Cambria Health Case Study:

Implementing SMAs at UC San Diego Health System

THE CLIENT

UC San Diego Health System (UCSD) is an academic institution composed of UC San Diego Medical Center, Thornton Hospital, a range of specialty facilities and UC San Diego Medical Group, which includes primary and specialty practices and clinics throughout Southern California. The main hospital is a Level 1 trauma center and was ranked as one of America's Best Hospitals by *U.S. News & World Report* in 2012, as well as one of the 100 Top Hospitals by Thomson Reuters.

THE DECISION

The Department of Medicine at UCSD has made patient-centered care a priority. Leaders view it as encompassing access, care coordination and patient empowerment, all factors addressed by shared medical appointments (SMAs). Research showed that within the clinics and medical practices, patients highly value face time with physicians, and more time with doctors brings better understanding of treatment recommendations.

Being an academic organization, clinical leaders sought an evidence-based approach to evaluate whether and how to adopt SMAs. A literature review led to a visit from Edward B. Noffsinger, PhD, a pioneer of drop-in medical group appointments at Kaiser Permanente Medical Center in San Jose, Calif., in the 1990s and SMAs at the Palo Alto (Calif.) Medical Foundation. Later, Noffsinger worked on SMAs at Harvard Vanguard Medical Associates/Atrius Health in Boston, and published a magisterial guidebook called *Running Group Visits in Your Practice*. The UCSD team also consulted with Zeev Neuwirth, MD, who established dozens of specialty and primary care SMAs at Harvard Vanguard and is now chief medical officer of the Physician Services Group at Carolinas Healthcare System.

Dr. Neuwirth referred UCSD leaders to Cambria Health and its president and CEO, Rick Siegrist, MBA, MS, CPA, to evaluate and help establish SMAs. "We found that there are a very limited number of SMA experts out there in the field," said Daniel Bouland, MD, MS, vice chair of clinical operations for theDepartment of Medicine.

UCSD also sent two of its leaders – Katherine Brewster, director of ambulatory care services/clinics for the medical group; and Catherine Dehaan, director of clinic operations for the Department of Medicine – to Harvard Vanguard to see SMAs in action.

"You can read the books and listen to the talks, but I don't think anything can replace observing the process of shared medical appointments first-hand, in learning from the people who are instrumental in starting them, and talking to patients about their experiences," Dehaan said. "Once we did that, we were sold."

THE IMPLEMENTATION

With a decision made to go ahead with at least a few pilots, Bouland reached out to physician leaders of every clinical area. “I wanted to know where my physician champions were; without engaged doctors, you can’t do anything,” he said.

Cambria Health was engaged to take it from there. The team arrived on site with its value assessment tool, which has 16 weighted criteria in three major domains. The domains include patient factors (e.g., a chronically ill population), staff factors (e.g., an enthusiastic physician sponsor) and organizational factors (e.g., strong administration support).

Based on response to Bouland’s initial physician outreach, 10 clinical areas were scored, and three leaders emerged – AIDS/HIV, diabetes and liver disease.

“One of Cambria's greatest strengths is the value assessment tool. It serves as a keystone and brings objective measures to the entire process,” Bouland said. “How do you identify the right physician leader? Is this the right clinic? (Cambria) looks at all these factors, and you get an actual number that’s weighted and can be compared across the spectrum of specialties or clinics, and get a real idea of where the strength and weaknesses of each are in terms of whether they are right for SMAs. That was a very valuable exercise for us to go through, and what we are seeing is that the value assessment tool has been validated as we have started rolling out these clinics.”

Adds Brewster: “When we were in Boston observing, we had a pretty good idea of which services are appropriate for SMAs, and the value assessment tool supported that impression. The other thing it did was bring a structure and formalization to the process, and that conveyed to the groups that were interested that this was a serious undertaking, which helped us with the commitment level of those folks.”

Following that process, Cambria and UCSD leaders commenced a 90-day implementation phase, with regular consultative phone calls as SMA teams were assembled. In addition to physicians, each SMA would have a medical assistant, a facilitator or behaviorist and a documenter or scribe. The facilitator is there to manage the meetings and engage patients in the group experience.

After the teams were assembled, Cambria came out to do training for the teams and help conduct mock appointments, so the staff would be able to see what might happen in a live session. “The mock SMA training was good because it showed how the flow of shared medical appointments go,” said Suzanne Lohnes, RN, who facilitates the diabetes SMAs.

The team agreed that the patient role-playing during the mock appointments needed work, mainly to introduce more realistic questions for the physicians. Cambria is working with specialists to develop those questions for future mocks.

The UCSD SMAs take approximately two hours of which 90 minutes is for the session itself. Patients are checked in by the medical assistant and sign a confidentiality agreement. The physician arrives at the start of the session. The facilitator is also the timekeeper, keeping the session on track.

Each SMA at UCSD differs based on the nature of the patient population and physician preferences. For example, the AIDS/HIV sessions have all the colors of the rainbow – multiple races, ethnicities, genders, sexual orientations and age ranges – all represented in the room. “It’s a really diverse group that represents my real-life practice,” says Amy Sitapati, MD, who has attained a national reputation working to improve the quality of life for people living with HIV through the delivery of comprehensive primary care.

The diabetes SMA, led by Steven V. Edelman, MD, a nationally renowned expert on diabetes education and founder of the not-for-profit organization Taking Control of Your Diabetes, has taken the opposite approach. “In choosing people for the SMA I looked at all my patients and I separated out Type 1 diabetics from Type 2, and separated men from women. I also tried to pick people from the same age group. The more homogenous the group, the more people are going to feel comfortable talking about sensitive issues,” he said.

For diabetes, those issues include sexual dysfunction and hormonal imbalances unique to the disease. Type 1 diabetics, who have lived with the disease for years and face more of a challenge in controlling glucose, are quite different from adult onset Type 2 diabetics, who struggle with lifestyle changes such as exercise and nutrition.

EARLY SUCCESSES AND CHALLENGES

One AIDS/HIV session was going well, with patients interacting and sharing things they had learned about the disease. On a white board Sitapati had put up some de-identified test results for instructional purposes, showing a detectable viral load. The doctor noticed one patient just sitting in the middle, not saying anything or making eye contact with others. “I asked this patient why they did not open up, and the patient said, ‘I am really ashamed to be here today, because I am the person whose viral load numbers are on the board, and I know they really aren’t good for me, and I know I can do better.’ And then the tears started to come. The patient said, ‘I feel like my family doesn’t care; they never ask about my status. I’ve seen friends die from this illness and it’s really hard to be committed to this, as I have all these feelings inside.’ ”

Instantly, other patients stepped in, saying they had been in the patient’s shoes, struggling with their numbers. And one patient said, “I know about stigma. When I go to my family’s house, I take my own drinking cup because I know it makes them more comfortable.” At the end, the first patient looked up and committed to taking the meds and find help with the psychological trauma.

John Fontanesi, PhD, director of UCSD’s Center for Management Science in Health, who did much of the early research on SMAs and is working on an evaluation of their success, said that is a common anecdote. Patients report a problem they are having in tracking medications or controlling blood sugars, and other patients speak up to show that they are not alone in their struggles. “The result is that patients are no longer isolated by their chronic disease,” he said.

Exit interviews with patients in the first two rounds of SMAs found three common themes, Fontanesi said. Patients most enjoyed the sharing of common problems and solutions. The greatest level of unhappiness was with scheduling; team members weren’t clear with when the sessions were starting

and how long they would last. “The third element, which we had not expected, was the teaching moment, and in fact is that they learned more about their chronic illness in this group setting than they had in all their individual sessions with physicians,” he said. “They just didn’t think that inherently there was as much information in the routine visits.”

Edelman had patients sharing their experiences with their continuous glucose monitor, exercise with diabetes and the attributes of various features of the insulin pump. Edelman has lived with Type 1 diabetes for 42 years, and is the author of a popular book of the same name as his not-for-profit, *Taking Control of Your Diabetes*. His facilitator, Lohnes, also has Type 1 and is a certified diabetes educator. “These patients get a lot of good education in our appointments,” he said.

Sitapati says the biggest challenge for her has been the complexity of her patients’ care. Her practice delivers primary care plus chronic disease management for conditions such as congestive heart failure, plus the HIV component. “The average patient is on at least seven medications, and we have at least 22 prevention activities we have to run through. So how do you get all those drugs and tests ordered and reconciled in 90 minutes with that many patients?”

Having said that, Sitapati says she “loves SMAs.” She thinks they challenge doctors to efficiently deliver primary care and expose problems, such as medication reconciliation in electronic medical records, which can be covered up in one-to-one care.

Another surprise in the SMAs has been the way the staff has responded, Fontanesi said.

“In our fractured healthcare system, not only the patients are feeling disenfranchised. It is also the staff. If you look at the staff satisfaction throughout the nation, you will find that employees feel disconnected from their fellow employees. In a group visit, staff start to feel like they have a greater part in helping others. The group makes it clear how populations are going to be able to work together to advance health.”

Lohnes echoes that conclusion. “I definitely come out of the appointments feeling like I am part of a team working together to help the patient, and the patient is very much involved in it. It is definitely much more rewarding for me personally.”

Physicians have also been enthusiastic champions, Bouland says. “They really have embraced SMAs. They stay up at night thinking about this, and have addressed the topic of creating shared medical appointments at national conferences.”

THE FUTURE

The early results of shared medical appointments at UC San Diego Health System are positive enough that it is only a matter of time before other specialties and general internal medicine get their own SMAs, Bouland says. “We are seeing the power of the group visit. If you see nine patients individually, you may wind up saying the same thing nine times. Here in a group visit you can say it once. So there's a greater opportunity to cover a lot of territory with those nine patients in the shared medical appointment than if you were seeing those patients individually.”

Brewster said SMAs won't replace traditional medical care. Many patients will still need one on one time with the doctor, and many healthcare services innately involve a need for privacy. "SMAs are something that we can add to our portfolio, our menu of services," she says. "It's a very rich experience for the patient, and I always like we are able to get a hold of something that makes the patient experience better."

Added Edelman: "Done well, it's a cost-efficient and medically effective model for delivering healthcare."