sanchez noted.

Progress notes were kept, and outcomes tracked using an electronic medical record system. Initially scheduled once a week with 12 people in the group, the SMAs have recently been expanded to twice weekly. It's important to tell patients that the SMAs are not a choice, but are to be kept just as they would a medical appointment. Participation initially varied from 30% to 100%, but now hovers around 90%.

Of 70 patients seen between September and November 2009, 65 had a second visit and 49 a third. Prior to initiation of the program, 75% had not had a urine albumin measurement in the previous 12 months, 34% had not had an eye exam, and 55% were not on daily aspirin. All of these standards of care were implemented as part of the SMA, which resulted in increased revenue from services such as eye exams and urine screens, Dr. Sanchez pointed out.

Average hemoglobin A_{1c} at initiation was 7.95%. That dropped to 7.48% on second measurement, and rose slightly to 7.51% at a third measurement. For those with a second HbA_{1c} value, 25 (42%) had an increase and 34 (58%) had a decrease. The differences were not statistically significant, but they were clinically significant, she said. Dr. Sanchez reported having no financial disclosures. ■