Shared Medical Appointments (SMAs)

Facilitator Training
Session 1

Facilitator Training 1 280814.pptx

Different Types of SMAs (Canadian)
Training Goals

• To encourage the use of Shared Medical Appointments (SMAs) in chronic disease management

• To improve efficiency and effectiveness in chronic disease management through SMAs

• To accredit Facilitators to plan, arrange, implement and evaluate Shared Medical Appointments

• To provide Facilitators with the generic (and specific) knowledge to assist in running SMAs for a range of chronic disease problems.

Health Promotion

“The process of enabling people to increase control over and improve their health” (WHO, 2009).
SOPIE A Model for Planning & Initiating Health Promotion

**Situational Analysis:** “Identify and accurately represent the extent of the problem and identify possible causes.”

**Objective setting:** “Set overall goals and specific behavioural and communication objectives for the intended audience.”

**Planning:** “Develop specific project components.”

**Implementation:** “Manage and monitor the process.”

**Evaluation:** “Assess the degree to which a program meets its objectives.”
Temporal Trends in Disease Epidemiology

Acute diseases
Causes: Hygiene; sanitation; water; micro-organisms

Chronic Diseases (NCDs)
Causes: Lifestyle; environment; economic development

Mortality and Morbidity

Late 19th Century
Early 21st Century

Infectious (Communicable) Disease Era: 0 - ~1950
Chronic (Non-Communicable) Disease Era: 1980 - ?

Proportion of disability-adjusted life years (DALYs) by age and sex, 1990 and 2010 (World)

Infectious Diseases

‘Germ Theory’

Hygiene & Public Health

Antibiotics/Immunisation

Chronic Disease

Lifestyle Medicine

“A form of health promotion and branch of medicine targeting prevention and management of lifestyle-related diseases with evidence-based interventions that integrate improvements in nutrition, physical activity, stress management, social support and environmental exposures.”

(Global Lifestyle Medicine Association 2014)
Components of Lifestyle Medicine

- **Content** - the ‘science’
  (ie. what are the lifestyle/environmental ‘determinants of chronic disease?)

- **Process** - the ‘art’
  (ie. what are the principles/practices of changing these lifestyle/environmental Determinants?)
The Hierarchy of Drivers in Modern Diseases

- **Public Health**
  - Environment (macro & Micro)
    - Physical/Socio-Cultural/Political/Economic
  - ‘Cause of the cause of the cause’

- **Lifestyle**
  - Stress
  - Anxiety
  - Depression
  - Sleep
  - Relationships
  - Inequality
  - Nutrition
  - Inactivity
  - Smoking
  - Sun expos
  - Pollution
  - ‘Penicillin of LM’
  - ‘Cause of the cause’

- **Medicine**
  - Risk Factors/Markers
  - OBESITY
  - BP
  - Lipids
  - -Apos
  - -Tg
  - -LDL-C
  - -HDL-C
  - High FPG
  - IGT
  - CRP
  - HBA1C
  - CHD
  - Diabetes
  - Stroke
  - Cancers
  - Injury
  - STDs
  - PCOS
  - Infertility
  - COPD
  - Gallstones

- **Conventional Medicine**
  - Disease
Our inflammatory internal environment – ‘metaflammation’

Inflammation
Immune
Defense
Resolution
Basal Homeostasis

Classical, Acute, Infectious Response

Modern, Chronic, Non-infectious Response

Classical Inflammation vs ‘Metaflammation’

Lifestyle/Environmental ‘Inducer’
Microbial Pathogen/‘Antigen’

‘Dys-Metabolism’
Insulin Resistance
Oxidative stress

Chronic Allostasis

Metaflammation
Chronic (Non-Communicable) Disease

Lifestyle

- Smoking
- Starvation
- Over-Nutrition
- Excess Alcohol
- Diet
- Stress/Depression
- Inactivity
- Over-exercise
- Drug use

Metaflammation
+ Other Mechanisms (eg. oxidative stress, insulin resistance etc)

Chronic (Non-Communicable) Disease


Timeline of introduction of inflammatory and anti-inflammatory 'inducers'

Anti-inflammatory
- Breast milk
- MUFA meats
- Fish
- Fibre
- Low EI/EE ratio
- Physical Activity
- Fruit/Veg
- Nuts/seeds/soy
- Low N6/N3 ratio

Pro-inflammatory
- Alcohol (moderate)
- Wine
- Vinegar
- Beer
- Olive oil
- Herbs/spices
- Cocoa
- Tea

Timeline
- Pre-Neolithic
- Neolithic Revolution
- Agrarian Revolution
- Industrial Revolution
- Green Revolution

TIMELINE
- 10,000BP
- 1,000BP
- 200BP
- 50BP
- Present

‘Anthropogens’
- Smoking
- Air pollution
- EDCs
- SAFA meats
- High EI/EE ratio
- Inactivity
- Sleep depriv
- Chronic stress
- High N6/N3
- ‘Fast foods’
- Obesity
- Over-activity
“Anthropogens”:

‘Man-made environments, their bi-products and lifestyles encouraged by these, some of which may be detrimental to human health.’

Egger G. Preventing Chronic Disease, 2012

‘Clearly, if disease is man-made, it can be man-prevented’

Ernst Wynder, 1975

Two categories of Disease: multiple Causes

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<th>TIMELINE</th>
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<td>‘Anthropogens’ Theory</td>
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<td>Lifestyle Medicine including Public Health &amp; Environmental Modifications</td>
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Exercise

With the person next to you, take 2.5 minutes each to find out the main factors that cause, or would cause you both to put on weight.

Or

the barriers for obtaining ideal weight

A. CONTENT: Determinants of Chronic Disease

* Level of evidence for ‘Metaflammatory Response – Independent of obesity

| N | Nutrition - excess energy, fat, sugar, salt; malnutrition etc. | *** |
| A | Activity - inactive leisure &/or work time; excessive sitting. | *** |
| S | Stress - ‘burn-out’, ‘brown out’; anxiety, depression. | *** |
| T | Technology-induced-pathology - adverse effects of technology. | *
| I | Inadequate Sleep – sleep disorders; sleep time. | *** |
| E | Environment - air pollution; endocrine disrupting chemicals, injury. | *** |

| M | Meaninglessness – ‘learned helplessness | *
| A | Alienation - from society | *
| L | Loss of culture/identity | *

| O | Occupation – shift work; occupation hazards etc | **
| D | Drugs and alcohol –iatrogenesis; recreational drugs. | ***
| U | Over exposure – sunlight, radiation. | **
| O | Under exposure - light, sunlight | **
| R | Relationships – support; social inequality etc | **
| S | Social inequality – ratio between rich and poor | ***
A Systems Approach to Chronic Disease

Medication and/or Monotherapy

LEANNESS/GOOD HEALTH — Diet/exercise etc.

MACRO ENVIRONMENT

A Systems Approach to Chronic Disease

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LEANNESS/GOOD HEALTH — Diet/exercise etc.

MACRO ENVIRONMENT

Components of Lifestyle Medicine

- Process - the ‘art’

(i.e. what are the principles/practices of changing these lifestyle/environmental Determinants?)
Components of a Lifestyle Medicine Approach

A. Content - the ‘science’

B. Process - the ‘art’

Clinical

1:1 Counseling
Brief Assessments
Brief interventions
Motivational Interviewing
Health coaching
Self-Management training

1:X Group visits (SMAs)
Self-help groups
Educational groups

Environmental

Advocacy
Protest
Policy change

DIGMA – Drop in Group Medical Appointment

SMA TEAM
Doctor
Facilitator
Practice Nurse
Documenter

“..comprehensive medical visits run in a supportive group setting of consenting patients with similar concerns.”
(eg. see www.groupvisits.com)
Where SMAs Fit

Clinical care
(1:1)
1 Doc; 1 Patient

Shared Medical Appointment
1 Doc; 1 Facilitator
6-12 patients

Group education
(1:X)
1 Educator; 15-20 patients

Increasing Outcomes

Evidence for Improvements of Group Visits over 1:1 consults for:

- Type 2 diabetes (Riley and Marshall, 2010)
- Heart disease (Masley et al., 2001)
- Hypertension (Kawasaki et al., 2007)
- Arthritis (. Shojania and Ratzlaff, 2010)
- The Disadvantaged (Clancy et al., 2003)
- Metabolic syndrome sufferers (Greer and Hill, 2011)
- Cancer recoverers (Visser et al., 2011)
- Children and their caregivers (Wall-Haas et al., 2012)
- COPD (Fromer et al., 2010)
- Obesity (Paul-Ebhoimhen and Avenell, 2009)
- The inadequately insured (Clancy et al., 2007)
Shared Medical Appointments

“...comprehensive medical visits run in a supportive group setting of consenting patients with similar concerns.”
Background to SMAs

• Began in the USA with Dr Ed Noffsinger (‘The ABC of group visits’ (2012); ‘Running group visits in your practice’ (2010))

• Used in the Netherlands, Italy and Norway to increase patient compliance (mainly Type 2 Diabetes)

• Thought not to be possible in Australia because of MBS rules, but trialled under an RACGP grant in 2013-14, with high patient and provider satisfaction

• Over 500 papers published now showing increased patient satisfaction and improvements over 1:1 clinical consults in a range of areas

Perceived Barriers to SMAs

**Barrier:** You can’t use Medicare item numbers to bill for a group consultation

**Barrier:** Patients will be concerned about confidentiality.

**Barrier:** Australians are different to Americans and are much more reticent to ‘open up’ in a group.

**Barrier:** Doctors are resistant to changing their ways after years of operating in the one fashion.

**Barrier:** There will be special attention from Government because of concern of over-servicing.

**Barrier:** There will be problems attracting patients.
Review

1. What does SOPIE stand for and what is it used for?

2. Why is it necessary for an SMA Facilitator to know the basics of Lifestyle Medicine?

3. What does the acronym NASTIE MAL ODOURS stand for?

4. What are ‘anthropogens’?

5. What are Shared Medical Appointments and why are they important in the modern health care system?