

GROUP MEDICAL VISITS FOR WOMEN WITH DIABETES: MGH EXPERIENCE



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Group Interventions for Medically Ill Patients

- Pratt in 1907 used educational model
- Since then groups used for medically ill patients for conditions such as asthma, diabetes, ulcerative colitis, multiple sclerosis, cancer, stress,
- Goodman (1989) reported improved compliance with medical regimens.



Groups for Medical Patients

- Evidence for benefits (Ulman, 1993)
 - Increased compliance
 - Increased adaptation to illness
 - Decrease in symptoms
 - Decrease in office visits, admissions
 - Improved blood pressure and blood glucose levels



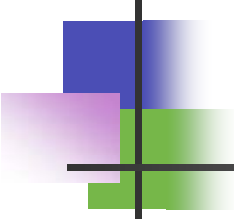
Rationale for Group Interventions for Medical Patients

Rationale for all group treatment is that people in groups are more suggestible and feel more powerful than outside the group and experience contagion and intensification of affect that helps them make desired changes



Rationale for Group Interventions for Medical Patients

Groups provide a unique opportunity to reduce shame and isolation associated with diabetes by bringing individuals together in a protected space and creating a healing community in which members can be validated. (Adapted from R. Klein)



Curative Factors in Groups for Medical Patients (Yalom, 2005)

- Instillation of hope
- Universality
- Imparting of information
- Altruism
- Imitative behavior



Curative Factors in Groups for Medical Patients

- Insight
- Group cohesiveness
- Catharsis
- Existential factors
- Reduction of shame



Models for Groups for Medical Patients

- Vary according to the goals and theoretical orientation of leader; can include:
 - **Didactic material**
 - **Teaching of behavioral techniques to manage symptoms**
 - **Open ended discussion of feelings and exploration of obstacles to change**



Models for Groups for Medical Patients

- Open-ended or time-limited
- Fixed membership or drop-in
- Some include family members
- Active leader vs. facilitator
- Varying levels of structure



Unique Aspects of Our Group Model

- Open-ended and time limited
- Flexible membership
- Moderately active leader
- Leader creates a group boundary or envelope by asking for confidentiality and promoting the development of group cohesion



Unique Aspects of Our Group Model

- Teaches behavioral techniques, as done in many medical and stress groups
- Session flows from moderate structure and teaching of relaxation, to open-ended discussion and exploration of feelings

Unique Aspects of Our Group Model

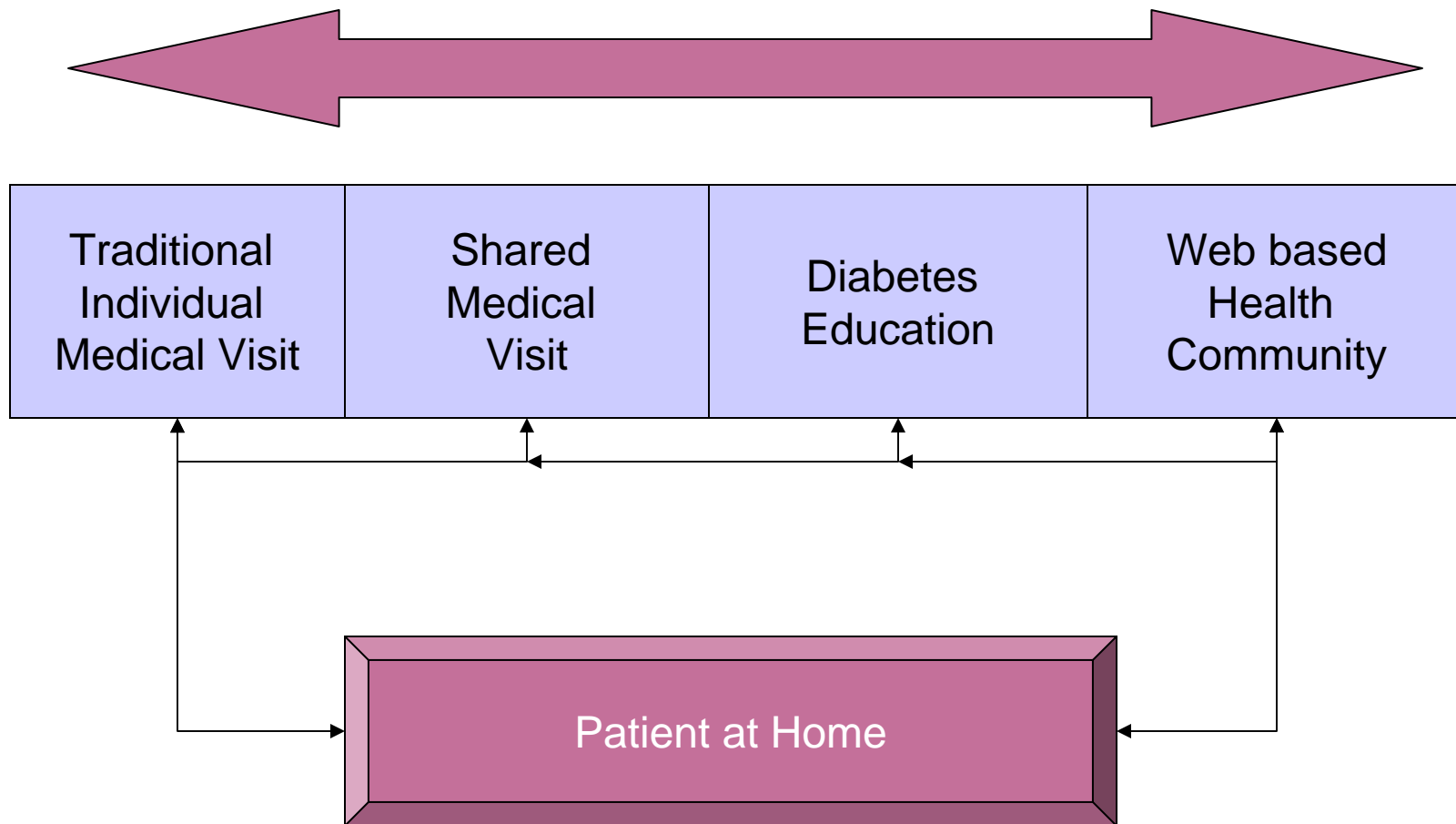


- Major emphasis is on open-ended discussion in which members are encouraged to reflect on and discuss internal obstacles to change



Diabetes Shared Medical Care: A Group Visit Model at MGH

The Continuum of Care





The Shared Medical Visit (Group Visit)

- Expert multi-disciplinary guidance
- Social support and community building
- Ongoing communication and feedback
- A focus on taking positive steps in an incremental way that get positively reinforced
- Create a safe environment that supports behavioral change together with ongoing medical care



WHA Diabetes Group Visit

- 2005- 2008, once a month, for 8 months/yr
- 2 ½ hour session at mid-day, at practice site
- Offered to 85-110/ 600 women with diabetes followed at Women's Health Associates, MGH
- Stable group of 7-15 women
- Sign a group medical release of information
- Billing:
 - MEDICAL: A Level 3 or 4 medical visit for each patient depending on complexity
 - PSYCHOLOGICAL: Charge for Group determined by # attendees (great than or less than 10 patients)



Diabetes Shared Visit: Format

- **Personal measurements:** supervised by NP/ MD of weight, BP and glucose with overview of personal glucose readings
- **Open forum:** to discuss stress factors related to monitoring/ testing, medications, meal planning and exercise
- **Education:** Short didactic portion by NP/MD, often with a giveaway to patient such as glucose monitoring device, foot cream
- **Medical Visit:** Mini-exam with documentation by MD/ NP including fundoscopic, cardiac, and foot exam
- **Group Discussion:** facilitated by psychologist
- **Group Planning:** for future sessions



Schedule

12:00 noon-12:15 PM: Patient check in and vital signs and/or blood will be drawn

12:15 PM-12:45 PM: Introduction to Program and Educational Topic of the Day

12:45- 1:00 PM: Lunch and the start of individual medical visits

1:00 PM-2:30 PM: Group discussion with psychologist and wrap up

Specific Topics for Diabetes Education



- **Home glucose monitoring:** with demonstration and sharing of logs
- **Medication review:** Insulin management, medication scheduling and interactions
- **Meal Planning and Weight loss Strategies:** Management of carbohydrate counting and portion size
- **Diabetes related topics:** Advertising and sugar substitutes, the impact of herbal remedies, sick day management, women's reproductive health
- **Exercise:** developing a realistic plan and how to use a pedometer
- **Stress and depression:** relationship between diabetes and depression



Pre-Program Descriptors

- Average age 60 years (N=30)
- 100% female
- 78% Caucasian/20% Afro American/ 2% Latino
- 96% Type 2 Diabetes
- 63% on insulin
- Years of Diabetes range from 1-15 years



Pre-Program HgbA1C

- Average HgbA1c 8.0%
- 57% had HgbA1c > 7%
(range 6.4-11.8%)
- 15% had HgbA1c > 9%



Pre-Program Risk Factors

- 13 % had cholesterol above target
- 60% were above ideal body weight, with 56% weighing > 200 pounds (range 154-329)
- 30% BP above target



Observations

- Patients liked the group, and preferred group size of 8-10
- Enjoyed more open discussion, rather than scripted presentations
- Depression was identified and treated in 30% of the participants
- Contacted each other after group for support



Outcomes

- There was a general downward trend in the average HgbA1c from 8.0% to 7.2%
- 50% of the women who participated lost weight, reporting that they were unable to loose weight prior to the program
- Average weight loss was 8 pounds over an 8 month period



Patient Comments

- “I told my doctor that everyone should take this program and I like the way you (the team) work with my doctor. I drove down all the way from Lynn, but it is worth it.”
- “You don’t know what to do. You can’t do this and you can’t do that. You feel trapped and nothing gets better...it’s great to talk to others who have the same problem”.
- “I know I am fat and I can’t lose weight. I feel so bad. I know I have to do something because I see the sugar going up and up. Something is different now...”



Observed Changes

- Increase in compliance with medication
- Bonding of group members; happy to see one another at each visit and sad when program ended
- Increase in involvement with education about diabetes. Many brought in articles from magazines and strategies to share
- Quick referral to diabetes specialists for vexing medical problems



Benefit to the Participant

- Develop confidence about self-management
- Experience real-time connections with others
- Understand how to make intelligent tradeoffs and address stressors
- Actively partake in promoting positive group reinforcement
- Learn diagnostic tools that can help them assess their own daily progress
- Identify clear strategies for achieving success in a time- and cost-effective way



Benefits to the Provider

- More personal contact with patients
- Better continuity of care
- Holistic approach to chronic care management
- Time effective
- Cost neutral



Summary

- If appropriate staff available, this is a good option to try for those with type 2 diabetes, especially for those trying to lose weight
- There are few restrictions in choosing which patients to invite to participate in a group
- One needs a critical size for the group, and the staffing to increase # groups offered



Summary

- Groups need to be tailored for the needs of non-English speaking patients, but in our experience level of literacy is not an issue
- More research needs to be done to study the impact of the shared medical visit on patient satisfaction and diabetes related health outcome measures

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