

# Diabetes Group Visits – A Collaborative & Supportive Approach to Patient Care

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# SUMMERVILLE

## Family Health Team

## BACKGROUND

Diabetes is an illness with a significant burden of care. Evidence-based guidelines state that care should be organized around patients with diabetes with a focus on self-management and supported by a multidisciplinary team. However, in current clinical practices of individual appointments with physicians, patients miss the opportunity of regular support from their peers and allied health providers, and may not get timely follow-up.

## AIM STATEMENT

To create an efficient, sustainable team-based model for routine diabetic visits that provides patients with:

- Routine screening as recommended by the CDA guidelines
- Individual time with their physician
- Diabetes education facilitated by an allied health professionals
- Peer learning and support
- Self-management coaching
- Engagement in self-monitoring of their chronic disease

## METHODS

The Etobicoke Site met regularly to plan, develop and implement the Group Visit model. It was developed using the following tools:

- **Review of group visit models in other FHTs**
- **Environmental Scan – reflected on Clinical Experience** for inefficiencies in current practice and identified gaps in care:
  - Several patients do want to go to the Diabetes Education Centre
  - Not all patients require intense one-on-one education
  - Inefficiencies in one-on-one visits
- **Review of the CDA guidelines** as to how often process measures are suggested to be done compared to how often they were actually being done in practice.
- Use of **EMR** to generate a list of patients with diabetes, including teasing out those who were uncontrolled, have not been in for follow-up, or with Type 1 or gestational diabetes.

Throughout implementation, we regularly used PDSA cycles to reflect on what was working and what needed further improvement, and kept sustainability in mind through the planning process.

## INTERVENTION

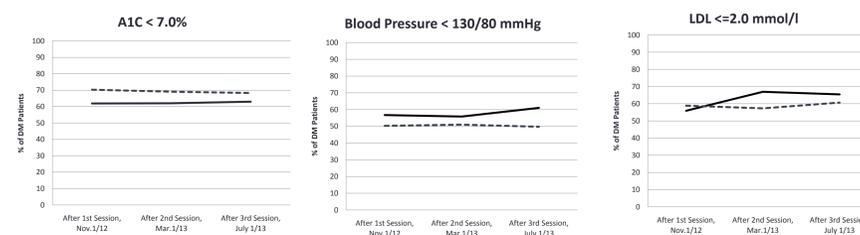
Patients attend a 1.5 hour Group Visit every 4 months, led by an allied health professional. The visit includes:

<b>15 min prior to Group</b>	<b>Vitals:</b> BP (single BP or BpTRU if not at target), height, weight, waist circumference and/or foot exam		<b>Nurse(s)</b>
<b>10 min</b>	<b>Introductions:</b> 1 <sup>st</sup> Visit: Outline, signing confidentiality forms Subsequent visits: Report on progress re: self mgmt goal		<b>MD/ Facilitator(s)</b>
<b>10 min</b>	<b>Diabetes Passport:</b> Patients handed copy of blood work and fill out Diabetes Passport, learn to monitor trends		<b>Facilitator(s)</b>
<b>60 min</b>	<b>Educational Session</b> <i>Examples:</i> Conversation Map: How Diabetes works?, Carbohydrate Counting, Medications, Foot Care, Diabetes Burnout, Exercise <b>Self Management Goal</b>	<b>Facilitator(s)</b>	<b>Individual visit with Physician</b> Review bloodwork, medication renewals, address questions, referral to allied health providers if necessary
<b>5 min</b>	<b>Wrap up:</b> - 4 month follow-up appt. scheduled in Passport - Given next required blood work requisition.		<b>Facilitator(s)</b>

## OUTCOMES

**Participation from July 2012 – present:** 140 Individuals and 415 Patient Visits

**Clinical Outcome Measures:**



— Participants, n = 137

- - - Non-participants, n = 466

## OUTCOMES

**Process Measures:**



**Qualitative Measures:**

- **83%** of respondents (n= 72) agreed or strongly agreed that “Today’s visit will help me manage my diabetes better.”
- Patients report (n =66) what they like the most is:
  - **Information & better understanding of diabetes**
  - **Discussion and learning from others**
  - **Social support**

**Patient Feedback:**

*“I don’t feel alone in this.”      “This will help me stay on track.”*

*“Glad I was with the group when I was told to go on pills.”*

## DISCUSSION & CONCLUSIONS

After a 1 year pilot, results show a high level of patient satisfaction and peer support, an increase in self-management behaviours (such as monitoring trends), a significant improvement in the timeliness of diabetes tests and favorable preliminary results for Blood Pressure and LDL outcomes. These group visits demonstrate multidisciplinary collaboration and provide a promising approach to optimal care of patients with diabetes.

**Etobicoke Site:**

Jean Ann Carscadden, MSW, RSW; David Daien, MD; Luisa DeAcetis; Ayesha Hussain, MD; Martin Kates, MD; Pari Oza, MD; Jeannette Palframan, RPN; Anita Park, NP; Cadi Reece, MD; Darren Sukerman, MD; Lori Trofymowych, RN; Lorrie Waddell