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STFM: The 28th Forum for Behavioral Science in Family Medicine
Category: Seminar

"Harnessing the Cascade of Change in Family Medicine: The Critical Role of Behavioral Science."

September 27-30, 2007
Hilton Suites Chicago Magnificent Mile
198 Delaware Place, Chicago, Il

Submitted Proposal from St Peter Family Medicine Residency, March 7, 2007

Title:

Rebuilding Chronic Care Three Patients at a Time

Presenter:

Devin Sawyer, MD

Abstract:

Although more and more people live with chronic disease, the current primary care structure is ill-equipped to manage these patients under its traditional acute care, symptom based system of medicine. Because much of disease management depends on patient behaviors and skills, self management support is essential for long term success. Recent literature has shown that group visits are promising approaches to chronic care that may be as or more effective than traditional methods, and can incorporate patient self-management support. With adequate planning mini-group visits emerge as promising alternatives to chronic care management.

Description of Session:

Mini-group visits occur when a physician meets with three patients at a time with the same chronic illness (i.e. diabetes mellitus) for approximately one hour. Blood pressure, HbA1c, weight, LDL, medications, history, challenges and successes are discussed. Though the purpose of the mini-group visit is medical care, patients experience peer support and increased confidence to manage their disease. We have learned that patient health outcomes, patient empowerment and satisfaction are better when there is a comprehensive program of care built around a proactive team in which patients have multiple opportunities to share their stories and explore solutions to their stressors with others. Patients appreciate being involved in their health care and follow through is more likely when they "own" the plan. The goal setting process incorporated into the mini-group visit allows for two way dialogue between the patients and providers, making the patient-provider relationship more of a partnership. Consequently, patients feel better

equipped and more empowered to manage their health, and feel more accountable when the care is shared with similar patients.

Objectives:

At the end of this lecture, participants will be able to:

1. Understand that primary care is becoming more about chronic care than acute care.
2. Recognize self-management as the trend in primary care and the solution to chronic disease.
3. Explain how mini-group visits support self-management, can be incorporated into practice, and taught to resident physicians in training.

Project Evaluation:

Data over a 3 year period showed that patients that participated in group medical visits and set goals had lower HbA1c's than the clinic average and that difference increased over time. Cholesterol data was also very encouraging with the clinic LDL average decreasing from first to last measure from 116 to 101.6. Documented self management goal setting increased from an initial 37% to 78%. Patient survey data suggested that patients began to value and trust the medical assistants more, describing them as "critical members of the health care team". Patients felt well cared for, better supported, and more successful and confident.

The theme of the 2007 Forum is: Harnessing the Cascade of Change in Family Medicine: The Critical Role of Behavioral Science. What change or challenge affecting Family Medicine does your proposal address?

Over the last 30 years, chronic disease in the U.S. has significantly increased, affecting 90 million Americans and accounting for 70% of all U.S. deaths. Chronic illnesses including heart disease, stroke, diabetes, cancer and HIV account for more than 75% of the nation's $1.4 trillion medical care costs and one-third of the years of potential life lost before age 65. Although more and more people live with chronic disease, the current primary care structure is ill-equipped to manage these patients under its traditional acute care, symptom based system of medicine. As a result, primary care organizations continue to experience suboptimal patient health outcomes, missed opportunities to maximize care, and greater medical costs. To answer these challenges, the medical community has been challenged to create new models and approaches to chronic care. Recent literature has shown that group visits are promising approaches to chronic care that may be as or more effective than traditional methods, and can incorporate patient self-management support. Group visits work especially well when patients are motivated and medical providers are prepared and have sufficient time. Published data suggests that, in the short term, group care improves metabolic control and, over time, prevents deterioration of metabolic control and quality of life. The key is patient engagement and participation.